



# **Doral Dental Services of Illinois, LLC**

**Effective January 1, 2007**

## **Dental Office Reference Manual**

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Mequon, WI 53092  
888.281.2076  
Fax 262.241.7401  
[www.doralusa.com](http://www.doralusa.com)

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**Doral Dental Services of Illinois, LLC  
Address and Telephone Numbers**

**Doral Dental Services of Illinois, LLC**

**Customer Service**

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

**Information Systems**

12121 North Corporate Parkway  
Mequon, WI 53092  
1.888.875.7482

**Prior Authorization/Retrospective Review**

12121 North Corporate Parkway  
Mequon, WI 53092  
1.888.875.7482  
Fax: 262.241.7150  
Email: ddusa\_um@doralusa.com

**Prior Authorizations and Retrospective  
Reviews should be sent to:**

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

**Dental claims should be sent to:**

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

**Electronic files or diskettes should be sent  
to:**

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

**Provider Relations (Claims Questions)**

12121 North Corporate Parkway  
Mequon, WI 53092  
1.888.875.7482  
Fax: 262.241.7379  
Email: denclaims@doralusa.com

IL Department of **Healthcare and Family  
Services (HFS)**

201 South Grand Avenue East  
Springfield, IL 62763  
1.217.524.7478

HFS Provider Hotline  
1.800.842.1461

HFS Beneficiary Hotline  
1.800.226.0768

TTY (Hearing Impaired) Hotline  
1.877.204.1012

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

Fair Hearings (Appeals)  
Healthcare and Family Services  
Bureau of Administrative Hearings  
401 South Clinton Street, 6<sup>th</sup> floor  
Chicago, IL 60607  
1.800.435.0774

Fraud Hotline  
1.800.252.8903

TTY (Hearing Impaired) Fraud Hotline  
1.800.447.6404

HFS Primary Care Case Management  
Phone: 1-877-912-1999  
Website: [www.illinoishealthconnect.com](http://www.illinoishealthconnect.com)



## **Doral Dental Services of Illinois, LLC**

### **Statement of Beneficiary Rights and Responsibilities**

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

1. All Beneficiaries have a right to receive pertinent written and up-to-date information about Doral, the services Doral provides, the participating dentists and dental offices, as well as Beneficiary rights and responsibilities.
2. All Beneficiaries have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care, which is a private and personal service.
3. All Beneficiaries have the right to fully participate with caregivers in the decision making process surrounding their health care.
4. All Beneficiaries have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
5. All Beneficiaries have the right to voice a complaint against Doral, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Beneficiary's expectations.
6. All Beneficiaries have the right to appeal any decisions related to patient care and treatment.
7. All Beneficiaries have the right to make recommendations regarding Doral's/Healthcare and Family Service's Beneficiary rights and responsibilities policies.

Likewise:

1. All Beneficiaries have the responsibility to provide, to the best of their abilities, accurate information that Doral Dental and its participating dentists need in order to provide the highest quality of health care services.
2. All Beneficiaries have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
3. All Beneficiaries, have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.



## Doral Dental Services of Illinois, LLC

### Statement of Provider Rights and Responsibilities

Enrolled Participating Providers shall have the right to:

1. Communicate with patients, including Beneficiaries regarding dental treatment options.
2. Recommend a course of treatment to a Beneficiary, even if the course of treatment is not a covered benefit, or approved by Healthcare and Family Services/Doral.
3. File an appeal or complaint pursuant to the procedures of Healthcare and Family Services /Doral.
4. Supply accurate, relevant, factual information to a Beneficiary in connection with a complaint filed by the Beneficiary.
5. Object to policies, procedures, or decisions made by Healthcare and Family Services /Doral.

Likewise:

1. If a recommended course of treatment is not covered, e.g., not approved by Healthcare and Family Services/Doral, the participating dentist, if intending to charge the Beneficiary for the non-covered services, must notify the Beneficiary. See Section 2.01 of the DORM.
2. A provider intending to terminate participation in the HFS dental program due to retirement, relocation or voluntary termination is requested to provide Doral with written notification of termination at least 90 days prior to expected final date of participation. A list of existing Illinois All Kids/HFS Dental Program patients currently in treatment and the treatment status should accompany the notification. All other HFS patients should be referred to the Doral's toll free referral number (1.888.286.2447) to find another dentist in the area taking referrals when services are needed.
3. A provider may not bill both medical and dental codes for the same procedure.

\* \* \*

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

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## 1.00 Beneficiary Eligibility Verification Procedures and Services to Beneficiaries

### 1.01 Beneficiary Identification Card

HFS Beneficiaries are issued identification cards monthly.

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

Doral recommends that each dental office make a photocopy of the Beneficiary's identification card each time treatment is provided. It is important to note that the identification card does not need to be returned should a Beneficiary lose eligibility. **An identification card guarantees that a Beneficiary is currently enrolled in the HFS Medical Benefits Program for the dates identified on the card.**

If medical coverage is restricted in any way, a printed message will appear on the front of the card. Examples of these printed restriction messages include:

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

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

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

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

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

### 1.02 Handbook for Providers of Medical Services

The Department's *Handbook for Providers of Medical Services* is available for your review at <http://www.hfs.illinois.gov/handbooks/>. Please refer to Chapter 100 (General Policy and Procedures), provider information necessary for providers to receive payment from the Department. If you do not have access to the Internet, please call 217.782.0538 or 217.524.7306 to request a copy of the handbook.

### 1.03 Doral Eligibility Systems

Enrolled Participating Providers may access Beneficiary eligibility information through:

- 1) Doral's Interactive Voice Response (IVR) system (eligibility hotline at 888.875.7482)
- 2) the "Providers Only" section of Doral's website at [www.doralusa.com](http://www.doralusa.com)



- 3) Affiliated Network Services' (ANS) website at [www.ANSlink.com](http://www.ANSlink.com)
- 4) Doral's Customer Service Department at 888.281.2076

The eligibility information received from either system will be the same information you would receive by calling Doral's Customer Service Department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

#### **Access to eligibility information via the IVR line**

To access the IVR, simply call Doral's Customer Service Department at 888.875.7482 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Beneficiaries as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Beneficiary history, which you may have. Using your telephone keypad, you can request eligibility information on a HFS Beneficiary by entering your 6 digit Doral location number, the Beneficiary's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Beneficiary information you entered, you will be transferred to a Customer Service Representative.

#### **Directions for using Doral's IVR to verify eligibility:**

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

#### **Access to eligibility information via [www.doralusa.com](http://www.doralusa.com)**

Doral's website currently allows Enrolled Participating Providers to verify a Beneficiary's eligibility as well as submit claims directly to Doral. You can verify the Beneficiary's eligibility on-line by entering the Beneficiary's date of birth, the expected date of service and the Beneficiary's identification number or last name and first initial. To access the eligibility information via Doral's website, simply log on to the website at [www.doralusa.com](http://www.doralusa.com). Once you have entered the website, click on "Doral Dental USA" and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their 6 digit Doral Location ID, office name and office address. Please refer to your payment remittance or contact Doral's Customer Service Department at 888.875.7482 to obtain your location ID.

Once logged in, select “eligibility look up” and enter the applicable information for each Beneficiary you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

**Access to eligibility information via [www.ANSLink.net](http://www.ANSLink.net)**

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

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

[info@affnetserv.com](mailto:info@affnetserv.com)

**Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.** If you are having difficulty accessing either the IVR or websites, please contact the Customer Service Department at 888.875.7482. They will be able to assist you in utilizing either system.

**1.04 All Kids/HFS Dental Program Copayments**

Eligibility cards authorizing services are issued in generally the same manner as the MediPlan Card, except that the All Kids card is canary yellow in color. The card will indicate All Kids and will be issued on a monthly basis. Some Beneficiaries will have copayment responsibilities. Copayment amounts will be noted on the eligibility card. The copayment amount is in addition to state reimbursement for the procedure and is collected at the dentist’s discretion. If the family has reached the maximum, it will be printed on the eligibility card (or the Beneficiary may have a written notice stating this) and no copayment should be collected. Please see **Attachment X** for a full list of Beneficiary Copayments.

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

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

**1.05 Expanded Dental Services for Certain Beneficiaries**

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

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

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

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

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

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

#### **1.06 Transportation Benefits for Certain Beneficiaries**

Members who need assistance with transportation should contact Doral's customer service department directly at 888.286.2447.

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

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

Please note: If a Beneficiary is seeing a specialist and he/she needs transportation, the Beneficiary must have a written referral from a general dentist. There are **no specific forms**. The general dentist may simply provide a notation of treatment required on office 'letter head'. This written referral is required by HFS' transportation contractor and HFS in order for the Beneficiary to receive transportation to go to the Specialist.

#### **1.07 Consent Process for DCFS Wards**

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

As a general rule, DCFS and private agency caseworkers should be the contact for obtaining a consent. If you have not been given a signed consent for providing care to a DCFS ward, please speak with the child's caseworker (or have the foster parent speak with the caseworker) about the need for a signed consent appropriate for the type of care being provided. For a consent involving medical/surgical treatment, please be prepared

to give detailed information upon request regarding the procedure, including its risks and benefits.

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

**1.08 All Kids/HFS Dental Program Brochures**

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

[www.doralusa.com](http://www.doralusa.com).

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

**1.09 Doral Customer Service Numbers**

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

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

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

## 2.00 Covered Benefits

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

<u>Coverage</u>	<u>Attachment</u>
Children	X
Adult	Y

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

HFS Beneficiaries are to be allowed the same access to dental treatment as any other patient in the dental practice. **Enrolled Participating Providers are not allowed to charge Beneficiaries for missed appointments.** Pursuant to Section 140.12(h) of the Illinois Administrative Code, payment made must be accepted as payment in full for covered services. Private reimbursement arrangements may be made only for non-covered services.

### Missed Appointments

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

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

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

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

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

**If an HFS Beneficiary exceeds your office policy for missed appointments and you choose to discontinue seeing the patient, please inform them to contact Doral for a referral to a new dentist.**

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

**888.281.2076**

Doral recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the patient’s file for record retention and review. Patient records must be kept for a minimum of 7 years and must be available in a paper form for at least the first two years. **All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.**

For reimbursement, Enrolled Participating Providers should bill only per unique surface regardless of locations. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA procedure code D2140. Furthermore, Doral will reimburse for the total number of surfaces restored per tooth, per day; (i.e. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration). When submitting claims, always indicate your billed charges. Doral will reimburse you for approved covered services at the lesser of your billed charges or the approved HFS fee.

The Doral claim system can only recognize dental services described using the current American Dental Association CDT code list **or** procedure codes as defined by HFS. All other procedure codes not contained in the following tables will be rejected when submitted for payment. A complete copy of the current CDT book can be purchased from the American Dental Association at the following address:

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

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

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

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

## 2.01 Payment for Non-Covered Services

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

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

Doral encourages Enrolled Participating Providers to obtain this agreement in writing, and on the date the service(s) is/are rendered, when possible.

## 2.02 Electronic Attachments

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

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

For more information or to sign up for FastAttach go to [www.nea-fast.com](http://www.nea-fast.com) or call NEA at 800.782.5150.

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

For more information or to sign up for **OrthoCAD™** go to [www.orthocad.com](http://www.orthocad.com) or call **OrthoCAD™** at 800.577.8767.

### 3.00 Prior Authorization, Retrospective Review, and Documentation Requirements

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

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

#### Procedures Requiring Prior Authorization

Doral has specific dental utilization criteria as well as a prior authorization and retrospective review process to manage the utilization of services. Consequently, Doral's operational focus is on assuring compliance with its dental utilization criteria.

One method used on a limited basis to assure compliance is to require providers to supply specified documentation prior to authorizing payment for certain procedures. **Services that require prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for non-emergency services. Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Beneficiary, the State of Illinois or any agents, and/or Doral.**

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

Requests for prior authorization should be sent with the appropriate documentation on a standard ADA approved claim form. **The tables of covered services, Attachments Y and Z, contain a column marked Prior Authorization Required. A "Yes" in this column indicates that the service listed requires prior authorization to be considered for reimbursement.** There is also a column that indicates what documentation, in addition to the completed claim form, needs to be submitted for consideration.

Any claims or Prior Authorizations submitted without the required documentation will be denied and must be resubmitted to obtain reimbursement.

The basis for granting or denying approval shall be whether the item or service is medically necessary, whether a less expensive service would adequately meet the Beneficiary's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community.

During the prior authorization process it may become necessary to have your patient clinically evaluated. If this is the case, you will be notified of a date and time for the examination. It is the responsibility of the participating dentist to ensure attendance at this appointment. Patient failure to keep an appointment will result in denial of the treatment.



### **Retrospective Review**

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

After the Doral Consultant reviews the documentation, an authorization number will be provided to the submitting office for their records. **This authorization number will normally be provided within ten business days from the date the documentation is received.**

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

#### **4.00 Dental Services in a Hospital Setting**

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

##### **Patient Criteria**

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

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

##### **Dental Billing Procedures**

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

##### **Hospital/ASTC Billing Procedures**

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

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

##### **Participating Hospitals/ASTCs**

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

## 5.00 Claim Submission Procedures (claim filing options)

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

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

### 5.01 Electronic Claim Submission Utilizing Doral's Internet Website

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

To submit claims via the website, simply log on to [www.doralusa.com](http://www.doralusa.com). Once you have entered the website, click on "Doral Dental USA", and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their Doral 6 digit Location ID prior to logging in. Once logged in, select "enter a claim now" and enter the Beneficiary's applicable information in the field provided. It is NOT necessary to enter the Beneficiary's last name and/or first initial; only the identification number, date of birth, and date of service are required. Next you will click on the word "before" that appears below the Beneficiary's DOB field to verify eligibility and populate the name fields automatically. Once this information is generated you may now begin to enter the claim line detail to complete the submission.

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

[operations@doralusa.com](mailto:operations@doralusa.com)

### 5.02 Electronic Claim Submission via Affiliated Network Services (ANS)

Enrolled Participating Providers may also submit claims to Doral through the ANS' website at [www.info@ANSDirect.com](http://www.info@ANSDirect.com). Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Beneficiary's eligibility prior to providing the service. When online, type [www.info@ANSDirect.com](http://www.info@ANSDirect.com) into the web browser. This will take you to the screen that allows you to enter the ANSLink® system. After pressing the enter button, the log-in screen will appear. If the office signing-in has a user ID and password, that information is entered in the appropriate spaces. If it is the first time for an office using the system, the "NEW OFFICE" button is selected, which will take the user through a step-by-step registration process to gain access into ANSLink®.

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

[info@affnetserv.com](mailto:info@affnetserv.com)

### 5.03 Electronic Claim Submission via Clearinghouse

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

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

#### **5.04 HIPAA Compliant 837D File**

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

#### **5.05 Paper Claim Submission**

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

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

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

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

- The treating Provider's name;
- The location in which the treatment occurred;
- The billing (business office) location; and
- The treating Provider's Doral Provider ID or Illinois License #.

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

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

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

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

Claims should be mailed to the following address:

DDS of Illinois - Claims  
12121 N. Corporate Parkway  
Mequon, WI 53092

## **5.06 Claims Adjudication and Payment**

Doral's system adjudicates all claims automatically on a weekly basis. It also has the ability to automatically update individual and family claim history, perform claim payment calculations, calculate and update co-payment/deductible accumulations, and track benefit maximums and frequency limits.

The Claim Adjudication Module serves as Doral's primary claims processing tool. The average turn around time between receipt of the claim and adjudication is 14 days. During this 14-day period, Doral's Claims Adjudication Module imports the data, edits the data for completeness and correctness, analyzes the data for clinical and coding correctness/appropriateness, and audits against product and benefit limits. Once these edits are complete, a remittance summary and check is printed. This occurs every Friday.

Payments are released on a weekly basis, but this is dependent upon funding from the State of Illinois and is subject to a 30-day lag. In other words, a check cut on August 6, 2007, will not be released until September 6, 2007.

## 6.00 Inquiries, Complaints and Appeals

Doral Dental Services of Illinois, LLC, is committed to providing high quality dental services to all Beneficiaries. As part of this commitment, Doral supports a complaints and appeals protocol that assures that all Beneficiaries have every opportunity to exercise their rights to a fair and expeditious resolution to any and all inquiries, complaints and appeals. Towards that end, Doral has developed a procedure to meet the following goals:

- To ensure that Beneficiaries receive a fair, just and speedy resolution to inquiries, complaints and appeals;
- To allow Beneficiaries to be treated with dignity and respect at all levels of the complaints and appeals resolution process;
- To inform Beneficiaries of their full rights as they relate to complaints and appeals resolution, including their rights of appeal at each step in the process;
- To have Beneficiary complaints and appeals resolved in a satisfactory and acceptable manner within the Doral protocol;
- To comply with all regulatory guidelines and policies with respect to Beneficiary inquiries, complaints and appeals; and
- To efficiently track the resolution of provider related complaints, so as to be able to track continuing unacceptable patterns of care over time.

Doral Dental Services of Illinois, LLC provides customer services, the primary purpose of which is to insure Beneficiary access to information, services, and assistance on issues affecting their coverage. The designated complaint coordinator is dedicated to the expedient, satisfactory resolution of Beneficiary inquiries, complaints and appeals.

### Inquiry

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

Customer Service Representatives are trained to respond in a prompt and courteous fashion, and to resolve any surrounding issues in an expedient manner. Customer Service Representatives have at their disposal all internal resources of Doral to insure prompt resolution of any problems. If specific corrective action is requested by the Beneficiary or determined to be necessary by Doral, then the inquiry is upgraded to complaint.

### Complaints

A complaint is any issue a Beneficiary presents to Doral either orally or written, which is subject to informal resolution by panel within a 30-day period.

Doral uses the following approach to resolve all Beneficiary complaints within a 30-day period:

- A. When a complaint is received by any representative of Customer Services, either orally or in writing, it will be forwarded to the Doral Complaint Representative as quickly as possible.
- B. The Complaint Representative will then assign the appropriate trending code and will make every effort to resolve the complaint on an immediate basis, (within 24 hours whenever possible). The Complaint Representative will handle the complaints themselves, or identify the appropriate Doral personnel, and forward the complaint to that department requesting resolution within three days. The Complaint Representative will do appropriate follow-up as needed to ensure expedient handling and to keep the Beneficiary informed as to the stage of investigation and resolution.
- C. If the Beneficiary chooses to appeal the decision, the Customer Services Representative will assist them by providing the information on how to initiate the appeals process.

D. For any complaints involving a provider, a copy of the complaint and all attachments will be forwarded to the Credentialing Department and placed in the provider file.

E. The toll free number to call to file a complaint is:

1.888.875.7482

F. The address to file a complaint is:

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

**Appeals**

A. Beneficiary Appeals

A Beneficiary may contact his/her caseworker for assistance in filing an appeal concerning the denial of benefits under the Dental Program. In addition, the Illinois Department of Human Services will help a Beneficiary file an appeal. Beneficiaries must file an appeal within 60 days following the date the denial letter was mailed by Doral. Beneficiaries can ask for a hearing by calling the Fair Hearings Section at 1.800.435.0774 (TTY: 312.793.2697 or 800.526.0857) or by writing to Healthcare and Family Services, Bureau of Administrative Hearings, 401 South Clinton Street, 6<sup>th</sup> floor, Chicago, IL 60607.

A Beneficiary may appeal any Doral decision that denies or reduces services. Such appeals will be reviewed by HFS under its existing administrative appeal procedure.

Once Healthcare and Family Services is notified, they will forward a request for additional information to Doral. Doral will have seven (7) days to provide the hearing office with a report of the incident cited.

The matter will be heard before an Administrative Hearing Officer. Doral will provide and pay for any services which the Department or any Court of any jurisdiction orders rendered, provided the Beneficiary is eligible.

Doral assists HFS in preparing for dental appeals and shall make expert testimony available.

B. Dentist Appeal Procedures

In the operation of the Doral program, differences may develop between Doral and the dentist concerning the decision regarding the Prior Authorization Option and payment for service. Since many of these problems result from misunderstanding of processing policy, service coverage or payment levels, thorough acquaintance with Doral will help prevent such problems. Doral provides the following mechanism for resolving these differences.

**To request reconsideration the provider may call or write:**

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

**If the problem cannot be resolved at this level, the dentist shall be requested to submit his appeal for reevaluation in writing.**

**C. Request for Reevaluation**

The provider's request for reevaluation must be in writing with complete documentation that includes identifying the Attending Dentist's Statements and specifically describes the disputed action or inaction. If the request refers to an action by a Doral Dental Consultant, the request will be considered by the Reevaluation Committee. This committee shall make a decision based upon the available information, Doral processing policies, and applicable state regulation, or they may refer the problem to a regional consultant (a practicing dentist who has been selected by Doral on the recommendation of a component dental society) for review and recommendation. The Doral Reevaluation Committee shall make a final review of the request based on all information obtained and send a written report of the conclusion to the dentist within 60 days of the acknowledgement of receipt of all required information.

**D. Quality Control/Peer Review**

Doral has formed a Peer Review Committee composed of the Doral Dental Director, HFS dental consultants, and a minimum of five participating dentists that submit at least 25 All Kids/HFS Dental Program claims per year. The Committee evaluates the operational procedures and policies as they affect the administration of the All Kids/HFS Dental Program. In addition, the Committee is involved in reviewing Attending Dentists Statements with respect to pre-treatment estimates and actual services rendered. Finally, the Peer Review committee is responsible for evaluating the care provided under this program. Various methods are used to identify those dentists whose services do not conform to standards deemed acceptable by Doral. Claim forms, analysis of Beneficiary complaints, utilization of certain procedures or excessive treatment will identify those providers who are delivering services to Beneficiaries when those services may not be in the best interest of the dental health of the Beneficiary.

The goal of the Peer Review Committee is to provide guidelines for the assessment of clinical quality and professional performance as well as guidelines for reviewing services provided by dentists. By communicating problem areas to the dentist, Doral shall provide a framework for correction so that questionable practice patterns may be eliminated. Thus, Doral's program is geared to take corrective action before abuses in the system affect the Beneficiary.

The data from the claim forms shall be entered into Doral's computer system to permit assessment of treatment plans as well as the quality of care. To that end, Doral plans to conduct various dental evaluation studies during the course of each year to address a clinical problem or diagnostic category and from its findings, recommend changes in the program. Thereafter, a follow-up study shall be done to assess the effect of any program changes.



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

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

**6.01 Receipt and Audit of Claims**

In order to ensure timely, accurate remittances to each dentist, Doral performs an edit of all claims upon receipt. This edit validates Beneficiary eligibility, procedure codes and provider identifying information. A Regional Benefit Analyst dedicated to Illinois dental offices analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact Doral's Provider Relations Department at 888.281.2076 with any questions you may have regarding claim submission or your remittance.

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

If a dentist wishes to appeal any reimbursement decision, they need to submit an appeal in writing, along with any necessary additional documentation within 60 days to:

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

Doral will have 30 days to respond in writing to the dentist with outcome of the appeal. This notice will contain the information necessary to appeal this decision. To validate accuracy, on a monthly basis Doral will perform an audit of a statistically significant sample of all the claim forms entered and adjudicated in the prior month.

**7.00 Health Insurance Portability and Accountability Act (HIPAA)**

As a healthcare provider, if you transmit any health information electronically your office is required to comply with all aspects of the HIPAA regulations that have gone/will go into effect as indicated in the final publications of the various rules covered by HIPAA. The compliance dates for the various HIPAA rules are as follows:

- Privacy Standards – April 14, 2003
- Administrative Simplification Standards – October 16, 2003 (If you filed for the one year extension beyond the initial October 16, 2002 date).
- Security Standards – April 21, 2005

Doral has implemented various operational policies and procedures to ensure that it is compliant with the Privacy Standards as well. Doral also intends to comply with all Administrative Simplification and Security Standards by their compliance dates. One aspect of our compliance plan will be working cooperatively with providers to comply with the HIPAA regulations.

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

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

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

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

**8.00 Utilization Management Program**

**8.01 Introduction**

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. The Illinois State Legislature annually appropriates or “budgets” the amount of dollars available for reimbursement to dentists for treating Illinois HFS Beneficiaries. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. The fair and appropriate distribution of these limited funds is critical.

**8.02 Community Practice Patterns**

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

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

**8.03 Evaluation**

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

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

**8.04 Results**

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

### **8.05 Fraud and Abuse**

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

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

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

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

Doral is contractually obligated to report suspected fraud, abuse or misuse by Beneficiaries and Participating Dental Providers to Healthcare and Family Services Office of Inspector General and/or the Illinois Department of Financial and Professional Regulation.

## 9.00 Quality Improvement Program (Policies - 200 Series)

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

- Beneficiary satisfaction surveys
- Provider satisfaction surveys
- Complaint Monitoring and Trending
- Peer Review Process
- Utilization Management and practice patterns
- Quarterly Quality Indicator tracking

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

[denclaims@doralusa.com](mailto:denclaims@doralusa.com).

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

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

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

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

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

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

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

## 10.00 Preventive Dental Services Provided Out-of-Office “School Services”

Recognizing the challenges presented to providers participating in Out-of-Office delivery of services, unique protocols have been developed for this aspect of the All Kids/HFS Dental Program.

### 10.01 Participation Guidelines and Forms

Providers who wish to participate as a School Services Provider must meet the following requirements:

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

The process for provider enrollment is outlined in Attachment H.

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

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

**3. School Providers must complete a School Provider Registration application. (Attachment Q)**

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

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

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

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

**4. School Providers must complete an Illinois Department of Public Health School Exam Form for every child seen. (Attachment S)**

A copy of this form can be found on the Illinois Department of Public Health Website at: <http://www.idph.state.il.us/HealthWellness/oralhlth/DentalExamProof.pdf>

**5. School Providers must complete a School Exam Follow-up Form (to be sent home with student) for every child seen. (Attachment R )**

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

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

- 6. School providers must complete and submit a roster of the Beneficiaries seen at every school based event to HFS. This roster must include each Beneficiary's "Oral Health Score" , as assigned on the School Exam Follow up Form. The roster must follow the format outlined in Attachment T.**

The completed roster must be submitted within 30 days after the event to the following address:

Illinois Department of Healthcare and Family Services  
ATTN: Dental Program Manager  
201 South Grand Avenue East  
Springfield, IL 62763

- 7. School providers must complete and maintain a dental health record for each Beneficiary receiving school based services. This record must include, but is not limited to the following information:**

- Beneficiary's name and birth date
- Beneficiary's All Kids/HFS Dental Program Recipient ID#
- School Information (Name and address of where services were rendered)
- Pathology observed
- Listing of services provided (including tooth # for sealants)
- Follow-up treatment required or recommended
- Date of Service
- Name and signature of treating Provider

- 8. School providers must obtain a permission slip for each Beneficiary prior to providing services.**

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

In accordance with the Illinois Department of Public Health's policy, signed permission slips are valid for 365 days from the date of parent/guardian signature.

Standard school forms will be completed for all Beneficiaries receiving an exam. In cases where the facility being visited is a school, a copy of the form will be directly forwarded to the school and a copy given to the Beneficiary. In other situation the form will be given to the Beneficiary only. Please visit the State website for more information:

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

Providers who do not adhere to any portion of the above requirements for participation may not be eligible for reimbursement.

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

**10.02 Place of Service (POS) Definition**

Group prevention may be performed in a school setting or other location. Services designated as "school" are those that are limited to the four preventive codes. In this situation the treating provider does not provide the full scope of dental services (restorative, diagnostic, etc.).

**10.03 Designating a POS on a Claim**

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

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




## ATTACHMENT A


### General Definitions

The following definitions apply to this Dental Office Reference Manual:

- A. **“Covered Services”** is a dental service or supply that satisfies all of the following criteria:
- provided by an Enrolled Participating Provider to a Beneficiary;
  - authorized by Doral in accordance with the Provider’s Certificate of Coverage; and
  - submitted to Doral according to Doral’s filing requirements.
- B. **“Doral”** shall refer to Doral Dental Services of Illinois, LLC.
- C. **“Enrolled Participating Provider”** is a dental professional or facility or other entity that has entered into a written agreement with Healthcare and Family Services (HFS) through Doral to provide dental services. Any dentist providing services to Beneficiaries of a HFS Medical Benefits Program is required to be enrolled with the Department (89 IL ADC 140.23). The provider of service must bill as the treating dentist. The provider of service may elect to be his/her own payee or identify an alternate payee.
- D. **“All Kids/HFS Dental Program”** means dental program administered by Healthcare and Family Services for Medicaid and All Kids Beneficiaries.
- E. **“Medically Necessary”** means those Covered Services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law to prevent disease, disability and other adverse health conditions or their progression, or prolong life. In order to be Medically Necessary, the service or supply for medical illness or injury must be determined by Plan or its designee in its judgement to be a Covered Service which is required and appropriate in accordance with the law, regulations, guidelines and accepted standards of medical practice in the community.
- F. **“Beneficiary”** means any individual who is enrolled in the Illinois Medicaid or All Kids/HFS Dental Program.
- G. **“HFS”** means Illinois Department of Healthcare and Family Services.
- H. **“DHS”** means Illinois Department of Human Services.
- I. **“DCFS”** means Illinois Department of Children and Family Services.
- J. **“DPH”** means Illinois Department of Public Health.

**ATTACHMENT B**

00000001	 <b>State of Illinois - Healthcare and Family Services</b> <b>MediPlan Card</b>	
	Case ID Number <input type="text"/>	Eligibility Period <input type="text"/> Through <input type="text"/>

00000001	 <b>Governor Blagojevich's</b> <b>Healthcare Programs for Families</b>	 <b>Moms &amp; Babies</b>
	Case ID Number <input type="text"/>	Eligibility Period <input type="text"/> Through <input type="text"/>

1. Control Area

Not relevant.

2. Case ID Number

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

3. Eligibility/Coverage Period

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

4. Case Names and Address

The case name appears in conjunction with the mailing address. It is the main identifier associated with the case identification number. The individual whose name appears as the case name is not eligible for medical services unless the name also is shown in the listing of "eligible persons" on the back of the card. In instances in which a second individual, a bank, an agency or

an institution has been designated as guardian, protective payee or representative payee, the applicable name and identifying initials will appear as part of the mailing address.

5 Messages

A variety of explanatory messages may appear in this area. They include such subjects as allowable co-payments and benefit restrictions for certain programs. See 1.01 for limited benefit programs relevant to the All Kids/HFS Dental Program.

6 Special Limitations

Not relevant.

<b>00000001</b>	<b>HFS</b> State of Illinois - Healthcare and Family Services <b>MediPlan Card</b>	
	Case ID Number: <input type="text"/>	Eligibility Period: <input type="text"/> Through: <input type="text"/>
<small>HFS 489 (R-4-25)</small>		<small>IL473-0234</small>

<input type="text"/>	<input type="text"/>	
Eligibility Period Through	Case ID Number	
<b>ONLY THE FOLLOWING PERSONS ARE ELIGIBLE:</b>		
<small>- Please see front of card for important information</small>		

**1 Items Repeated from the Front of the Card**

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

**2 Name of Covered Beneficiaries**

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

**3 Recipient Identification Number (RIN)**

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

**4 Date of Birth**

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

5 Medicare Coverage

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

<u>CODE</u>	<u>TYPE OF COVERAGE</u>
PART A	HOSPITAL INSURANCE
PART B	MEDICAL INSURANCE
PART AB	BOTH OF THE ABOVE

6 TPL

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

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

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

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

7 Total Person

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

**ATTACHMENT C**

**THE STATE OF ILLINOIS ENCOURAGES ALL KIDS/HFS DENTAL PROVIDERS TO ADOPT THE “DENTAL HOME” CONCEPT IN THEIR PRACTICES.**

**Are you building a “Dental Home” for your patients?**

Effective July 1, 2006, the Illinois State of Illinois’ dental coverage for children expanded under the provisions of Governor Blagojevich’s new All Kids/HFS Dental Program. What was previously known as Medicaid and KidCare was renamed the All Kids/HFS Dental Program.

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

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

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

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

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

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

ADA Dental Claim Form

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services       Request for Predetermination/Preauthorization

EPSDT/Title XIX

2. Predetermination/Preauthorization Number

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

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

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

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

13. Date of Birth (MM/DD/CCYY)      14. Gender  
 M    F

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

16. Plan/Group Number      17. Employer Name

**OTHER COVERAGE**

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

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

6. Date of Birth (MM/DD/CCYY)      7. Gender  
 M    F

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

**PATIENT INFORMATION**

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

19. Student Status  
 FTS    PTS

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

9. Plan/Group Number      10. Patient's Relationship to Person Named in #5  
 Self    Spouse    Dependent    Other

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

21. Date of Birth (MM/DD/CCYY)      22. Gender  
 M    F

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

**RECORD OF SERVICES PROVIDED**

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

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)	Permanent								Primary								32. Other Fee(s)	33. Total Fee										
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16			A	B	C	D	E	F	G	H	I	J
																	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

**AUTHORIZATIONS**

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

X \_\_\_\_\_  
 Patient/Guardian signature      Date

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

X \_\_\_\_\_  
 Subscriber signature      Date

**ANCILLARY CLAIM/TREATMENT INFORMATION**

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

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

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

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

42. Months of Treatment Remaining      43. Replacement of Prosthesis?  
 No    Yes (Complete 44)

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

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

46. Date of Accident (MM/DD/CCYY)      47. Auto Accident State

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

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

49. NPI      50. License Number      51. SSN or TIN

52. Phone Number ( ) -      52A. Additional Provider ID

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

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

X \_\_\_\_\_  
 Signed (Treating Dentist)      Date

54. NPI      55. License Number

56. Address, City, State, Zip Code      56A. Provider Specialty Code

57. Phone Number ( ) -      58. Additional Provider ID



American Dental Association  
www.ada.org

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

**GENERAL INSTRUCTIONS**

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

**COORDINATION OF BENEFITS (COB)**

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

**NATIONAL PROVIDER IDENTIFIER (NPI)**

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

**ADDITIONAL PROVIDER IDENTIFIER**

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

**PROVIDER SPECIALTY CODES**

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

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

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

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA’s web site at: [www.ada.org/goto/dentalcode](http://www.ada.org/goto/dentalcode)



**ATTACHMENT E**

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

Beneficiary Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Case Name: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date: \_\_\_\_\_

Records Received:

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

Quality:

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

**A. INTRA-ARCH DEVIATION**

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

Total Score \_\_\_\_\_

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

**B. Inter-Arch Deviation  
1. Anterior Segment**

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

Total Score \_\_\_\_\_

\*Score maxillary or mandibular incisors.

**2. Posterior Segment**

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

Total Score \_\_\_\_\_

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

Grand Total \_\_\_\_\_

**C. Dentofacial Deviations**

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

Possible Surgical Indication Yes No	1. Facial and oral clefts	
	2. Lower lip palatal to maxillary incisor teeth	
	3. Occlusal interference	
	4. Functional jaw limitations	
	5. Facial asymmetry	
	6. Speech impairment	
	7. Total Score	
		<b>TOTAL SALZMANN INDEX:</b>

**Malocclusion Severity Assessment**

**By J.A. Salzman, DDS, F.A.P.H.A.**

**Summary of instructions**

Score: 2 points for each maxillary anterior tooth affected.

1 point for each mandibular incisor and all posterior teeth affected.

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

**Instruction for using the “Handicapping Malocclusion Assessment Record”**

**Introduction**

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

**A. Intra-Arch Deviations**

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

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

- a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
- b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
- c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.
- d. Spacing
  - (1) Open spacing refers to tooth separation that exposes to view the interdental papillae on the alveolar crest. Score the number of papillae visible (not teeth).
  - (2) Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

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

- a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
- b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
- c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.
- d. Spacing
  - (1) Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).
  - (2) Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

## **B. Interarch Deviations**

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

1. Anterior segment: **A value of 2 points is scored for each affected maxillary tooth only.**
  - a. Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.
  - b. Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.
  - c. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.
  - d. Open-bite refers to vertical interarch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.
2. Posterior segment: **A value of 1 point is scored for each affected tooth.**
  - a. Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.
  - b. Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.
  - c. Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

## **C. Dentofacial Deviations**

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

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

## ATTACHMENT F



# COMPANION GUIDE FOR 837 HEALTH CARE CLAIM TRANSACTIONS FOR DENTAL

**Doral Dental Services of Illinois, LLC**

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## **Article I      Introduction**

### **Section 1.01 Intended Users**

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

### **Section 1.02 HIPAA Overview**

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

### **Section 1.03 HIPAA Background**

In the early 1990s, the first Bush Administration assembled an advisory group of healthcare industry leaders to discuss ways to reduce health care administrative costs across the nation. This group, which is now recognized as the Workgroup for Electronic Data Interchange (WEDI), recommended that Federal legislation be passed to implement a nationwide standard of transaction and code sets to be used by the healthcare industry. This law was entitled "The Health Insurance Portability and Accountability Act" and was enacted on August 21, 1996 under the Clinton Administration.

HIPAA requires several provisions. One provision, already in effect, deals with the portability of health insurance coverage during a change in employment, and primarily affects employers and health insurers. Another provision, often referred to "Administrative

Simplification”, deals with the implementation of healthcare standards, of which transaction and code sets are but one part. Following is a list of the standard healthcare transactions and their accompanying transaction sets that Doral Dental will support:

- (a) **Eligibility Inquiry and Response**: HIPAA mandates X12 Version 4010A1 of the 270/271 Eligibility and Benefit Inquiry and Response EDI Transactions for this purpose.
- (b) **Claim Status Inquiry and Response**: HIPAA mandates X12 Version 4010A1 of the 276/277 Claim Status Inquiry and Response EDI Transaction for this purpose.
- (c) **Referral Certification and Authorization**: HIPAA mandates X12 Version 4010A1 of the 278 Health Care Service Review EDI Transaction for this purpose.
- (d) **Claim Payment and Remittance Advice**: HIPAA mandates X12 Version 4010A1 of the 835 Healthcare Claim Payment/Advice EDI Transaction for this purpose.
- (e) **Claims and Encounters**: HIPAA mandates the X12 Version 4010A1 837D of the Health Care Claim: Dental EDI Transaction for this purpose.
- (f) **Functional Acknowledgement** : HIPAA recommends X12 Version 4010 of the 997 Functional Acknowledgment Transaction for this purpose.

HIPAA also requires the standardization of code sets. Any coded field or data element contained in a HIPAA transaction must adhere to a national set of code set values, including dental procedures. As such, with implementation of the HIPAA standard transactions, only published code sets will be allowed.

#### **Section 1.04 Additional HIPAA Requirements**

In addition to the transaction and code set aspects, there are other requirements of the “Administrative Simplification” provision of HIPAA:



- (a) **Privacy**: Standards must be adopted by all health plans, clearinghouses, and providers that ensure the protection and appropriate disclosure of individually identifiable health information. The final rule had a mandatory implementation of April 14, 2003.
- (b) **Security**: Standards must be adopted by all health plans, clearinghouses, and providers that ensure the integrity and confidentiality of healthcare information. The security rule addresses healthcare information in all types of media instead of just electronic format. The final rule has an implementation date of April 2005.
- (c) **National Identifier Codes**: Standards must be adopted by all health plans, clearinghouses, and providers regarding unique identifiers for providers, plans, employers, and individuals (beneficiaries). Presently, a final rule has been issued for the Employer ID. The Department of Health and Human Services has not published final rules for the remaining identifiers.
- (d) **Enforcement**: The Office of Civil Rights has been appointed to enforce the privacy rule and has been given the authority to levy penalties for compliance failures. CMS has been designated to monitor the transaction and code sets compliance.

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

### **Section 1.05 HIPAA Internet Links**

The following is a list of government agencies, industry leaders, and transaction and code set standards organizations associated with HIPAA. Although not an exhaustive list, the information located in these resources represents a wealth of information that could not otherwise be included in this Companion Guide.

Accredited Standards Committee (ASC X12) - ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. <http://www.x12.org/>

American Dental Association (ADA) - The Dental Terminology 3<sup>rd</sup> and 4<sup>th</sup> Edition codes (CDT-4, HCPCS Level II “D” codes) and the Dental Content Committee that sets standards for the dental claim form and maintains dental codes can be linked from this site. <http://www.ada.org>

Association for Electronic Health Care Transactions (AFEHCT) - A healthcare association dedicated to promoting the interchange of electronic healthcare information. <http://www.afehct.org>

Centers for Medicare and Medicaid Services (CMS) - Formerly known as HCFA, this site provides links to multiple web sites. The Electronic Health Care Transactions and Code Sets Model Compliance Plan. <http://www.cms.gov/hipaa/hipaa3> The Healthcare Common Procedure Coding System (HCPCS). <http://cms.hhs.gov/medicare/hcpcs> For Medicaid HIPAA information related to the Administrative Simplification provision. <http://www.cms.gov/medicaid/hipaa/admsimp> For HIPAA administrative simplification questions, CMS maintains an e-mail address at [askhipaa@cms.hhs.gov](mailto:askhipaa@cms.hhs.gov) and a toll free number at (866) 282-0659.

Designated Standard Maintenance Organizations (DSMO) - This site is a resource for information about the standard setting organizations, and transaction change request system. <http://www.hipaa-dsmo.org>

Health Level Seven (HL7) - HL7 is one of several ANSI accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. <http://www.hl7.org>

Medicaid HIPAA Compliant Concept Model (MHCCM) -

This site presents the Medicaid HIPAA Compliance Concept Model, information and a toolkit. <http://www.mhccm.org>

Office for Civil Rights (OCR) - OCR is the Health and Human Services Office responsible for enforcing the Privacy Rule under HIPAA. <http://www.hhs.gov/ocr/hipaa> For HIPAA privacy questions, OCR can be contacted at [OCRPrivacy@hhs.gov](mailto:OCRPrivacy@hhs.gov) or by calling (866) 627-7748.

United States Department of Health and Human Services (DHHS) - This site is a resource for the Notice of Proposed Rule Making, and lists rules and other information regarding HIPAA. <http://aspe.hhs.gov/admsimp>

Washington Publishing Company (WPC) - WPC is the official publisher for HIPAA transaction implementation guides and code sets. <http://www.wpc-edi.com/hipaa>

Workgroup for Electronic Data Interchange (WEDI) - A workgroup dedicated to improving healthcare through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative simplification provisions of HIPAA. <http://www.wedi.org>

## Article II      TRADING PARTNER AGREEMENTS

### Section 2.01   General Overview

Separate Trading Partner Agreements for the purpose of processing and exchanging specified healthcare transactions with Doral providers will **not** be required.

### Section 2.02   Doral Electronic Data Interchange Exchange Form

Doral will require an EDI Exchange form to be completed for each business entity desiring to exchange transaction information. The EDI Exchange Form is completed by the entity and provides a summary of the information exchanged between the entity and Doral. This form contains information about:

- (a) **Who is the contract entity?**
- (b) **Who is authorized to add or change the data being provided or received or the users authorized to access the data?**
- (c) **Who will be actually submitting the data, if different from the contracted entity?**
- (d) **What type of data will be accessible to the entity (e.g., or claims files, electronic remittance advice data, eligibility inquiry, etc. )?**
- (e) **How the data exchange will occur (e.g., FTP via VPN, Internet Site, or secure email)?**
- (f) **Will establish entity's User credentials, passwords, and sender IDs for reference in the control segments of the transaction guide(s)?**

**(g) Which transactions will generate a functional acknowledgement from the entity?**

**Section 2.03 Doral User Security Agreement**

The Doral User Security Agreement, outlines the responsibilities associated with access to Doral data. All users are expected to and will be required to comply with all Federal, State and laws regarding data confidentiality, privacy, security, and user access.

**Article III TECHNICAL INTERCHANGE**

**Section 3.01 Doral Communications Requirements**

Doral will maintain various methods of obtaining EDI information with its providers. These methods will include Doral's Secure Web Server, FTP, 3.5" diskette, Compact Disc (CD), and Bulletin Board System. The preferred method of facilitating EDI exchange is via Doral's Secure Web Server. Outgoing transmissions, including all response transactions and functional acknowledgements will be available ONLY through Doral's Secure Web server or FTP with data encryption.

**Section 3.02 File Encryption Procedures**

Encryption is handled automatically as part of SSL (Secured Socket Layer) Web session created upon login to the Doral Secure Web Server. Data that pass through the SSL session are encrypted using a 128-bit algorithm and managed via The VeriSign<sup>™</sup> Secure Site Program.

**Section 3.03 File and Directory Naming Conventions**

The directory structure on the Web server is designed to provide logical access to all files, ease troubleshooting searches, and simplify security for account set ups and maintenance. Doral is developing final naming conventions.

Individual file naming standards are also designed to provide ease in identifying a file and in troubleshooting searches.

### **Section 3.04 HIPAA Requirements**

HIPAA standards are specified in the Implementation Guide (IG) for each transaction set and any authorized addenda. The guides include:

- (a) Format and contents of interchanges and functional groups**
- (b) Format and contents of the header, detail and trailer segments specific to the transaction set**
- (c) Code sets and values authorized for use in the transaction set**
- (d) Allowed exceptions to specific transaction set requirements**

### **Section 3.05 Multiple Transactions Within a File**

Doral cannot allow multiple transaction types to be submitted within a single file submission. While the X12 standards do support the handling of multiple transaction set types such as an 837D and 276 to be submitted within a single file, Doral will not support transaction bundling within a file. Transaction sets must be sent separately with uniform naming conventions.

### **Section 3.06 Size of Transmissions/Batches**

Fee-For-Service transmission sizes are limited based upon the number of Segments/Records allowed by HIPAA standards. HIPAA standards for the maximum file size of each transaction set are specified in the appropriate Implementation Guide or its authorized addenda. For 837 dental transactions, Doral is imposing a submission limit of 50,000 claim transactions (CLM Segments) per submission.

### **Section 3.07 Complete Transmission Check**

All transactions are checked to ensure that the transmission is complete. The transaction header and footer must balance before a transaction file is processed.

### **Section 3.08 Balancing Data Elements**

Doral will utilize any balancing requirements that can be derived from the transaction implementation guides. All financial amount

fields must be balanced at all levels available within the transaction set. The number of transactions in the header and footer must equal and be the same as the number of transactions in the file.

## **Article IV    ACKNOWLEDGMENT PROCESSES**

### **Section 4.01   Overview of Acknowledgment Processes**

Acknowledgment transactions let the sender know that the receiver received their transactions and that the transactions were accepted with no errors, accepted with errors, or rejected. The two types of Acknowledgment Transactions available are the:

- (a)   Interchange (TA1) Acknowledgment**
- (b)   Functional Acknowledgment Transaction Set (997)**

### **Section 4.02   Doral Requirements**

- (a)   Doral plans on using the 997 transaction to acknowledge all transmission files.**
- (b)   A provider may elect to send Doral an acknowledgement on any transmission files. These acknowledgements should be listed on the EDI Exchange Form.**

### **Section 4.03   997 Functional Acknowledgment Transaction Sets**

The 997 Functional Acknowledgment Transaction (997 Transaction) is designed to check each functional group in an interchange for data and syntax errors and send the results back to the sending trading partner. The 997 Transaction can accept or reject records at the functional group, transaction set, segment or data element level. The HIPAA statute and current implementation guides do not mandate the use of the 997 Transaction but recommend its usage. Characteristics of the 997 Transaction include:

- (a) One 997 Transaction corresponds to one functional group in the interchange.**
- (b) 997 Transactions are transaction sets and thus are included in the interchange control structure (envelopes) for transmission.**
- (c) Many commercially available translators can automatically reconcile the 997 Transaction back to the previously sent functional group. This process allows the sending trading partner to identify any transaction sets that have not been acknowledged by the receiving trading partner.**
- (d) 997 Transactions should not be used to acknowledge the receipt of other 997 Transactions. Details on the format and syntax of the 997 Transaction can be found in Appendix B of each Transaction Set's Standard Implementation Guide.**

#### **Section 4.04 Rejected Transmissions and Transactions**

The process for handling rejected transactions and transmissions will vary based on the error(s) causing the rejection.

- (a) Interchanges or functional groups may be completely rejected for IG format violations.**
- (b) Individual records or transaction sets within a functional group/interchange will be rejected only in Fee-For-Service Claims files.**

Numerous edits will be performed on each transaction processed. Each of these edits has a severity level associated with it that in conjunction with the number of errors will determine accept/reject status.

## CONTROL SEGMENT DEFINITIONS FOR DORAL DENTAL SERVICES of ILLINOIS

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

### ISA - Interchange Control Header Segment

Reference	Definition	Values
ISA01	Authorization Information Qualifier	00
ISA02	Authorization Information	[space fill]
ISA03	Security Information Qualifier	00
ISA04	Security Information	[space fill]
ISA05	Interchange ID Qualifier	ZZ
ISA06	Interchange Sender ID	[Doral-assigned 12 digit Trading Partner ID]
ISA07	Interchange ID Qualifier	ZZ
ISA08	Interchange Receiver ID	DDS391933153
ISA09	Interchange Date	The date format is YYMMDD
ISA10	Interchange Time	The time format is HHMM
ISA11	Interchange Control Standards Identifier	U
ISA12	Interchange Control Version Number	00401
ISA13	Interchange Control Number	Must be identical to the interchange trailer IEA02
ISA14	Acknowledgment Request	1
ISA15	Usage Indicator	T= Test Data P = Production Data
ISA16	Component Element Separator	: (Colon)



### IEA - Interchange Control Trailer

Reference	Definition	Values
IEA01	Number of included Functional Groups	Number of included Functional Groups
IEA02	Interchange Control Number	Must be identical to the value in ISA13

### GS – Functional Group Header

Reference	Definition	Values
GS01	Functional Identifier Code	HC = Health Care Claim (837) HB = Eligibility Coverage or Benefit Information (270) HR = Health Care Claim Status Request (276) HI = Health Care Services Review Information (278)
GS02	Application Sender's Code	Must be identical to the value in ISA06
GS03	Application Receiver's Code	DDS421529687
GS04	Date	The date format is CCYYMMDD
GS05	Time	The time format is HHMM
GS06	Group Control Number	Assigned and maintained by the sender
GS07	Responsible Agency Code	X
GS08	Version/Release/Industry Identifier Code	004010X097A1 (Addenda Versions must be used)

### GE – Functional Group Trailer

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

## Recommended Delimiters for Doral Dental EDI Transactions

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

## SEGMENT DEFINITIONS

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

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

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

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

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

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

## INTRODUCTION TO THE 837 DENTAL HEALTHCARE CLAIMS TRANSACTION

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

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

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

This document consists of situational fields for the following transaction type that are required for processing Doral Dental Services Medicaid Dental claims; however, this document is not the complete EDI transaction format. This companion guide is based on the following transaction implementation guide. The full guide can be obtained from the Washington Publishing Company via their web site at [www.wpc-edi.com/hipaa/HIPAA\\_40.asp](http://www.wpc-edi.com/hipaa/HIPAA_40.asp).

**Dental Transaction**

**ASC X12N 837(004010X097A1) October 2002**

## FIELD DEFINITION

### COLUMN

- A The name of the loop as documented in the appropriate 837D Implementation Guide.
- B A loop ID number used to identify a group of segments that are collectively repeated in a serial fashion up to a specified maximum number of times as documented in the appropriate 837D Implementation Guide.
- C The field position number and segment number as specified in the appropriate 837D Implementation Guide.
- D The data element name and page number as indicated in the appropriate 837D HIPAA Implementation Guide.
- E The Values and Comments further describe the appropriate 837D Implementation Guide field data that Doral Dental will accept for processing a claim.
- F Corresponding ADA Claim Form Reference (2002 Version J515) where applicable.

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
Beginning of Hierarchical Transaction		010-BHT02	Transaction Set Purpose Code Pg 55	'00'= Original ; '18'= Reissue	
Beginning of Hierarchical Transaction		010-BHT06	Transaction Type Code Pg 56	'CH' Chargeable	
Submitter Name	1000A	020-NM109	Identification Code Pg 61	[Doral-assigned 12 digit Trading Partner ID]	
Submitter Name	1000A	045-PER03	Communication Number Qualifier Pg 64	'TE' Telephone	
Receiver Name	1000B	020-NM103	Name Last or Organization Name Pg 67	<b>DORAL DENTAL SERVICES</b>	
Receiver Name	1000B	020-NM109	Identification Code Pg 67	<b>DDS421529687</b>	

The EDI formatting location of Pay-To, Billing, Rendering and Referring Provider Information is dependant upon the situation being billed. Below are the circumstances and EDI billing locations of this information.

**Rendering Provider Location**

*Alternate Location 1:*

If the Rendering Provider is the same as the Billing and/or Pay-To Provider  
 And the Billing or Pay-To is not a group  
 Page 79 Loop 2000A

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Implementation Guide	Valid Values & Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
Billing/Pay-To Provider Hierarchical Level	2000A	003-PRV01	Provider Code Pg 12/Addenda	'BI' – If same as Billing Provider	

*Alternate Location 2:*

If the Rendering Provider is not the same as the Pay-To Provider  
 Page 196 Loop 2310B

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Implementation Guide	Valid Values & Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
Rendering	2310B	250-NM102	Entity Type Qualifier	'1' - Person	

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Implementation Guide	Valid Values & Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
Provider Name			Pg 196		
Rendering Provider Name	2310B	250-NM108	Identification Code Qualifier Pg 197	'34' – Social Security Number	

**Pay-To Provider Location**

*Alternate Location 1:*

If the Pay-To Provider is the same as the Billing Provider  
Page 84 Loop 2010AA

Billing Provider Name	2010AA	035-REF01	Reference Identification Qualifier Pg 84	'1D' – Medicaid Provider Number (Illinois Practitioner License Number)	
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*Alternate Location 2:*

If the Pay-To Provider is not the same as the Billing Provider  
Page 88 Loop 2010AB

Pay-To Provider Name	2010AB	035-REF01	Reference Identification Qualifier Pg 95	'1D' – Medicaid Provider Number (Illinois Practitioner License Number)	
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**Billing Provider Location**

Page 84 Loop 2010AA

Billing Provider Name	2010AA	035-REF01	Reference Identification Qualifier Pg 84	'1D' – Medicaid Provider Number (Illinois Practitioner License Number)	
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<b>Loop Name</b>	<b>Loop- ID</b>	<b>837 Field Position &amp; Segment</b>	<b>837 Data Element Name &amp; Page Number from Implementation Guide</b>	<b>Valid Values &amp;Comments</b>	<b>ADA Dental Claim Form Mapping Location</b>
A	B	C	D	E	F
Subscriber Hierarchical Level	2000B	001-HL04	Hierarchical Level Pg 97	'0' – No subordinate HL Segment in the Hierarchical Structure	
Subscriber Hierarchical Level	2000B	005-SBR01	Payer Responsibility Sequence Number Code Pg 99	'T' - Tertiary	
Subscriber Hierarchical Level	2000B	005-SBR09	Claim Filing Indicator Code Pg 102	'MC' - Medicaid	
Subscriber Name	2010BA	015-NM102	Entity Type Qualifier Pg 104	'1' Person	
Subscriber Name	2010BA	015-NM108	Identification Code Qualifier Pg 105	'MI' – Member Identification Number	
Subscriber Name	2010BA	015-NM109	Identification Code Pg 106	<b>IDPA RECIPIENT ID NUMBER</b>	<b>15</b>
Payer Name	2010BB	015-NM103	Name Last or Organization Name Pg 118	<b>DORAL DENTAL SERVICES</b>	<b>3</b>
Payer Name	2010BB	015-NM108	Identification Code Qualifier	'PI' – Payer Identification	

<b>Loop Name</b>	<b>Loop- ID</b>	<b>837 Field Position &amp; Segment</b>	<b>837 Data Element Name &amp; Page Number from Implementation Guide</b>	<b>Valid Values &amp;Comments</b>	<b>ADA Dental Claim Form Mapping Location</b>
A	B	C	D	E	F
			Pg 118		
Payer Name	2010BB	015-NM109	Identification Code Pg 118	<b>421529687</b>	<b>3</b>
Claim Information	2300	130-CLM11-1	Related Causes Code Pg 153	Reference Imp. Guide For Valid Values.	
Claim Information	2300	130-CLM12	Special Program Code Pg 155	<b>'01'</b> EPSDT	<b>1</b>
Referral Identification	2300	180-REF02	Reference Identification Referral Number Pg 182	Enter Provided Prior Authorization Number	<b>2</b>
Other Subscriber Information	2320	300-AMT02	Monetary Amount Payer Paid Amount Pg 220	Other Insurance paid Amount	
Tooth Information	2400	382-TOO02	Industry Code Tooth Number Pg 272	Tooth Number	<b>27</b>
Tooth Information	2400	382-TOO03 TOO03-1	Tooth Surface Tooth Surface Code Pg 272	Reference Imp. Guide For Valid Values.	<b>28</b>

<b>Loop Name</b>	<b>Loop- ID</b>	<b>837 Field Position &amp; Segment</b>	<b>837 Data Element Name &amp; Page Number from Implementation Guide</b>	<b>Valid Values &amp;Comments</b>	<b>ADA Dental Claim Form Mapping Location</b>
A	B	C	D	E	F
Date of Service	2400	455-DTP03	Date Time Period Service Date Pg 274		



# Provider Change Form

ATTACHMENT G

Our goal is to provide you effective and efficient dental administration services. To accomplish this, it is important that we have current information on you and your offices. Please use this form to notify us of any changes that affect our ability to process your claims quickly and completely.

### Section 1: Current Information

Name:

Address:

City:  State:  Zipcode:

Telephone:  E-mail:

Fax:

### Section 2: Location Change / Add Location / Payee Name Change

- Additional Location
- Payee Name Change Only
- Relocation of Existing Office

Location Name:   
*(if applicable)*

Address:

City:  State:  Zipcode:

Telephone:  E-mail:

Fax:

### Section 3: Tax ID Change

Old Tax ID Number:  New Tax ID Number:

### Section 4: Provider Status Change

- Add new Provider at location listed above

New Provider Name:

- Delete Provider at location listed above

Reason for removal:

Please return this form to: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doral  
12121 North Corporate Parkway  
Mequon, WI 53092  
FAX: 262.241.4077

Please be advised that changes in these areas will likely require additional paperwork, a possible site visit, and credentialing processes. We will contact you and work with you to complete any additional steps. Thank you for your cooperation.

**ATTACHMENT H**  
**ILLINOIS DENTAL PROVIDER ENROLLMENT PROCESS**  
**Doral Dental Services of Illinois, LLC**

**Definitions**

**New Provider** – a provider is considered a “New Provider” if he/she:

- Has never been enrolled as a provider in the Illinois All Kids/HFS Dental Program.

**Existing Provider** – a provider is considered an “Existing Provider” if he/she:

- Is currently enrolled as a participating provider with the Illinois All Kids/HFS Dental Program, regardless of provider’s payee or office location, and in “active” status.
- Has been terminated from the Illinois All Kids/HFS Dental Program; or
- Has been identified for re-enrollment by the Department of Healthcare and Family Services.

**Payee** – This is the location to which the provider’s checks are mailed:

- A provider may have more than one office location, but only one payee if the checks are sent to only one address.
- A provider may have more than one office location and multiple payees if the provider’s checks are mailed separately to each office location.

**New Provider Enrollment Forms**

**If Payee is linked to a Social Security Number:**

- Doral Provider Application
- Copy of State License
- IL Department of Healthcare and Family Services Application – DPA 2243
- Agreement for Participation in the IL HFS Medical Benefits Program – DPA 1413
- W-9
  - “Individual/Sole Practitioner” box checked
  - Provider’s social security number in Part I

**If Payee is linked to a TIN (Provider is 100% Owner of TIN)**

- Doral Provider Application
- Copy of State License
- IL Department of Healthcare and Family Services Application – DPA 2243
- Agreement for Participation in the IL HFS Medical Benefits Program – DPA 1413
- W-9
  - Appropriate box checked
  - TIN in Part I
  - Signature required
- Alternate Payee – DPA 2307
  - Effective date on Line 12
  - Credentialing provider completes “Practitioner” section
  - Credentialing provider’s SS# in “Payee” section
  - Credentialing provider is listed as 100% owner in “Payee” section
  - Signature of “Payee Representative”
  - TIN
  - Telephone #
  - D/B/A name and address (where payment is to be sent)

## **Doral Dental Services of Illinois, LLC**

- In lieu of Alternate Payee Form, provider may submit written correspondence stating that provider is 100% owner of the TIN, office location, effective date, phone and fax and tax number is legally registered in own name otherwise, there should be an alternate payee form.
- IL Power of Attorney (POA)– DPA 2306
  - Credentialing provider signs as “Practitioner”
  - Dental practice’s name is “Name of Agency”
  - Owner of practice or person responsible for billing completes and signs “Agent Name”
- In lieu of POA provider or Doral may submit this form with a notation that the “provider is responsible for any claims activity in the office”.

### **If Payee is linked to a TIN (Provider is Not 100% Owner)**

After May 1, 2005, new providers may designate the TIN of a practitioner owned group practice as an alternate payee *only* if the practitioner owned group practice is owned by *three or more full-time licensed individual practitioners who are eligible to participate in the Illinois Medical Dental Assistance program.*

However, new providers may enroll under a TIN that is owned by one (100%) or two providers (50%) if the TIN already exists and had non-owner providers enrolled prior to May 1, 2005.

- Doral Provider Application
- Copy of State License
- IL Department of Public Aid Provider Enrollment Application – DPA 2243
- Agreement for Participation in the IL HFS Medical Benefits Program – DPA 1413
- W-9
  - Appropriate box checked
  - Registered business name on “Name” line
  - Practice TIN listed
  - Name and TIN must match the name registered with the IRS.
  - Signature required
- Alternate Payee – DPA 2307
  - Effective date on Line 12
  - Credentialing provider completes “Practitioner” section
  - Signature of Payee Representative
  - TIN matches W-9
  - Owner(s) of practice are listed as based upon % of ownership
  - “Add” box is checked at bottom of page
- IL Power of Attorney – DPA 2306
  - Credentialing provider signs as “Practitioner”
  - Dental practice’s name is “Name of Agency”
  - Owner of practice or person responsible for billing completes and signs “Agent Name”

## **Existing Provider Forms**

### **Location Change or Addition – Payee (Billing Address) Unchanged**

Provider submits notification of change or addition to Doral. The State of Illinois does not require notification, since the Payee (TIN and address) remains unchanged. However, the notification may be forwarded to the Provider Participation Unit as a courtesy, and will be placed in the provider’s file.

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

#### **(If Payee is linked to Social Security Number):**

- W-9
  - Appropriate box checked
  - Provider’s social security number in Part I
  - Signature required

## ***Doral Dental Services of Illinois, LLC***

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- Correspondence from provider stating, "I am requesting another payment location with information as follows:
  - Provider Name
  - Provider License #
  - Social Security #
  - Effective Date
  - *The provider must state that he/she is submitting claims under his/her SS#.*
  - *The provider must sign the correspondence*

### These are not needed:

- Alternate Payee – DPA 2307
- IL Power of Attorney – DPA 2306

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

### **(If Payee is linked to TIN – Provider is 100% Owner of TIN):**

- W-9
  - Appropriate box checked
  - TIN in Part I
  - Name and TIN must match the name registered with the IRS
  - Signature required
- Alternate Payee – DPA 2307
  - Effective date on Line 12
  - Credentialing provider completes "Practitioner" section
  - Credentialing provider's SS# in "Payee" section
  - Credentialing provider is listed as 100% owner in "Payee" section
  - Signature of "Payee Representative"
  - TIN
  - Telephone #
  - D/B/A name and address (where payment is to be sent)
  - Indicate "add" or "change" at the bottom of the form, and circle the specific payee code number.
- IL Power of Attorney – DPA 2306
  - Credentialing provider signs as "Practitioner"
  - Dental practice's name is "Name of Agency"
  - Owner of practice or person responsible for billing completes and signs "Agent Name"
  - Or provider may write a statement on the form stating that he/she is responsible for all billing.

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

### **(If Payee is linked to TIN – Provider is Not 100% Owner):**

After May 1, 2005, existing providers may designate the TIN of a practitioner owned group practice as an alternate payee *only* if the practitioner owned group practice is owned by *three or more full-time licensed individual practitioners who are eligible to participate in the Illinois Medical Dental Assistance program.*

However, existing providers may enroll under a TIN that is owned by one (100%) or two providers (50%) if the TIN already exists and had active non-owner providers enrolled prior to May 1, 2005.

- W-9
  - Appropriate box checked
  - Registered business name on "Name" line
  - Practice TIN listed
  - Name and TIN must match the name registered with the IRS.
  - Signature required



## **Doral Dental Services of Illinois, LLC**

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- Alternate Payee – DPA 2307
  - Effective date on Line 12
  - Credentialing provider completes “Practitioner” section
  - Signature of Payee Representative
  - TIN matches W-9
  - Owner(s) of practice are listed as based upon % of ownership
  - “Add” or “change” box is checked at bottom of page indicating the specific payee number affected.
- IL Power of Attorney – DPA 2306
  - Credentialing provider signs as “Practitioner”
  - Dental practice’s name is “Name of Agency”
  - Owner of practice or person responsible for billing completes and signs “Agent Name”
  - Or provider may write a statement on the form stating that he/she is responsible for all billing.

### **Provider Referral Profile**

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

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

A provider may change his or her referral status with a simple call to Doral’s Provider Relations Department at 888-875-7482. There is no limit to how often a provider may change his or her referral status. In fact, many participating dentists cite this flexibility in Doral’s GeoAccess Referral Program as the primary reason they choose to participate in the Illinois All Kids/HFS Dental Program.

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

To make referral status changes call:

Doral’s Provider Relations Department at 888-875-7482.

### **Provider Re-enrollment Process**

#### **(If a provider has not submitted claims in the past 18 months)**

- Doral consistently monitors provider claims submission in conjunction with the State of Illinois’ provider participation guidelines. A systematic report is generated to determine if a provider has submitted claims within the last 18 months. If a provider has not submitted claims, HFS’ Provider Participation Unit (PPU) flags the provider for termination. The following steps are taken to ensure that no providers are terminated erroneously:
  - A report of affected providers and locations is generated and researched;
  - Claims activity is monitored and cross checked between State and Doral systems;
  - Provider outreach is initiated to determine if the provider still wishes to participate; and
  - The PPU is notified which providers can be safely terminated and which should remain in the system with active status.

**(If the State's Provider Participation Unit initiates a need for updated enrollment forms)**

- HFS' Provider Participation Unit (PPU) initiates a re-enrollment effort on an annual basis. The goal is to refresh each participating provider's enrollment forms every 5 years. A letter is sent from PPU in February explaining the process and requesting that all forms enclosed with the letter are returned to PPU within a given time frame, if they fail to do so the provider's participation will be terminated as of July 1<sup>st</sup> of the given year. As part of the process two follow up letters are mailed by PPU to assure that any provider who wishes to continue his or her participation in the Illinois All Kids/HFS Dental Program (All Kids) has an opportunity to submit needed materials.
- To ensure that providers interested in continuing participation in the Illinois All Kids Program are identified, and that those selected for re-enrollment receive support and assistance in completing the re-enrollment process, Doral completes an extensive provider outreach project consisting of outbound calls and mailers. The goal of the outreach is to provide education about re-enrollment and determine the following:
  - Did the provider receive the re-enrollment materials from HFS (the State)?
  - If yes, have they been completed and sent back to HFS?
  - If no, does the provider need a new packet of enrollment materials?

\*\*\*\* If the provider wishes to continue involvement with the All Kids program all forms need to be returned to the Illinois Department of Healthcare and Family Services Provider Participation Unit (PPU) not Doral. Re-enrollment forms must be completed for each practice location. Keep copies for your records.

**\*\*\* Important \*\*\* If the enrollment materials are not completed and returned by July 1<sup>st</sup>, the provider will be terminated and claims will be rejected.**

## **ATTACHMENT I**

### **Patient Recall System Requirements**

#### Recall System Requirements

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

#### Office Compliance Verification Procedures

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

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

**ATTACHMENT J**

**The Patient Record**

**A. Organization**

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

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

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

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

10. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:
  - a. Procedure
  - b. Localization (area of mouth, tooth number, surface)
  
11. Adequate documentation of the periodontal status, if necessary, which is dated and describes:
  - a. Periodontal pocket depth
  - b. Furcation involvement
  - c. Mobility
  - d. Recession
  - e. Adequacy of attached gingiva
  - f. Missing teeth
  
12. Adequate documentation of the patient's oral hygiene status and preventive efforts, which documents:
  - a. Gingival status
  - b. Amount of plaque
  - c. Amount of calculus
  - d. Education provided to the patient
  - e. Patient receptiveness/compliance
  - f. Recall interval
  - g. Date
  
13. Adequate documentation of medical and dental consultations within and outside the practice, which describes:
  - a. Provider to whom consultation is directed
  - b. Information/services requested
  - c. Consultant's response
  
14. Adequate documentation of treatment rendered which verifies the claims submitted, identifying:
  - a. Date of service/procedure
  - b. Description of service, procedure and observation
  - c. Type and dosage of anesthetics and medications given or prescribed
  - d. Localization of procedure/observation (tooth #, quadrant etc.)
  - e. Signature of the Provider who rendered the service
  
15. Adequate documentation of the specialty care performed by another dentist that includes:
  - a. Patient examination
  - b. Treatment plan
  - c. Treatment status

C. Compliance

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

**ATTACHMENT K**

**Office Claim Audit**

A. Purpose

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

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

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

B. Random Chart Audits

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

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

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



**ATTACHMENT L**

**Radiology Guidelines**

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

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

**A. Radiographic Examination of the New Patient**

**Child – Primary Dentition**

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

**Child – Transitional Dentition**

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

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

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

**Adult – Dentulous**

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

**Adult – Edentulous**

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

**B. Radiographic Examination of the Recall Patient**

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

**a. Child – Primary and Transitional Dentition**

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

**b. Adolescent**

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

**c. Adult – Dentulous**

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

d. Adult – Edentulous

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

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

a. Child – Primary Dentition

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

b. Adolescent

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

c. Adult – Dentulous

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

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

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

4. Growth and Development Assessment

Child – Primary Dentition

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

Child – Transitional Dentition

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

Adolescent

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

Adult

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

**ATTACHMENT M**

ALLERGY	PRE MED	MEDICAL ALERT
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**INITIAL CLINICAL EXAM**

PATIENT'S NAME \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

	GINGIVA <hr/> MOBILITY <hr/> PROTHESIS EVALUATION <hr/> OCCLUSION    1    11    111 <hr/> PATIENT'S CHIEF COMPLAINT
--	---

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

**CLINICAL FINDINGS/COMMENTS**

RADIOGRAPHS	B/P	RDH/DDS
-------------	-----	---------

**RECOMMENDED TREATMENT PLAN**

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST \_\_\_\_\_

DATE \_\_\_\_\_

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

**N**

**ATTACHMENT N**

**RECALL EXAMINATION**

PATIENT'S NAME \_\_\_\_\_

CHANGES IN HEALTH STATUS/MEDICAL HISTORY \_\_\_\_\_

	OK		OK	CLINICAL FINDINGS/COMMENTS
<b>LYMPH NODES</b>		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		
RADIOGRAPHS	B/P		RDH/DDS	

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

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RECALL EXAMINATION**

PATIENT'S NAME \_\_\_\_\_

CHANGES IN HEALTH STATUS/MEDICAL HISTORY \_\_\_\_\_

	OK		OK	CLINICAL FINDINGS/COMMENTS
<b>LYMPH NODES</b>		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		
RADIOGRAPHS	B/P		RDH/DDS	

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

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**ATTACHMENT O**

**Authorization for Dental Treatment**

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

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

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

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

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

Procedure(s): \_\_\_\_\_

Tooth Number(s): \_\_\_\_\_

Date: \_\_\_\_\_

Dentist: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Legal Guardian/  
Patient Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

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

**ATTACHMENT P**

**MEDICAL AND DENTAL HISTORY**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Why are you here today? \_\_\_\_\_

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

If yes, what type and where? \_\_\_\_\_

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

Medical Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

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

If yes, please list medications: \_\_\_\_\_

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?

Yes  No

If yes, please list: \_\_\_\_\_

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

Do your ankles swell during the day?  Yes  No

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

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

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

Are you on a special diet?  Yes  No

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

If yes, where? \_\_\_\_\_

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

If yes, how often and how much? \_\_\_\_\_

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

**Doral Dental Services of Illinois, LLC**

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

If yes, please list: \_\_\_\_\_

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

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

**For Women Only:**

Are you pregnant?  Yes  No

If yes, what month? \_\_\_\_\_

Are you nursing?  Yes  No

Are you taking birth control pills?  Yes  No

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

**ATTACHMENT Q**

Doral Dental Services of Illinois, LLC  
12121 North Corporate Parkway, Mequon, WI 53092  
ATTN: Illinois Outreach and Quality Coordinator  
Fax (262) 241-7401

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

The following documents are **REQUIRED** for consideration of privileges to participate in the Illinois **All Kids School Based Services Program**.

- \_\_\_ 1. A **COMPLETED** Provider Registration Application that is signed and dated in addition to the in Illinois All Kids/HFS Medical Benefits Program Provider Enrollment forms.
- \_\_\_ 2. A copy of your **SCHEDULE OF SCHOOL EVENTS** planned for the upcoming quarter or year. (This will need to be updated annually or quarterly as events are scheduled and will be audited against claims annually)
- \_\_\_ 3. A copy of your **CURRENT** referral network resource directory for follow-up care to Beneficiaries and/or proof that all public clinics and at least 5 private dental practices in the local area were contacted in an attempt to arrange follow-up care for Beneficiaries.

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

- \_\_\_ 1. A **COMPLETED** Illinois Department of Public Health School Exam Form;
- \_\_\_ 2. A **COMPLETED** School Exam Follow up Form (including contact information for the Provider(s) willing to complete follow-up care, if necessary) to be sent home with the student;
- \_\_\_ 3. A roster of the students receiving care, including the students' names, Recipient ID's and their corresponding Oral Health Scores, **to be sent to HFS**.

**PLEASE REMEMBER:**

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



**All Kids School Based Dental Services Program**

**Participation Guidelines and Forms**

Providers who wish to participate as a School Services Provider must meet the following requirements:

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

Providers interested in enrollment may call Doral's IL Provider Relations Representative at 800.710.2629.

**School Providers must have the ability to render the full scope of preventive school-based services approved to be rendered in an out-of office setting:**

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

**School Providers must complete a School Provider Registration application.**

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

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

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

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

**School Providers must complete an Illinois Department of Public Health School Exam Form for every child seen.**

A copy of this form can be found on the Illinois Department of Public Health Website at: <http://www.idph.state.il.us/HealthWellness/oralhlth/DentalExamProof.pdf>

**School Providers must complete a School Exam Follow-up Form (to be sent home with student) for every child seen.**

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

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

**School providers must complete and submit a roster of the Beneficiaries seen at every school based event to HFS. This roster must include each Beneficiary's "Oral Health Score", as assigned on the School Exam Follow up Form. The roster must follow the format outlined in the Illinois Dental Office Reference Manual.**

The completed roster must be submitted within 30 days after the event to the following address:

Illinois Department of Healthcare and Family Services  
ATTN: Dental Program Manager  
201 South Grand Avenue East  
Springfield, IL 62763

**School providers must complete and maintain a dental health record for each Beneficiary receiving school based services. This record must include, but is not limited to the following information:**

- Beneficiary's name and birth date
- Beneficiary's All Kids/HFS Dental Program Recipient ID#
- School Information (Name and address of where services were rendered)
- Pathology observed
- Listing of services provided (including tooth # for sealants)
- Follow-up treatment required or recommended
- Date of Service
- Name and signature of treating Provider

**School providers must obtain a permission slip for each Beneficiary prior to providing services.**

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

In accordance with the Illinois Department of Public Health's policy, signed permission slips are valid for 365 days from the date of parent/guardian signature.

Standard school forms will be completed for all Beneficiaries receiving an exam. In cases where the facility being visited is a school, a copy of the form will be directly forwarded to the school and a copy given to the Beneficiary. In other situation the form will be given to the Beneficiary only. Please visit the State website for more information:

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

Providers who do not adhere to any portion of the above requirements for participation may not be eligible for reimbursement.

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

**Place of Service (POS) Definition**

Group prevention may be performed in a school setting or other location. Services designated as “school” are those that are limited to the four preventive codes. In this situation the treating provider does not provide the full scope of dental services (restorative, diagnostic, etc.)

**Designating a POS on a Claim**

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

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



**CERTIFICATION, STATEMENTS, AND SIGNATURE**

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

I certify that:

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

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Principal

Please print name: \_\_\_\_\_

**All applications are subject to review and approval by DORAL.**

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



**ILLINOIS ALL KIDS SCHOOL BASED DENTAL PROGRAM  
PROVIDER REFERRAL NETWORK**

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

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

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

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

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

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



**ATTACHMENT R**

**SCHOOL EXAM FOLLOW-UP CARE FORM**

To be given to student for communication to parent/guardian

Student's Name: \_\_\_\_\_  
Last
First
M.I.

**Oral Hygiene Status**

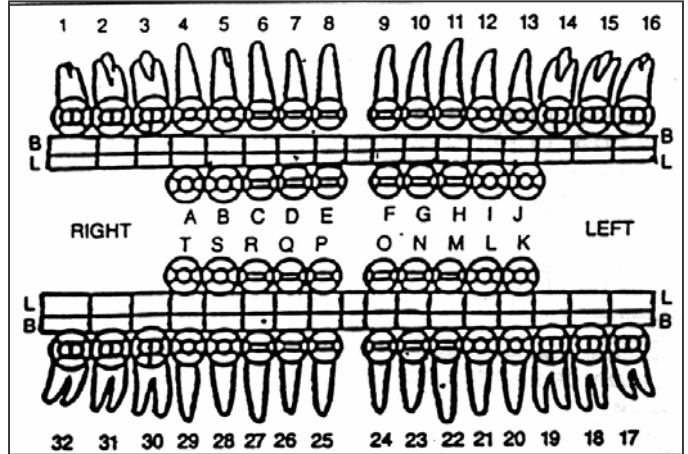
\_\_\_\_ Good      \_\_\_\_ Fair      \_\_\_\_ Poor

**Periodontal (Gum) Status**

\_\_\_\_ Good      \_\_\_\_ Fair      \_\_\_\_ Poor

**Cavity(ies) Present**

\_\_\_\_ Yes      \_\_\_\_ No



**Treatment Received**

- \_\_\_\_ Dental Exam/Screening
- \_\_\_\_ Prophylaxis (Cleaning)
- \_\_\_\_ Fluoride Treatment (gel)
- \_\_\_\_ Fluoride Treatment (varnish)
- \_\_\_\_ Dental Sealants (List Teeth)

**Notes/Comments:**

Oral Health Assessment Rating	
Score	Description
1	There is no visual evidence of caries activity or periodontal pathology.
2	One or a few areas of incipient or small frank caries and/or evidence of mild periodontal pathology.
3	A moderate number of frank carious lesions or one or a few carious lesions of significant depth without obvious pulpal involvement. This rating may also be assigned when moderate periodontal pathology is present.
4	Areas of significant caries destruction evident and/or pulpal involvement. Abscesses may be present. Areas of significant periodontal pathology may also be present.

**Student's Oral Health Assessment Rating:**

\_\_\_\_\_  
 Score

**Contact this dental provider for follow-up care:**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address \_\_\_\_\_

Treatment Date: \_\_\_\_\_ Dentist Name: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_



**ATTACHMENT S**

**Illinois Department of Public Health  
PROOF OF SCHOOL DENTAL EXAMINATION FORM**



To be completed by the parent (please print):

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

To be completed by dentist:

**Oral Health Status (check all that apply)**

- Yes  No **Dental Sealants Present**
- Yes  No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1<sup>st</sup> molars.
- Yes  No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.
- Yes  No **Soft Tissue Pathology**
- Yes  No **Malocclusion**

**Treatment Needs (check all that apply)**

- Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling
- Restorative Care** — amalgams, composites, crowns, etc.
- Preventive Care** — sealants, fluoride treatment, prophylaxis
- Other** — periodontal, orthodontic

Please note \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Street City ZIP Code

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

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

A copy of the Illinois Department of Public Health Proof of School Dental Examination Form can be found on line at: <http://www.idph.state.il.us/HealthWellness/oralHlth/DentalExamProof.pdf>



**Attachment U**

**Doral Dental Services of Illinois, LLC  
Healthcare and Family Services  
All Kids/HFS Dental Program Fee Schedule for Children Beneficiaries  
Rates Effective January 1, 2007**

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

**Doral Dental Services of Illinois, LLC**

<b>Procedure Code</b>	<b>Procedure</b>	<b>Maximum Allowance</b>
D2910	Recement Inlays	11.30
D2915	Recement cast or prefabricated post and core	23.50
D2920	Recement Crown	23.50
D2930	Prefabricated Stainless Steel Crown (SSC) Primary Tooth	73.40
D2931	Prefabricated Stainless Steel Crown (SSC) Permanent Tooth	73.40
D2932	Prefabricated Resin Crown	56.45
D2933	Prefabricated Stainless Steel crown with resin window	56.45
D2940	Sedative fillings	11.30
D2951	Pin Retention-Per Tooth	9.40
D2954	Prefabricated Post and Core	32.90
D3220	Therapeutic Pulpotomy	52.70
D3230	Pulpal Therapy – (resorbable filing) – anterior, primary tooth (excl. final restoration)	52.70
D3310	Anterior Root Canal (Excluding Final Restoration)	136.40
D3320	Bicuspid Root Canal (Excluding Final Restoration)	155.25
D3330	Molar Root Canal (Excluding Final Restoration)	202.30
D3351	Apexification/Recalcification Initial Visit	28.20
D3352	Apexification/Recalcification Interim Visit	14.10
D3353	Apexification/Recalcification Final Visit	14.10
D3410	Apicoectomy/Periapical Surgery — Per Tooth, First Root	112.90
D4210	Gingivectomy or Gingivoplasty — 4+ Teeth, Per Quadrant	131.70
D4211	Gingivectomy or Gingivoplasty — 1 to 3 Teeth, Per Quadrant	65.85
D4240	Gingival Flap Procedure, w/ Root Planing – 4+ Teeth, Per Quadrant	229.60
D4241	Gingival Flap Procedure, w/ Root Planing – 1 to 3 Teeth, Per Quadrant	114.80
D4260	Osseous Surgery – 4+ Teeth, Per Quadrant	277.60
D4261	Osseous Surgery – 1 to 3 Teeth, Per Quadrant	138.80
D4263	Bone Replacement Graft — First Site in Quadrant	141.15
D4264	Bone Replacement Graft, Each Additional Site in Quadrant	70.60
D4270	Pedicle Soft Tissue Graft	141.15
D4271	Free Soft Tissue Graft	141.15
D4273	Subepithelial Connective Tissue Graft Procedure	141.15
D4274	Distal or Proximal Wedge	70.60
D4320	Provisional Splinting, Intracoronal	188.20
D4321	Provisional Splinting, Extracoronal	56.50
D4341	Periodontal Scaling and Root Planing – 4+ Teeth, Per Quadrant	80.00
D4342	Periodontal Scaling and Root Planing – 1 to 3 Teeth, Per Quadrant	40.00
D4910	Periodontal Maintenance Procedure	47.05
D5110	Complete Denture - Maxillary	376.35
D5120	Complete Denture - Mandibular	376.35
D5130	Immediate Denture – Maxillary	376.35
D5140	Immediate Denture – Mandibular	376.35
D5211	Maxillary Partial Denture — Resin Base	357.55
D5212	Mandibular Partial Denture — Resin Base	357.55
D5213	Maxillary Partial Denture — Cast Metal Framework	366.95
D5214	Mandibular Partial Denture — Cast Metal Framework	366.95
D5510	Repair Complete Denture Base	61.15
D5520	Replace Missing or Broken Teeth, Complete Denture	38.10
D5610	Repair Partial Denture Base	51.75
D5620	Repair Cast Framework	79.05

**Doral Dental Services of Illinois, LLC**

<b>Procedure Code</b>	<b>Procedure</b>	<b>Maximum Allowance</b>
D5630	Repair or Replace Broken Clasp	71.50
D5640	Replace Broken Teeth, Each Additional Tooth	37.65
D5650	Add Tooth to Existing Partial	42.35
D5730	Reline Complete Maxillary Denture, Chairside	70.60
D5731	Reline Complete Mandibular Denture, Chairside	70.60
D5740	Reline Maxillary Partial Denture, Chairside	70.60
D5741	Reline Mandibular Partial Denture, Chairside	70.60
D5750	Reline Complete Maxillary Denture, Laboratory	117.60
D5751	Reline Complete Mandibular Denture, Laboratory	117.60
D5760	Reline Maxillary Partial Denture, Laboratory	117.60
D5761	Reline Mandibular Partial Denture, Laboratory	117.60
D5911	Facial Moulage-sectional	By Report
D5912	Facial Moulage-complete	By Report
D5913	Nasal Prosthesis	By Report
D5914	Auricular Prosthesis	By Report
D5915	Orbital Prosthesis	By Report
D5916	Ocular Prosthesis	By Report
D5919	Facial Prosthesis	By Report
D5922	Nasal Septal Prosthesis	By Report
D5923	Ocular Prosthesis, interim	By Report
D5924	Cranial Prosthesis	By Report
D5925	Facial Augmentation implant Prosthesis	By Report
D5926	Nasal Prosthesis, replacement	By Report
D5927	Auricular Prosthesis, replacement	By Report
D5928	Orbital Prosthesis, replacement	By Report
D5929	Facial Prosthesis, replacement	By Report
D5931	Obturator Prosthesis, surgical	By Report
D5932	Obturator Prosthesis, definitive	By Report
D5933	Obturator Prosthesis, modification	By Report
D5934	Mandibular Resection Prosthesis with guide flanges	By Report
D5935	Mandibular Resection Prosthesis without guide flanges	By Report
D5936	Obturator Prosthesis, interim	By Report
D5937	Trismus Appliance	By Report
D5951	Feeding Aid	By Report
D5952	Speech Aid Prosthesis, pediatric	By Report
D5953	Speech Aid Prosthesis, adult	By Report
D5954	Palatal Augmentation, Prosthesis	By Report
D5955	Palatal Lift Prosthesis, definitive	By Report
D5958	Palatal Lift Prosthesis, Interim	By Report
D5959	Palatal Lift Prosthesis, modification	By Report
D5960	Speech Aid Prosthesis, modification	By Report
D5982	Surgical Stent	By Report
D5983	Radiation Carrier	By Report
D5984	Radiation Shield	By Report
D5985	Radiation Cone Locator	By Report
D5986	Fluoride Gel Carrier	By Report
D5987	Commissure Splint	By Report
D5988	Surgical Splint	By Report
D5999	Unspecified Maxillofacial Prosthesis	By Report
D6210	Pontic crown – metal high noble	178.80

**Doral Dental Services of Illinois, LLC**

<b>Procedure Code</b>	<b>Procedure</b>	<b>Maximum Allowance</b>
D6211	Pontic crown – metal base	178.80
D6212	Pontic crown – metal noble	178.80
D6240	Pontic crown – porc/metal high noble	178.80
D6241	Pontic crown - porc/base Metal	178.80
D6242	Pontic crown – porc metal noble	178.80
D6251	Pontic-Resin/Base Metal	103.50
D6721	Crown-Resin/Predominately Base Metal	136.40
D6750	Crown – porc/metal high noble	159.95
D6751	Crown-Porcelain/Predominately Base Metal	159.95
D6752	Crown – porc/metal noble	159.95
D6790	Crown – full metal high noble	159.95
D6791	Crown - full metal base	159.95
D6792	Crown - full metal noble	159.95
D6930	Recement Fixed Partial Denture	32.90
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	26.35
D6999	Unspecified, fixed prosthodontic procedure, by report	By Report
D7140	Extraction – Erupted Tooth or Exposed Root	39.12
D7210	Surgical Removal of Erupted Tooth	57.40
D7220	Removal of Impacted Tooth — Soft Tissue	66.80
D7230	Removal for Impacted Tooth — Partially Bony	86.60
D7240	Removal of Impacted Tooth — Completely Bony	100.70
D7250	Surgical Removal of Residual Roots	57.40
D7280	Surgical access of unerupted tooth	50.80
D7283	Placement of device to facilitate eruption of impacted tooth	45.00
D7310	Alveoloplasty in Conjunction with Extractions — per quadrant	64.00
D7311	Alveoloplasty w/ extraction – 1-3 teeth/spaces per quad	64.00
D7320	Alveoloplasty Not in Conjunction With Extractions — per quadrant	64.00
D7321	Alveoloplasty w/o extractions – 1- 3 teeth/spaces per quad	64.00
D7450	Removal of Odontogenic Cyst or Tumor up to 1.25cm	94.30
D7451	Removal of Odontogenic Cyst or Tumor over 1.25cm	199.60
D7460	Removal of Non-Odontogenic Cyst or Tumor up to 1.25cm	94.30
D7461	Removal of Non-Odontogenic Cyst or Tumor over 1.25cm	199.60
D7510	Incision and Drainage Abscess	36.70
D7511	Incision & drainage – intraoral - complicated	36.70
D7610	Maxilla Open Reduction, Teeth Immobilized	657.95
D7620	Maxilla Closed Reduction, Teeth Immobilized	471.50
D7630	Mandible-Open Reduction, Teeth Immobilized	824.65
D7640	Mandible-Closed Reduction, Teeth Immobilized	706.95
D7710	Maxilla-Open Reduction	1059.35
D7720	Maxilla-Closed Reduction	706.35
D7730	Mandible-Open Reduction	1059.35
D7740	Mandible-Closed Reduction	706.20
D7810	Open Reduction of Dislocation	438.60
D7820	Closed Reduction of Dislocation	177.65
D7960	Frenulectomy-Separate Procedure (frenectomy or frenotomy)	77.15
D7963	Frenuloplasty	77.15
D8080	Initial Orthodontic Appliance Placement	588.05
D8660	Initial Examination, Records, Radiographs & Facial Photographs	75.30
D8670	Monthly Adjustments	89.90
D8999	Initial Orthodontic Evaluation/Study Models	47.05
D9110	Palliative (emergency) Treatment of Dental Pain-Minor Procedures	14.10
D9220	General Anesthesia – Require Dental Sedation Permit B to bill	59.30
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	12.20

***Doral Dental Services of Illinois, LLC***

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<b>Procedure Code</b>	<b>Procedure</b>	<b>Maximum Allowance</b>
D9241	Intravenous Sedation – Require Dental Sedation Permit A to bill	59.30
D9248	Non-intravenous conscious sedation – Require Dental Sedation Permit A to bill	35.00
D9310	Consultation	17.10
D9610	Therapeutic Drug Injection	By Report
D9630	Other Drugs and Medicaments	23.50
D9999	Unspecified Procedure, By Report	By Report

**ATTACHMENT V**

**Doral Dental Services of Illinois, LLC  
Healthcare and Family Services  
All Kids/HFS Dental Program Fee Schedule for Adult Beneficiaries  
Rates Effective January 1, 2007**

<b>Procedure Code</b>	<b>Procedure</b>	<b>Maximum Allowance</b>
D0140	Limited Oral Examination - Problem Focused	16.20
D0150	Comprehensive Oral Examination	21.05
D0210	Intraoral-Complete Series (including bitewings)	30.10
D0220	Intraoral - periapical —first film	5.60
D0230	Intraoral periapical – 1 additional film	3.80
D0270	Bitewings Single Film	5.60
D0272	Bitewings-Two Films	9.40
D0274	Bitewings-Four Films	16.90
D0277	Vertical Bitewings – 7-8 Films	16.90
D0330	Panoramic Film	22.60
D2140	Amalgam-1-Surface, Primary or Permanent	30.85
D2150	Amalgam-2-Surfaces, Primary or Permanent	48.15
D2160	Amalgam-3-Surfaces, Primary or Permanent	58.05
D2161	Amalgam-4+-Surface, Primary or Permanent	58.05
D2330	Resin-Based Composite - 1-Surface, Anterior	34.60
D2331	Resin-Based Composite - 2-Surfaces, Anterior	51.90
D2332	Resin-Based Composite - 3-Surfaces, Anterior	61.80
D2335	Resin-Based Composite – 4+ surfaces, or involving Incisal Edge, Anterior	61.80
D2391	Resin-Based Composite – 1-surface, Primary or Permanent	30.85
D2392	Resin-Based Composite – 2-surfaces, Primary or Permanent	48.15
D2393	Resin-Based Composite – 3-surfaces, Primary or Permanent	58.05
D2394	Resin-Based Composite – 4+surfaces, Primary or Permanent	58.05
D2740	Crown – porc/ceramic	235.20
D2750	Crown – porc/metal high noble	235.20
D2751	Crown-Porcelain/Base Metal	235.20
D2752	Crown-Porcelain/metal noble	235.20
D2790	Crown – full metal high noble	145.85
D2791	Crown - Full Cast Base Metal	145.85
D2792	Crown – full metal noble	145.85
D2910	Recement Inlays	11.30
D2915	Recement cast of prefabricated post and core	23.50
D2920	Recement Crown	23.50
D2931	Prefabricated Stainless Steel Crown (SSC) Permanent Tooth	73.40
D2932	Prefabricated Resin Crown	56.45
D2940	Sedative fillings	11.30
D2951	Pin Retention-Per Tooth	9.40
D2954	Prefabricated Post and Core	32.90
D3310	Anterior Root Canal (Excluding Final Restoration)	136.40
D5110	Complete Denture - Maxillary	376.35
D5120	Complete Denture - Mandibular	376.35
D5130	Immediate Denture – Maxillary	376.35
D5140	Immediate Denture – Mandibular	376.35
D5510	Repair Complete Denture Base	61.15



**Doral Dental Services of Illinois, LLC**

<b>Procedure Code</b>	<b>Procedure</b>	<b>Maximum Allowance</b>
D5520	Replace Missing or Broken Teeth, Complete Denture	38.10
D5610	Repair Partial Denture Base	51.75
D5620	Repair Cast Framework	79.05
D5630	Repair or Replace Broken Clasp	71.50
D5640	Replace Broken Teeth, Each Additional Tooth	37.65
D5650	Add Tooth to Existing Partial	42.35
D5730	Reline Complete Maxillary Denture, Chairside	70.60
D5731	Reline Complete Mandibular Denture, Chairside	70.60
D5740	Reline Maxillary Partial Denture, Chairside	70.60
D5741	Reline Mandibular Partial Denture, Chairside	70.60
D5750	Reline Complete Maxillary Denture, Laboratory	117.60
D5751	Reline Complete Mandibular Denture, Laboratory	117.60
D5760	Reline Maxillary Partial Denture, Laboratory	117.60
D5761	Reline Mandibular Partial Denture, Laboratory	117.60
D5911	Facial Moulage-sectional	By Report
D5912	Facial Moulage-complete	By Report
D5913	Nasal Prosthesis	By Report
D5914	Auricular Prosthesis	By Report
D5915	Orbital Prosthesis	By Report
D5916	Ocular Prosthesis	By Report
D5919	Facial Prosthesis	By Report
D5922	Nasal Septal Prosthesis	By Report
D5923	Ocular Prosthesis, interim	By Report
D5924	Cranial Prosthesis	By Report
D5925	Facial Augmentation implant Prosthesis	By Report
D5926	Nasal Prosthesis, replacement	By Report
D5927	Auricular Prosthesis, replacement	By Report
D5928	Orbital Prosthesis, replacement	By Report
D5929	Facial Prosthesis, replacement	By Report
D5931	Obturator Prosthesis, surgical	By Report
D5932	Obturator Prosthesis, definitive	By Report
D5933	Obturator Prosthesis, modification	By Report
D5934	Mandibular Resection Prosthesis with guide flanges	By Report
D5935	Mandibular Resection Prosthesis without guide flanges	By Report
D5936	Obturator Prosthesis, interim	By Report
D5937	Trismus Appliance	By Report
D5951	Feeding Aid	By Report
D5953	Speech Aid Prosthesis, adult	By Report
D5954	Palatal Augmentation, Prosthesis	By Report
D5955	Palatal Lift Prosthesis, definitive	By Report
D5958	Palatal Lift Prosthesis, Interim	By Report
D5959	Palatal Lift Prosthesis, modification	By Report
D5960	Speech Aid Prosthesis, modification	By Report
D5982	Surgical Stent	By Report
D5983	Radiation Carrier	By Report
D5984	Radiation Shield	By Report
D5985	Radiation Cone Locator	By Report
D5986	Fluoride Gel Carrier	By Report
D5987	Commissure Splint	By Report
D5988	Surgical Splint	By Report
D5999	Unspecified Maxillofacial Prosthesis	By Report

**Doral Dental Services of Illinois, LLC**

<b>Procedure Code</b>	<b>Procedure</b>	<b>Maximum Allowance</b>
D6930	Recement Fixed Partial Denture	32.90
D6999	Unspecified, fixed prosthodontic procedure, by report	By Report
D7140	Extraction – Erupted Tooth or Exposed Root	39.12
D7210	Surgical Removal of Erupted Tooth	57.40
D7220	Removal of Impacted Tooth — Soft Tissue	66.80
D7230	Removal for Impacted Tooth — Partially Bony	86.60
D7240	Removal of Impacted Tooth — Completely Bony	100.70
D7250	Surgical Removal of Residual Roots	57.40
D7450	Removal of Odontogenic Cyst or Tumor up to 1.25cm	94.30
D7451	Removal of Odontogenic Cyst or Tumor over 1.25cm	199.60
D7460	Removal of Non-Odontogenic Cyst or Tumor up to 1.25cm	94.30
D7461	Removal of Non-Odontogenic Cyst or Tumor over 1.25cm	199.60
D7510	Incision and Drainage Abscess	36.70
D7511	Incision and drainage – intraoral – complicated	36.70
D7610	Maxilla Open Reduction, Teeth Immobilized	657.95
D7620	Maxilla Closed Reduction, Teeth Immobilized	471.50
D7630	Mandible-Open Reduction, Teeth Immobilized	824.65
D7640	Mandible-Closed Reduction, Teeth Immobilized	706.95
D7710	Maxilla-Open Reduction	1059.35
D7720	Maxilla-Closed Reduction	706.35
D7730	Mandible-Open Reduction	1059.35
D7740	Mandible-Closed Reduction	706.20
D7810	Open Reduction of Dislocation	438.60
D7820	Closed Reduction of Dislocation	177.65
D9110	Palliative (emergency) Treatment of Dental Pain-Minor Procedures	14.10
D9220	General Anesthesia – Require Dental Sedation Permit B to bill	59.30
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	12.20
D9241	Intravenous Sedation – Require Dental Sedation Permit A to bill	59.30
D9248	Non-Intravenous conscious sedation – Require Dental Sedation Permit A to	35.00
D9310	Consultation	17.10
D9610	Therapeutic Drug Injection	By Report
D9630	Other Drugs and Medicaments	23.50
D9999	Unspecified Procedure, By Report	By Report

**ATTACHMENT W**

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

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

## **Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Diagnostic services include the oral examinations and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health. Completion of a mandated school exam form is considered part of the oral examination. Providers must complete the exam form free of charge if requested by the parent or guardian within six (6) months of the oral examination.

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

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

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

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

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

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

**PLACE OF SERVICE MUST BE INDICATED ON ALL CLAIMS.**

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

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

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation	0 - 20		No	One per 12 months. Participants are also eligible for one periodic oral evaluation (D0120) performed in school setting per 12 months. Completion of a mandated school exam form is considered part of the oral examination.	Place of service.
D0140	limited oral evaluation - problem focused	0 - 20		No	Limited emergency exam will only be covered when performed in conjunction with treatment to address an emergency situation. An emergency will be defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding or traumatic injury. Not allowed with D9110.	Description of the emergency and description of services provided with claim.
D0150	comprehensive oral evaluation - new or established patient	0 - 20		No	One comprehensive exam per patient per dentist or dental group per lifetime.	
D0210	intraoral - complete series (including bitewings)	0 - 20		No	One per 36 months.	
D0220	intraoral - periapical first film	0 - 20		No	Maximum of one (1) per day per patient per dentist or dental group.	

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0230	intraoral - periapical each additional film	0 - 20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single film	0 - 20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two films	0 - 20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four films	0 - 20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	0 - 20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0330	panoramic film	1 - 20		No	One per 36 months. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

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

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

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

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

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

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

PLACE OF SERVICE MUST BE INDICATED ON ALL CLAIMS.

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

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

Preventive						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1120	prophylaxis - child	0 - 20		No	One per 6 months. Removal of plaque, calculus and stains from the tooth surfaces. Intended to control local irrational factors.	Place of service.



**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Preventive						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1203	topical application of fluoride (prophylaxis not included) - child	0 - 20		No	One per 12 months. Prescription strength fluoride designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional.	Place of service.
D1206	topical application of fluoride (including prophylaxis) - adult	0 - 20		No	One per 12 months. Prescription strength fluoride designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional.	Place of service.
D1351	sealant - per tooth	5 - 17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Once per lifetime. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	
D1510	space maintainer - fixed - unilateral	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	Covered when indicated due to premature loss of posterior primary teeth.	Pre-operative radiographs.
D1515	space maintainer - fixed - bilateral	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No	Covered when indicated due to premature loss of posterior primary teeth.	Pre-operative radiographs.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Preventive						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1520	space maintainer - removable - unilateral	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No		
D1525	space maintainer - removable - bilateral	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No	Covered when indicated due to premature loss of posterior primary teeth.	Pre-operative radiographs.
D1550	re-cementation space maintainer	1 - 20		No		

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

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

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

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	amalgam - one surface, primary or permanent	0 - 20	Teeth 1 through 32, A through T	No		
D2150	amalgam - two surfaces, primary or permanent	0 - 20	Teeth 1 through 32, A through T	No		
D2160	amalgam - three surfaces, primary or permanent	0 - 20	Teeth 1 through 32, A through T	No		
D2161	amalgam - four or more surfaces, primary or permanent	0 - 20	Teeth 1 through 32, A through T	No		

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2330	resin-based composite - one surface, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2331	resin-based composite - two surfaces, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2332	resin-based composite - three surfaces, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2335	resin-based composite - four or more surfaces or involving incisal angle, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - one surface, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2392	resin-based composite - two surfaces posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2393	resin-based composite - three surfaces, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2394	resin-based composite - four or more surfaces, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2740	crown - porcelain/ceramic substrate	0 - 20	Teeth 4 - 13, 20 - 29	Yes	One per 60 months.	Pre-operative radiographs.
D2750	crown - porcelain fused to high noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2751	crown - porcelain fused to predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.
D2752	crown - porcelain fused to noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.
D2790	crown - full cast high noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.
D2791	crown - full cast predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.
D2792	crown - full cast noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2910	recement inlay, onlay, or partial coverage restoration	0 - 20	Teeth 1 through 32	No		
D2915	recement cast or prefabricated post and core	0 - 20	Teeth 1 through 32	No		
D2920	recement crown	0 - 20	Teeth 1 through 32, A through T	No		
D2930	prefabricated stainless steel crown - primary tooth	0 - 20	Teeth A through T	No		
D2931	prefabricated stainless steel crown - permanent tooth	0 - 20	Teeth 1 through 32	Yes	Authorization required for three (3) or more crowns. Not compensated with construction of permanent crown.	Pre-operative radiographs.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2932	prefabricated resin crown	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	Authorization required for three (3) or more crowns.	Pre-operative radiographs.
D2933	prefabricated stainless steel crown with resin window	0 - 20	Teeth C - H, M - R	No		
D2940	sedative filling	0 - 20	Teeth 1 through 32, A through T	No		
D2951	pin retention - per tooth, in addition to restoration	0 - 20	Teeth 1 through 32	No		
D2954	prefabricated post and core in addition to crown	0 - 20	Teeth 1 through 32	Yes		Endodontic fill radiograph.



**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

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

The following guidelines must be followed when providing endodontic services:

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

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

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

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

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0 - 20	Teeth A through T	No	Not reimbursable when performed in conjunction with a root canal - Primary Teeth Only.	
D3230	pulpal therapy - (resorbable filing) - anterior, primary tooth (excluding final restoration)	0 - 20	Teeth C - H, M - R	No		

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	root canal - anterior (excluding final restoration)	1 - 20	Teeth 6 - 11, 22 - 27	No	Once per lifetime.	
D3320	root canal - bicuspid (excluding final restoration)	1 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Once per lifetime.	
D3330	root canal - molar (excluding final restoration)	1 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	No	Once per lifetime.	
D3351	apexification/recalcification - initial visit (apical closure/clacific repair of perforations, root receptions, etc.)	1 - 20	Teeth 1 through 32	Yes	Once per lifetime.	Pre-operative radiograph.
D3352	apexification/recalcification - interim medication replacement (apical closure/clacific repair of perforations, root receptions, etc.)	1 - 20	Teeth 1 through 32	Yes	Once per lifetime.	Pre-operative radiograph with claim.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/clastic repair of perforations, root receptions, etc.)	1 - 20	Teeth 1 through 32	Yes	Once per lifetime.	Pre-operative radiograph and fill radiograph with claim.
D3410	apicoectomy/periradicular surgery - anterior	1 - 20	Teeth 6 - 11, 22 - 27	Yes	Not payable concurrently with root canal treatment of tooth.	Pre-operative radiograph.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy/gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes		Pre-operative radiographs and periodontal charting.
D4211	gingivectomy/gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes		Pre-operative radiographs and periodontal charting.
D4240	gingival flap w/ root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes		Pre-operative radiographs and periodontal charting.
D4241	gingival flap w/ root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes		Pre-operative radiographs and periodontal charting.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4260	osseous surgery - four or more contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes		Pre-operative radiographs and periodontal charting.
D4261	osseous surgery - one to three contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes		Pre-operative radiographs and periodontal charting.
D4263	bone replacement graft - first site in quadrant	0 - 20	Teeth 1 through 32	Yes		Pre-operative radiographs and periodontal charting.
D4264	bone replacement graft - each additional site in quadrant	0 - 20	Teeth 1 through 32	Yes		Pre-operative radiographs and periodontal charting.
D4270	pedicle soft tissue graft procedure	0 - 20	Teeth 1 through 32	Yes		Pre-operative radiographs and periodontal charting.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4271	free soft tissue graft procedure (including donor site surgery)	0 - 20	Teeth 1 through 32	Yes		Pre-operative radiographs and periodontal charting.
D4273	subepithelial connective tissue graft procedures, per tooth	0 - 20	Teeth 1 through 32	Yes		Pre-operative radiographs and periodontal charting.
D4274	distal or proximal wedge procedure (when not performed in conjunction with surgical procedures)	0 - 20	Teeth 1 through 32, 51 through 82 (SN)	Yes		Pre-operative radiographs and periodontal charting.
D4320	provisional splinting - intracoronal	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	Yes		Pre-operative radiographs and periodontal charting.
D4321	provisional splinting - extracoronal	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	Yes		Pre-operative radiographs and periodontal charting.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	One per 24 months. One full mouth service is covered every 24 months.	Pre-operative radiographs and periodontal charting.
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	One per 24 months. One full mouth service is covered every 24 months.	Pre-operative radiographs and periodontal charting.
D4910	periodontal maintenance	0 - 20		Yes	Only covered after active therapy has been performed.	Pre-operative radiographs and periodontal charting.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

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

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

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

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

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

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	0 - 20		Yes	One per 60 months. (D5110 or D5130).	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5120	complete denture - mandibular	0 - 20		Yes	One per 60 months. (D5120 or D5140).	Pre-operative full mouth radiographs. Date of prior placement (if applicable).



**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5130	immediate denture - maxillary	0 - 20		Yes	One per 60 months. (D5110 or D5130).	Pre-operative full mouth radiographs.
D5140	immediate denture - mandibular	0 - 20		Yes	One per 60 months. (D5120 or D5140).	Pre-operative full mouth radiographs.
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 - 20		Yes	One per 60 months. (D5211 or D5213).	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 - 20		Yes	One per 60 months. (D5212 or D5214).	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 - 20		Yes	One per 60 months. (D5211 or D5213).	Pre-operative full mouth radiographs. Date of prior placement (if applicable).

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 - 20		Yes	One per 60 months. (D5212 or D5214).	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5510	repair broken complete denture base	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0 - 20	Teeth 1 through 32	No		
D5610	repair resin denture base	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D5620	repair cast framework	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5630	repair or replace broken clasp	0 - 20		No		
D5640	replace broken teeth - per tooth	0 - 20	Teeth 1 through 32	No		
D5650	add tooth to existing partial denture	0 - 20	Teeth 1 through 32	No		
D5730	reline complete maxillary denture (chairside)	0 - 20		Yes	One per 24 months.	Date of denture placement.
D5731	reline complete mandibular denture (chairside)	0 - 20		Yes	One per 24 months.	Date of denture placement.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5740	reline maxillary partial denture (chairside)	0 - 20		Yes	One per 24 months.	Date of denture placement.
D5741	reline mandibular partial denture (chairside)	0 - 20		Yes	One per 24 months.	Date of denture placement.
D5750	reline complete maxillary denture (laboratory)	0 - 20		Yes	One per 24 months.	Date of denture placement.
D5751	reline complete mandibular denture (laboratory)	0 - 20		Yes	One per 24 months.	Date of denture placement.
D5760	reline maxillary partial denture (laboratory)	0 - 20		Yes	One per 24 months.	Date of denture placement.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5761	reline mandibular partial denture (laboratory)	0 - 20		Yes	One per 24 months.	Date of denture placement.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	0 - 20		Yes		Narrative of medical necessity.
D5912	facial moulage (complete)	0 - 20		Yes		Narrative of medical necessity.
D5913	nasal prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5914	auricular prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5915	orbital prosthesis	0 - 20		Yes		Narrative of medical necessity.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5916	ocular prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5919	facial prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5922	nasal septal prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5923	ocular prosthesis, interim	0 - 20		Yes		Narrative of medical necessity.
D5924	cranial prosthesis	0 - 20		Yes		Narrative of medical necessity.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5925	facial augmentation implant prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5926	nasal prosthesis, replacement	0 - 20		Yes		Narrative of medical necessity.
D5927	auricular prosthesis, replacement	0 - 20		Yes		Narrative of medical necessity.
D5928	orbital prosthesis, replacement	0 - 20		Yes		Narrative of medical necessity.
D5929	facial prosthesis, replacement	0 - 20		Yes		Narrative of medical necessity.



**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5931	obturator prosthesis, surgical	0 - 20		Yes		Narrative of medical necessity.
D5932	obturator prosthesis, definitive	0 - 20		Yes		Narrative of medical necessity.
D5933	obturator prosthesis, modification	0 - 20		Yes		Narrative of medical necessity.
D5934	mandibular resection prosthesis with guide flange	0 - 20		Yes		Narrative of medical necessity.
D5935	mandibular resection prosthesis without guide flange	0 - 20		Yes		Narrative of medical necessity.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5936	obturator prosthesis, interim	0 - 20		Yes		Narrative of medical necessity.
D5937	trismus appliance (not for TMD treatment)	0 - 20		Yes	Not for TMD Treatment.	Narrative of medical necessity.
D5951	feeding aid	0 - 20		Yes		Narrative of medical necessity.
D5952	speech aid prosthesis, pediatric	0 - 12		Yes		Narrative of medical necessity.
D5953	speech aid prosthesis, adult	13 - 20		Yes		Narrative of medical necessity.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5954	palatal augmentation prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5955	palatal lift prosthesis, definitive	0 - 20		Yes		Narrative of medical necessity.
D5958	palatal lift prosthesis, interim	0 - 20		Yes		Narrative of medical necessity.
D5959	palatal lift prosthesis, modification	0 - 20		Yes		Narrative of medical necessity.
D5960	speech aid prosthesis, modification	0 - 20		Yes		Narrative of medical necessity.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5982	surgical stent	0 - 20		Yes		Narrative of medical necessity.
D5983	radiation carrier	0 - 20		Yes		Narrative of medical necessity.
D5984	radiation shield	0 - 20		Yes		Narrative of medical necessity.
D5985	radiation cone locator	0 - 20		Yes		Narrative of medical necessity.
D5986	fluoride gel carrier	0 - 20		Yes		Narrative of medical necessity.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5987	commissure splint	0 - 20		Yes		Narrative of medical necessity.
D5988	surgical splint	0 - 20		Yes		Narrative of medical necessity.
D5999	unspecified maxillofacial prosthesis, by report	0 - 20		Yes		Narrative of medical necessity.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.

Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6210	pontic - cast high noble metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6211	pontic - predominantly base metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6212	pontic - cast noble metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6240	pontic - porcelain fused to high noble metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6241	pontic - porcelain fused to predominantly base metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6242	pontic - porcelain fused to noble metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6251	pontic - resin with predominantly base metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6721	crown - resin with predominantly base metal	1 - 20	Teeth 5 - 12, 20 - 29	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6750	crown - porcelain fused to high noble metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6751	crown - porcelain fused to predominantly base metal	1 - 20	Teeth 5 - 12, 20 - 29	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6752	crown - porcelain fused to noble metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	
D6790	crown - full cast high noble metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6791	crown - full cast predominantly base metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).
D6792	crown - full cast noble metal	1 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs. Date of prior placement (if applicable).



**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6930	recement fixed partial denture	0 - 20		No		
D6972	prefabricated post and core in addition to fixed partial denture retainer	1 - 20	Teeth 5 - 12, 20 - 29	Yes		Endodontic fill radiograph.
D6999	unspecified fixed prosthodontic procedure, by report	0 - 20		Yes		Pre-operative radiographs, description of service and narrative of medical necessity.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

PROVIDERS BILLING ANESTHESIA SERVICES WITH ORAL SURGERY SERVICES MUST HAVE THE APPROPRIATE PERMITS IN ORDER TO BE REIMBURSED FOR SEDATION. SEE ANESTHESIA CODES FOR FURTHER DETAIL (D9220 - D9248).

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No		
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7220	removal of impacted tooth - soft tissue	1 - 20	Teeth 1 through 32, 51 through 82 (SN)	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7230	removal of impacted tooth - partially bone	1 - 20	Teeth 1 through 32, 51 through 82 (SN)	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7240	removal of impacted tooth - completely bony	1 - 20	Teeth 1 through 32, 51 through 82 (SN)	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7250	surgical removal of residual roots (cutting procedure)	1 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7280	surgical access of unerupted tooth	1 - 20	Teeth 1 through 32	Yes	To expose crown of an impacted tooth not intended to be extracted.	Pre-operative radiographs.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7283	placement of device to facilitate eruption of impacted tooth	1 - 20	Teeth 1 through 32	Yes	Once per lifetime. ALLOWED ONLY ON APPROVED ORTHODONTIC CASES PER LIFETIME.	Pre-operative radiographs. For ortho cases only.
D7310	alveoloplasty in conjunction with extractions - per quadrant	1 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	Once per lifetime. Either D7310 or D7311 per quad.	Pre-operative radiographs.
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	1 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	Once per lifetime. Either D7310 or D7311 per quad.	Pre-operative radiographs.
D7320	alveoloplasty not in conjunction with extractions - per quadrant	1 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	Once per lifetime. Either D7320 or D7321 per quad.	Diagnostic models.
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	1 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	Once per lifetime. Either D7320 or D7321 per quad.	Diagnostic models.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	0 - 20		Yes		Copy of pathology report with claim.
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	0 - 20		Yes		Copy of pathology report with claim.
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	0 - 20		Yes		Copy of pathology report with claim.
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	0 - 20		Yes		Copy of pathology report with claim.
D7510	incision and drainage of abscess - intraoral soft tissue	0 - 20		Yes	Either D7510 or D7511 on date of service.	Pre-operative radiographs and narrative with claim.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0 - 20		Yes	Includes drainage of multiple fascial spaces. Either D7510 or D7511 on date of service.	Pre-operative radiographs and narrative with claim.
D7610	maxilla - open reduction (teeth immobilized, if present)	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7620	maxilla - closed reduction (teeth immobilized, if present)	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7630	mandible - open reduction (teeth immobilized, if present)	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7640	mandible - closed reduction (teeth immobilized, if present)	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7710	maxilla - open reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7720	maxilla - closed reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7730	mandible - open reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7740	mandible - closed reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7810	open reduction of dislocation	0 - 20		Yes		Narrative of medical necessity with claim.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7820	closed reduction of dislocation	0 - 20		Yes		Narrative of medical necessity with claim.
D7960	frenulectomy - (frenectomy or frenotomy) - separate procedure	1 - 20		Yes	Once per lifetime. One per arch per lifetime. Either D7960 or D7963.	Narrative of medical necessity. Study model or photo.
D7963	frenuloplasty	1 - 20		Yes	Once per lifetime. One per arch per lifetime. Either D7960 or D7963.	Narrative of medical necessity. Study model or photo.



## Attachment X: Benefits Covered – CHILDREN UNDER AGE 21

Participants between the ages of 2 and 20 may qualify for orthodontic care under the program. PARTICIPANTS MUST HAVE A SEVERE, DYSFUNCTIONAL, HANDICAPPING MALOCCLUSION AS DETERMINED BY A SCORE OF 42 POINTS OR GREATER ON THE MODIFIED SALZMANN INDEX, OR OBJECTIVE DOCUMENTATION THAT THE MALOCCLUSION IS AN IMPAIRMENT OF, OR A HAZARD TO THE ABILITY TO EAT, CHEW, SPEAK, OR BREATHE. If it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. INTERCEPTIVE ORTHODONTICS IS NOT A COVERED BENEFIT. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. THE PARTICIPANT MUST HAVE LOST ALL PRIMARY TEETH AND HAVE PERMANENT TEETH ERUPTING OR IN OCCLUSION TO BE CONSIDERED.

For cleft palate cases, please contact the Division of Specialized Care for Children (DSCC) at 1.800.322.3722.

All orthodontic services require prior authorization by a Doral Dental Consultant. Requests for prior authorization must include:

- \* Orthodontic examination and records
- \* Appropriate radiographs and facial photographs
- \* Study models properly trimmed and identified
- \* Detailed treatment plan with diagnosis and prognosis

The charge for the initial exam, radiographs and study models should be submitted under procedure code D8660.

The date of service for orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant's mouth. It is important to verify the Participant's eligibility, as the Participant must be eligible on this date of service.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

To initiate payment on an approved comprehensive orthodontic case, the dental office must submit a claim form indicating the date the appliances were placed (banding date). IN ORDER TO RECEIVE REIMBURSEMENT FOR MONTHLY ADJUSTMENTS, PROVIDER MUST BILL FOR EACH DATE OF SERVICE TREATMENT WAS RENDERED. If a Participant fails to keep an appointment for two consecutive months, the dental office must notify Doral.

Continuation of orthodontic care will be handled as follows:

1. For cases that were started prior to the date the Participant was enrolled in the Medical Assistance program, Doral will attempt to secure the original pre-treatment records for review by a Doral Dental Consultant. The Modified Salzman Index will be performed and the original records reviewed using the criteria for all new cases. If the original records pass the test of medical necessity, a continuation of benefits based on a proration of the remaining treatment will be authorized.
2. For cases that were started under the Medical Assistance Program, a Participant will be allowed to transfer treatment only under extreme situations. Usually this will be limited to when a Participant moves out of the immediate service area. In this instance, the dentist who will complete the treatment must submit a claim form indicating the treatment status of the case, his/her intention to continue care and a charge for the remaining treatment. Doral will review the request on a case by case basis and issue a determination of benefits.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8080	comprehensive orthodontic treatment of the adolescent dentition	1 - 20		Yes	Once per lifetime.	Study models (or OrthoCad equivalent) and radiographs.
D8660	pre-orthodontic treatment visit	1 - 20		Yes		Study models (or OrthoCad equivalent) and radiographs.
D8670	periodic orthodontic treatment visit (as part of contract)	1 - 20		Yes	Maximum of one (1) per month regardless of number of visits each month.	
D8999	unspecified orthodontic procedure, by report	1 - 20		Yes	Once per lifetime. Only covered if case fails to reach 42 points on the Modified Salzman Index.	

## Attachment X: Benefits Covered – CHILDREN UNDER AGE 21

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied.

Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act.

Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. Doral or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9230 – nitrous oxide, is a covered service for Participants who are mentally or physically challenged, or otherwise present with special management needs. Special consideration is granted to individuals under the age of six that require extensive dental treatment and/or exhibit rampant caries where patient management is a concern.

Only claims for nitrous oxide with documented medical necessity will be considered for payment. Medical necessity for the use of nitrous oxide would be broadly defined as some condition specific to the particular treatment situation that would preclude the performance of necessary dental treatment, with the use of a local anesthetic alone.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Some examples of conditions that would establish medical necessity for nitrous oxide are:

- \* Apprehensive child under the age of six when any treatment is rendered
- \* Apprehensive children between 6 and 10 years of age when restorative or surgery is performed
- \* Apprehensive children between the ages of 10 and 18 years when surgical services are performed

All other situations for nitrous oxide will be reviewed for coverage on a case-by-case basis.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

IN ACCORDANCE WITH THE ILLINOIS DENTAL PRACTICE ACT AS DEFINED IN THE ILLINOIS ADMINISTRATIVE CODE 1220.500, PROCEDURE CODES D9241 AND D9248 REQUIRE A DENTAL SEDATION PERMIT A OR DENTAL SEDATION PERMIT B IN ORDER TO PERFORM SERVICE.

PROCEDURE CODE D9220 REQUIRES AN DENTAL SEDATION PERMIT B IN ORDER TO PERFORM SERVICE.

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	0 - 20		No	Not covered wth D0140 on same date of service.	
D9220	deep sedation/general anesthesia - first 30 minutes	0 - 20		Yes		Narrative of medical necessity. All inclusive fee - Not limited to first 30 minutes.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	0 - 20		No		Narrative of medical necessity must be kept in patient records.
D9241	intravenous conscious sedation/analgesia - first 30 minutes	0 - 20		Yes		Narrative of medical necessity. All inclusive fee - Not limited to first 30 minutes.
D9248	non-intravenous conscious sedation/analgesia	0 - 20		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment..	Provider must possess a Class A or Class B anesthesia permit..
D9310	consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	0 - 20		No		Narrative of medical necessity shall be maintained in patient records.
D9610	therapeutic drug injection, by report	0 - 20		Yes		Narrative of medical necessity. Name of drug and amount administered.

**Attachment X: Benefits Covered – CHILDREN UNDER AGE 21**

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9630	other drugs and/or medications, by report	0 - 20		Yes		Narrative of medical necessity. Name of drug and amount administered.
D9999	unspecified adjunctive procedure, by report	0 - 20		Yes		Description of service and narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Diagnostic services include the oral examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant’s oral health. Periodic exams are not a covered benefit for Participants age 21 and over.

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

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

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

PLACE OF SERVICE MUST BE INDICATED ON ALL CLAIMS.

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0140	limited oral evaluation - problem focused	21 and older		No	Limited emergency exam will only be covered when performed in conjunction with treatment to address an emergency situation. An emergency will be defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding or traumatic injury. Not allowed with D9110.	Description of the emergency and description of services provided with claim.
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One comprehensive exam per patient per dentist or dental group per lifetime.	

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0210	intraoral - complete series (including bitewings)	21 and older		No	One per 36 months.	
D0220	intraoral - periapical first film	21 and older		No	Maximum of one (1) per day per patient per dentist or dental group.	
D0230	intraoral - periapical each additional film	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single film	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two films	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	



**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0274	bitewings - four films	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0330	panoramic film	21 and older		No	One per 36 months. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

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

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

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	amalgam - one surface, primary or permanent	21 and older	Teeth 1 through 32, A through T	No		
D2150	amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 through 32, A through T	No		
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 through 32, A through T	No		
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 through 32, A through T	No		

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2335	resin-based composite - four or more surfaces or involving incisal angle, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2392	resin-based composite - two surfaces posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2740	crown - porcelain/ceramic substrate	21 and older	Teeth 4 - 13, 20 - 29	Yes	One per 60 months.	Pre-operative radiographs.
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.
D2790	crown - full cast high noble metal	21 and older	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.
D2792	crown - full cast noble metal	21 and older	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2910	recement inlay, onlay, or partial coverage restoration	21 and older	Teeth 1 through 32	No		
D2915	recement cast or prefabricated post and core	21 and older	Teeth 1 through 32	No		
D2920	recement crown	21 and older	Teeth 1 through 32, A through T	No		
D2931	prefabricated stainless steel crown - permanent tooth	21 and older	Teeth 1 through 32	Yes	Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	Pre-operative radiographs.
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	Authorization required for two (2) or more crowns.	Pre-operative radiographs.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2940	sedative filling	21 and older	Teeth 1 through 32, A through T	No		
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 through 32	No		
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 through 32	Yes		Endodontic fill radiograph.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

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

The following guidelines must be followed when providing endodontic services:

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

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

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

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	root canal - anterior (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	Once per lifetime.	



**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable.

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

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

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

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

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	One per 60 months. (D5110 or D5130).	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5120	complete denture - mandibular	21 and older		Yes	One per 60 months. (D5120 or D5140).	Pre-operative full mouth radiographs. Date of prior placement (if applicable).

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5130	immediate denture - maxillary	21 and older		Yes	One per 60 months. (D5110 or D5130).	Pre-operative full mouth radiographs.
D5140	immediate denture - mandibular	21 and older		Yes	One per 60 months. (D5120 or D5140).	Pre-operative full mouth radiographs.
D5510	repair broken complete denture base	21 and older	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 through 32	No		
D5610	repair resin denture base	21 and older	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5620	repair cast framework	21 and older	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D5630	repair or replace broken clasp	21 and older		No		
D5640	replace broken teeth - per tooth	21 and older	Teeth 1 through 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 through 32	No		
D5730	reline complete maxillary denture (chairside)	21 and older		Yes	One per 24 months.	Date of denture placement.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5731	reline complete mandibular denture (chairside)	21 and older		Yes	One per 24 months.	Date of denture placement.
D5740	reline maxillary partial denture (chairside)	21 and older		Yes	One per 24 months.	Date of denture placement.
D5741	reline mandibular partial denture (chairside)	21 and older		Yes	One per 24 months.	Date of denture placement.
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One per 24 months.	Date of denture placement.
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One per 24 months.	Date of denture placement.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One per 24 months.	Date of denture placement.
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One per 24 months.	Date of denture placement.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		Yes		Narrative of medical necessity.
D5912	facial moulage (complete)	21 and older		Yes		Narrative of medical necessity.
D5913	nasal prosthesis	21 and older		Yes		Narrative of medical necessity.
D5914	auricular prosthesis	21 and older		Yes		Narrative of medical necessity.
D5915	orbital prosthesis	21 and older		Yes		Narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5916	ocular prosthesis	21 and older		Yes		Narrative of medical necessity.
D5919	facial prosthesis	21 and older		Yes		Narrative of medical necessity.
D5922	nasal septal prosthesis	21 and older		Yes		Narrative of medical necessity.
D5923	ocular prosthesis, interim	21 and older		Yes		Narrative of medical necessity.
D5924	cranial prosthesis	21 and older		Yes		Narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5925	facial augmentation implant prosthesis	21 and older		Yes		Narrative of medical necessity.
D5926	nasal prosthesis, replacement	21 and older		Yes		Narrative of medical necessity.
D5927	auricular prosthesis, replacement	21 and older		Yes		Narrative of medical necessity.
D5928	orbital prosthesis, replacement	21 and older		Yes		Narrative of medical necessity.
D5929	facial prosthesis, replacement	21 and older		Yes		Narrative of medical necessity.



**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5931	obturator prosthesis, surgical	21 and older		Yes		Narrative of medical necessity.
D5932	obturator prosthesis, definitive	21 and older		Yes		Narrative of medical necessity.
D5933	obturator prosthesis, modification	21 and older		Yes		Narrative of medical necessity.
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		Narrative of medical necessity.
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		Narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5936	obturator prosthesis, interim	21 and older		Yes		Narrative of medical necessity.
D5937	trismus appliance (not for TMD treatment)	21 and older		Yes	Not for TMD Treatment.	Narrative of medical necessity.
D5951	feeding aid	21 and older		Yes		Narrative of medical necessity.
D5953	speech aid prosthesis, adult	21 and older		Yes		Narrative of medical necessity.
D5954	palatal augmentation prosthesis	21 and older		Yes		Narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5955	palatal lift prosthesis, definitive	21 and older		Yes		Narrative of medical necessity.
D5958	palatal lift prosthesis, interim	21 and older		Yes		Narrative of medical necessity.
D5959	palatal lift prosthesis, modification	21 and older		Yes		Narrative of medical necessity.
D5960	speech aid prosthesis, modification	21 and older		Yes		Narrative of medical necessity.
D5982	surgical stent	21 and older		Yes		Narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5983	radiation carrier	21 and older		Yes		Narrative of medical necessity.
D5984	radiation shield	21 and older		Yes		Narrative of medical necessity.
D5985	radiation cone locator	21 and older		Yes		Narrative of medical necessity.
D5986	fluoride gel carrier	21 and older		Yes		Narrative of medical necessity.
D5987	commissure splint	21 and older		Yes		Narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5988	surgical splint	21 and older		Yes		Narrative of medical necessity.
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		Narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6930	recement fixed partial denture	21 and older		No		
D6999	unspecified fixed prosthodontic procedure, by report	21 and older		Yes		Pre-operative radiographs, description of service and narrative of medical necessity.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

PROVIDERS BILLING ANESTHESIA SERVICES WITH ORAL SURGERY SERVICES MUST HAVE THE APPROPRIATE PERMITS IN ORDER TO BE REIMBURSED FOR SEDATION. SEE ANESTHESIA CODES FOR FURTHER DETAIL (D9220 - D9248).

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No		
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7220	removal of impacted tooth - soft tissue	21 and older	Teeth 1 through 32, 51 through 82 (SN)	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7230	removal of impacted tooth - partially bone	21 and older	Teeth 1 through 32, 51 through 82 (SN)	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7240	removal of impacted tooth - completely bony	21 and older	Teeth 1 through 32, 51 through 82 (SN)	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7250	surgical removal of residual roots (cutting procedure)	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	21 and older		Yes		Copy of pathology report with claim.



**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	21 and older		Yes		Copy of pathology report with claim.
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	21 and older		Yes		Copy of pathology report with claim.
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	21 and older		Yes		Copy of pathology report with claim.
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older		Yes	Either D7510 or D7511 on date of service.	Pre-operative radiographs and narrative with claim.
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	Includes drainage of multiple fascial spaces. Either D7510 or D7511 on date of service.	Pre-operative radiographs and narrative with claim.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7610	maxilla - open reduction (teeth immobilized, if present)	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7620	maxilla - closed reduction (teeth immobilized, if present)	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7630	mandible - open reduction (teeth immobilized, if present)	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7640	mandible - closed reduction (teeth immobilized, if present)	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7710	maxilla - open reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7720	maxilla - closed reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7730	mandible - open reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7740	mandible - closed reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7810	open reduction of dislocation	21 and older		Yes		Narrative of medical necessity with claim.
D7820	closed reduction of dislocation	21 and older		Yes		Narrative of medical necessity with claim.

## Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied.

Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act.

Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. Doral or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9230 – nitrous oxide, is a covered service for Participants who are mentally or physically challenged, or otherwise present with special management needs. Special consideration is granted to individuals under the age of six that require extensive dental treatment and/or exhibit rampant caries where patient management is a concern.

Only claims for nitrous oxide with documented medical necessity will be considered for payment. Medical necessity for the use of nitrous oxide would be broadly defined as some condition specific to the particular treatment situation that would preclude the performance of necessary dental treatment, with the use of a local anesthetic alone.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Some examples of conditions that would establish medical necessity for nitrous oxide are:

- \* Apprehensive child under the age of six when any treatment is rendered
- \* Apprehensive children between 6 and 10 years of age when restorative or surgery is performed
- \* Apprehensive children between the ages of 10 and 18 years when surgical services are performed

All other situations for nitrous oxide will be reviewed for coverage on a case-by-case basis.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

IN ACCORDANCE WITH THE ILLINOIS DENTAL PRACTICE ACT AS DEFINED IN THE ILLINOIS ADMINISTRATIVE CODE 1220.500, PROCEDURE CODES D9241 AND D9248 REQUIRE A DENTAL SEDATION PERMIT A OR DENTAL SEDATION PERMIT B IN ORDER TO PERFORM SERVICE.

PROCEDURE CODE D9220 REQUIRES AN DENTAL SEDATION PERMIT B IN ORDER TO PERFORM SERVICE.

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	Not covered wth D0140 on same date of service.	
D9220	deep sedation/general anesthesia - first 30 minutes	21 and older		Yes		Narrative of medical necessity. All inclusive fee - Not limited to first 30 minutes.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	21 and older		No		Narrative of medical necessity.
D9241	intravenous conscious sedation/analgesia - first 30 minutes	21 and older		Yes		Narrative of medical necessity. All inclusive fee - Not limited to first 30 minutes.
D9248	non-intravenous conscious sedation/analgesia	21 and older		Yes		
D9310	consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	21 and older		No		Narrative of medical necessity shall be maintained in patient records.
D9610	therapeutic drug injection, by report	21 and older		Yes		Narrative of medical necessity. Name of drug and amount administered.

**Attachment Y: Benefits Covered – ADULTS – AGE 21 AND OVER**

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9630	other drugs and/or medications, by report	21 and older		Yes		Narrative of medical necessity. Name of drug and amount administered.
D9999	unspecified adjunctive procedure, by report	21 and older		Yes		Description of service and narrative of medical necessity.