



Dental Office Reference Manual

**Dental Program Administered by:
DentaQuest of Illinois, LLC**

**Illinois Department of Healthcare and Family Services
Issued June 2020**

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Revision History

Date	Reason for Revisions
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Foreword

The Department of Healthcare and Family Services (HFS) or “Department” is the agency that administers Illinois’ Medical Assistance (Medicaid) Program, as well as other public healthcare programs. This Dental Office Reference Manual (DORM) has been prepared for the information and guidance of dental providers that provide dental services to members in the Department’s Medical Fee-for-Service Program. Charges for services provided to participants enrolled in a [HealthChoice Illinois](#) managed care organization (MCO) must be billed according to the plan’s requirements.

It is important that both the provider of service and the provider’s billing personnel read all materials, prior to initiating services, to ensure a thorough understanding of the Department’s Medical Program’s policies and billing procedures, including the general provisions contained in the [Handbook for Providers of Medical Services](#).

Revisions and supplements to this manual will be released from time to time as operating experience and state or federal regulations require policy and procedure changes. The updates will be posted to the Department’s [Provider Notices and Bulletins page](#). Providers should register to receive [e-mail notification](#) when new provider information has been posted by the Department. There are times when a notice affects all providers and will only be posted under All Medical Assistance Providers so providers should also register to receive these notices.

Providers will be held responsible for compliance with all policy and procedures contained herein, including all aspects of the Health Insurance Portability and Accountability Act (HIPAA) regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

Providers should always verify eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant’s coverage. It is imperative that providers check HFS electronic eligibility systems prior to each date of service to determine eligibility. The [Recipient Eligibility Verification \(REV\)](#) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the [Medical Electronic Data Interchange \(MEDI\)](#) systems are available.

If providers need to contact the Department or DentaQuest, a list of contact information can be found in Attachment A.

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Acronyms and Definitions

The following definitions apply to this Dental Office Reference Manual:

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to the Medical Assistance 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 member practices that result in unnecessary cost to the Medical Assistance Program. Abuse does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible provider liability.

“ADA” means the American Dental Association

“CDT” means Current Dental Terminology

“Clean Claim” means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

“Covered Service” is a service for which payment can be made.

“DCFS” means Illinois Department of Children and Family Services.

“DentaQuest” shall refer to DentaQuest of Illinois, LLC. DentaQuest is currently the dental vendor for fee-for-service (FFS) dental with the Department.

“Department” refers to the Illinois Department of Healthcare and Family Services.

“DHS” means Illinois Department of Human Services.

“DPH” means Illinois Department of Public Health.

“Enrolled Participating Provider” is a dental professional or facility or other entity that has enrolled and been approved through the HFS’s IMPACT enrollment process. Any dentist providing services to members of an HFS Medical Benefits Program is required to be enrolled with the Department (89 IL Admin Code 140.23). The provider of service must bill as the treating dentist.

“EPSDT” (Early Periodic Screening Diagnosis and Treatment) Services” are benefits required by Federal Law that provide comprehensive and preventive health care services, including dental services, for children under age 21 who are enrolled in

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Medicaid. EPSDT Services can include necessary health care and diagnostic services, treatment, and other medically necessary measures.

“ERC” means Encounter Rate Clinic

“FQHC” means a Federally Qualified Health Center

“Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or State law.

“Harm” means physical, mental, or monetary damage to members or to the Medical Assistance Program.

“HFS” means Illinois Department of Healthcare and Family Services.

“HFS Dental Program” is the dental program administered by HFS for HFS members. When referring to HFS members under age 21, the HFS Dental Program is also referred to as the All Kids Dental Program.

“HIPAA” means Health Insurance Portability and Accountability Act

“HLD” means Handicapping Labio-Lingual Deviation Index

“IMPACT (Illinois Medicaid Program Advanced Cloud Technology)” means the Department’s web-based provider enrollment process.

“Member” is any individual who is enrolled in the Illinois Medicaid or HFS Dental Program.

“RHC” means a Rural Health Clinic

“Waste” means the unintentional misuse of medical assistance resources, resulting in unnecessary cost to the Medical Assistance Program. Waste does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible provider liability.

1.0 Provider Participation

All dental providers must enroll for participation through the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system in order to service members in the Medicaid program.

The following provider types are approved to enroll with Dental Services in IMPACT:

- 011 – Dentist

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- 040 – Federally Qualified Health Center (FQHC)
- 043 – Encounter Rate Clinic (ERC)
- 048 – Rural Health Clinic (RHC)
- 052 – Certified Local Health Departments

1.01 IMPACT Enrollment

To comply with the Federal Regulations at [42 CFR Part 455 Subpart E - Provider Screening and Enrollment](#), Illinois implemented the IMPACT system in July, 2015.

To obtain more information and/or to enroll in IMPACT, providers should go to the [IMPACT website](#).

The effective date of the enrollment for the provider is the date of application submission. Payment will not be made for services rendered prior to the effective date of enrollment.

1.02 Participation Requirements

In order for a provider to be approved for participation in the Illinois Medicaid Program, providers must agree to the requirements detailed in [89 Illinois Administrative Code 140, Subpart B](#) as well as in relevant topics throughout the [Department of Healthcare and Family Services](#) handbooks.

Providers are responsible for keeping their provider information updated in IMPACT. Any changes require a modification in IMPACT. See the [IMPACT website](#) for more information.

Change in ownership or corporate structure necessitating a new Federal Tax Identification Number terminates the participation of the enrolled provider.

Participation approval is not transferable. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

1.03 Provider Referrals

The U.S. Department of Health and Human Services publishes a list of providers enrolled in the HFS Dental Program on the [Insure Kids Now website](#). The Insure Kids Now (IKN) website specifies information on each provider, including whether or not he or she is accepting new patients, contact information, etc. The dental contractor (DentaQuest) is required to submit dental provider data files through the IKN Data Management website on a quarterly basis.

Members receive provider referrals by calling DentaQuest's Customer Service toll free at (888) 286-2447 or by accessing the provider referral system on the [DentaQuest website](#).

The provider referral system works in the following way: Once enrolled, a

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provider is added to DentaQuest’s GeoAccess Referral Program, which assists a Member 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.” DentaQuest’s referral system only refers a Member to a provider if that provider is entered as “Active, Accepting New Patients” and if that Member or referral meets certain criteria which the provider may specify to DentaQuest. Providers can limit their practices to certain age groups, to certain disabilities, and/or to members requiring specified dental services.

Providers can limit their practices to referrals from a certain provider or from a specified geographic area. A provider may change his or her referral status. There is no limit to how often a provider may change his or her referral status.

2.0 Claim Preparation and Submittal

2.01 Claims

Providers must include all applicable information on the [ADA claim form](#) from #1 - #58.

Providers should submit claims with their “Usual and Customary” charges with the proper CDT codes. DentaQuest reimburses providers for covered services at their billed charges or the approved HFS fee (see [dental fee schedule](#)), whichever is less.

Remember: As a Medicaid dental provider, you are accepting the rates identified by the Department on the [HFS dental fee schedule](#). A provider may not charge a Medicaid member the difference between usual and customary rate and the Medicaid fee schedule rate.

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

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

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

- Electronic claims via DentaQuest’s website
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims

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2.02 Electronic Claim Submissions

Via DentaQuest's Website

Participating providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of the DentaQuest website.

First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code.

To submit claims via the [DentaQuest Website](#):

1. Log on to the DentaQuest website
2. Click on "Dentists"
3. Choose "Illinois" as the network
4. Log in using your password and ID. First time users need to register by utilizing the business's NPI or TIN, state and zip Code.
5. Once logged in, click on "Claims/Pre-Authorizations"
6. Click on "Dental Claim Entry"

The dentist web portal allows you to attach electronic files (such as X-rays in jpeg format, reports and charts) to the claim.

Providers should reach out to their DentaQuest provider representative if education is needed for electronic claim submittal.

Via Clearinghouse

Dentists may submit their claims to DentaQuest via an electronic claim clearinghouse. Contact your software vendor to ensure DentaQuest is listed as a payor. Your software vendor will provide you with the information you need to ensure that submitted claims are forwarded to DentaQuest.

NPI Requirements

In accordance with HIPAA guidelines, the following NPI standards will simplify the submission of claims from all dental providers:

- Providers must register for the appropriate NPI classification at the [NPPES Web site](#) and provide this information to DentaQuest and HFS IMPACT in its entirety.
- All providers must register for an Individual NPI and may also be required to register for a group NPI (or as part of a group) dependent upon your designation.

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- Providers must submit all forms of NPI properly and in their entirety to DentaQuest for claims to be accepted and processed accurately. If a dentist is registered as part of a group, claims must be submitted with both the Group and Individual NPI. These numbers are not interchangeable.
- If a provider is presently submitting claims to DentaQuest through a clearinghouse or through a direct integration, please review the integration to assure that it is in compliance with the revised HIPAA compliant 837D format.

2.03 Paper Claim Submission

The Department prefers that providers submit electronic claims. If for some reason electronic claims cannot be submitted, paper claims must be sent in on a current [ADA Claim Form](#).

Do not mail paper claims to HFS. Mail paper claims to the following address:

DentaQuest of IL, LLC
 Claims
 P. O. Box 2906
 Milwaukee, WI 53201-2906

2.04 Third Party Payments

The Department is the payor of last resort and it is the responsibility of the provider to ascertain from the Member whether there is a third party resource that is available to pay for the services rendered. If a third party is billed, then the third party payment must be recorded on the subsequent claim submitted to the Department.

3.0 Reimbursement

For reimbursement, enrolled participating providers should bill only per unique surface regardless of locations. Providers should not submit CDT Code that have two different surface locations on the same tooth. Only the highest surface should be reported per surface location per tooth.

3.01 Claims Adjudication and Payment

DentaQuest adjudicates claims on a daily basis and releases payment cycles weekly. The average weekly turnaround time between receipt of a clean claim and check release is generally within 30 days. Checks not cashed within 180 days are considered void and will not be reissued.

3.02 Direct Deposit

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As a benefit to participating providers, DentaQuest offers electronic funds transfer (Direct Deposit) for claims payments. This process improves payment turnaround times as funds are directly deposited into the provider's banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Authorization Form, Attachment C
- Attach a voided check to the form. **The authorization cannot be processed without a voided check.**
- Send the Direct Deposit Authorization Form and voided check to DentaQuest.

Via Fax: (262) 241-4077
 Via Mail: DentaQuest of Illinois, LLC
 ATTN: PDA Department
 P. O. Box 2906
 Milwaukee, WI 53201-2906

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

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 2 -3 weeks. DentaQuest is not responsible for delays in funding if providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Dentist Web Portal. Providers may access their remittance statements by following these steps:

1. Login to the [Dentist Web Portal](#).
2. Under the Claims/Pre-Authorizations header, select Explanation of Benefits
3. The Explanation of Benefits page will appear and will automatically populate your remittance advices.
4. To view the Explanation of Benefits detail, click on **Check** or **EFT Trace Number** to view that particular EOB in the pop-up window.
5. Click on any column header to sort the results.
6. Click Download File to download a copy of the results page.

3.03 Coordination of Benefits (COB)

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim

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

When a primary carrier's payment meets or exceeds the HFS Dental Program fee schedule, DentaQuest considers the claim as paid in full and no further payment is made on the claim.

3.04 Timely Filing

The timely filing requirement for the HFS Dental Program is 180 calendar days from the date of service. This time limit applies to both initial and resubmitted claims. DentaQuest determines whether a claim has been filed timely by comparing the date of service to the date DentaQuest received the claim. If the span between these two dates exceeds 180 days, the claim is denied due to untimely filing.

Claims that are not submitted and received in compliance with the time limits for claim submittal will not be eligible for payment. Refer to [89 Ill. Adm. Code 140.20](#) for additional information on time limits for filing a claim.

3.05 Receipt and Audit of Claims

To ensure timely, accurate remittances to each dentist, DentaQuest performs an edit of all claims upon receipt. This edit validates member eligibility, procedure codes and provider identifying information. DentaQuest analyzes any claim conditions that would result in non-payment. When potential problems are identified, the provider may be contacted and asked to assist in resolving this problem.

Each enrolled participating provider office receives an "explanation of benefit" report with its remittance. This report includes member information and an allowable fee by date of service for each service rendered during the period.

4.0 Covered Services and Coverage Limitations

HFS members should receive the same access to dental treatment as any other patient in the dental practice.

Pursuant to [Section 140.12\(i\)](#) of 89 Illinois Administrative Code, a provider must accept a Medicaid payment as payment in full for covered services for any eligible Medicaid member. If a provider accepts an individual eligible for medical coverage from the Department, such provider must not bill, demand, or otherwise seek reimbursement from that individual or from a financially responsible relative or representative of the individual for any service for which reimbursement would have been available from the Department if the provider had timely and properly billed the Department.

Benefits may differentiate between children, adults and pregnant women. See Covered Services Comparison in Attachment H.

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4.01 Benefit Coverage for Children under the age of 21

Children under the age of 21 may be able to receive the following services:

- Diagnostic
- Preventive
- Restorative
- Endodontics
- Periodontics
- Prosthodontics
- Oral and Maxillofacial Surgery
- Orthodontics
- Adjunctive General

A detailed benefit table of the covered benefits for children is available in Exhibit A.

4.02 Benefit Coverage for Adults

Adults 21 years and older may be eligible for the following services:

- Diagnostic
- Preventive
- Restorative
- Endodontics
- Periodontics
- Prosthodontics
- Oral and Maxillofacial Surgery
- Adjunctive General Services

A detailed benefit table of the covered benefits for adults is available in Exhibit B.

4.03 Benefit Coverage for Medically Necessary Services for Children – EPSDT

Early and periodic screening, diagnostic and treatment (EPSDT) are required services under the Medicaid program for most individuals under the age of 21. EPSDT services include periodic screening, vision, dental and hearing services.

Per Section 1905(r)(3)(A) of the [Social Security Act](#), children's dental services are to be provided at intervals which meet reasonable standards of practice, or at such intervals indicated as medically necessary. Additionally, the statute requires that dental services shall, at a minimum, include relief of pain and infections. Also, for other necessary healthcare diagnostic services, treatment, and other measures to

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correct or ameliorate defects, illness and conditions discovered by the screening services shall be covered under EPSDT.

For dental services that are deemed medically necessary above and beyond what is published in the benefit tables and the dental periodicity schedule, the dental provider should submit for prior authorization of the requested EPSDT services on the [ADA Claim Form](#).

4.04 Benefit Coverage for Pregnant Women

Pregnant women receive preventive and periodontics dental service. Good oral health during pregnancy is critical for the health of both the woman and baby. Dental care during pregnancy is safe and reduces the risk of poor outcomes.

A detailed benefit table of the covered benefits for pregnant women is available in Exhibit C.

4.05 Member Eligibility Verification Procedures

Providers should always verify a member's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the member's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The [Recipient Eligibility Verification \(REV\) System](#), the Automated Voice Response System (AVRS) at (800) 842-1461, and the [Medical Electronic Data Interchange \(MEDI\)](#) systems are available.

REV, AVRS or MEDI are the systems with correct eligibility information. DentaQuest's web portal is not the location to verify eligibility and providers should not rely on DentaQuest's web portal for eligibility information.

It is recommended that each dental office make a photocopy of the member's medical card, photo identification card (driver's license or state identification card) and maintain the copy in the dental health record. If the member is a minor and does not have a photo identification card, it is recommended that the office make a photocopy of the parent's or guardian's photo identification card to maintain in the member's dental record.

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

4.06 Transportation Benefits

Transportation benefits to the nearest available appropriate provider are available to most members. Members who need assistance with transportation should contact DentaQuest's Customer Service Department directly at (888) 286-2447 or First Transit at (877) 725-0569.

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Eligible members must allow a minimum of seven (7) days before transportation is needed, as the Department requires this time to review and approve the request.

4.07 Consent Process for DCFS Wards

There are two types of consents for DCFS wards related to dental care – one for ordinary and routine medical and dental care and another for medical/surgical treatment. Caregivers for DCFS wards do not have the authority to provide consent; such consent must be provided by the DCFS Guardianship Administrator or an authorized agent. As a general rule, DCFS and private agency caseworkers are responsible for obtaining consents for children in their caseload. If you have not received a signed consent for providing care to a DCFS ward, please speak with the child’s caseworker (or ask the foster parent to speak with the caseworker) to obtain a signed consent form appropriate for the type of care being rendered.

To receive a consent form for rendering medical/surgical treatment, be prepared to give detailed information regarding the procedure, including its risks and benefits.

If you do not have a consent form, the DCFS Consent Unit can be reached at:

- **(800) 828-2179** if a DCFS ward arrives for dental care on a weekday (between 8:30 AM and 5:00 PM)
- **(866) 503-0184** on weekends, holidays or after hours.

The DCFS Consent Unit can facilitate obtaining the consent form so that the appointment does not need to be rescheduled.

4.08 Dental Periodicity Schedule

HFS has based the Dental Health Periodicity Schedule on the American Academy of Pediatric Dentistry Periodicity Schedule oral health recommendations and consultation with the medical and dental communities. This schedule is designed for the care of children who have no contributing medical conditions and should be modified for children with special health care needs or in the event of trauma or disease resulting in variations from the norm. See Attachment J for the complete Illinois Dental Periodicity Schedule.

4.09 Hospice Services

According to [89 Ill. Admin Code Section 140.469\(h\)](#), for adults 21 years of age and over, dental services are not covered for non-hospice providers serving patients enrolled in the Department’s hospice program.

4.10 Language Services

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All providers are obligated to make language services available to those with Limited English Proficiency (LEP). The Department is not required to reimburse providers the cost of interpretive services, nor are providers permitted to charge members of the Medicaid program.

4.11 Managed Long Term Services and Supports (MLTSS) Program

The Managed Long Term Services and Supports program is available in all Illinois counties and is part of HealthChoice Illinois. MLTSS members do not receive their dental services coverage through HealthChoice Illinois. MLTSS Members must meet these requirements:

- Have full Medicare and Medicaid benefits (“full dual eligible members”);
- Are not enrolled in the Medicare-Medicaid Alignment Initiative (MMAI) program; and
- Reside in a nursing facility or are in the following Home and Community-based Services (HCBS) waivers: Supportive Living Facilities, Persons with Disabilities, Persons with HIV or AIDS, Persons with Brain Injury, and Persons Who are Elderly.

MLTSS Member eligibility displays in MEDI with a “Special Information” message below that states the MCO is not responsible for the dental service and the dental service claims should be submitted to Medicaid fee-for-service, unless they are covered as part of a long term care facility per diem.

“Special Information: Medicare is primary payor. Medicaid MCO covers LTC, HCBS waiver services (excluding DD waivers), non-Medicare behavioral health and non-emergency transportation. Medicaid FFS covers Medicare crossovers and other services not covered by Medicare or the MCO.”

5.0 Member Cost Sharing

Federal regulations stipulate that a provider cannot deny services to an individual covered under Title XIX (Medicaid) or Title XXI (State Children’s Health Insurance Program) of the Social Security Act due to the person’s inability to pay a copayment. This requirement does not apply to All Kids Share, All Kids Premium Level 1 & 2 and Veterans Care. Providers may apply their office policies relating to the copayments and coinsurance to members covered under these programs. Providers can verify copayment information when checking member eligibility. Information on how to verify member eligibility can be found at 89 Ill. Adm. Code Section [140.402](#) and Section [148.90](#).

5.01 Non-Covered Services

Private reimbursement arrangements may be made only for non-covered services. Members must have prior knowledge that the service is non-covered, and a consent form must be completed and signed by the member or member’s guardian. A

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sample “Agreement to Pay for Non-Covered Services Form” is included as Attachment G.

The provider must obtain an agreement (in writing) from the member prior to rendering such service that indicates:

- The services to be provided;
- DentaQuest and HFS will not pay for or be liable for said services; and
- Member will be financially liable for such services.

5.02 Spenddown

The spenddown program provides medical coverage to members who would otherwise be ineligible because of income or assets or both which exceed the Department’s standards.

Refer to [Section 113 of the Handbook for Providers of Medical Services](#) for a more complete explanation of Spenddown policy.

5.03 Missed Appointments

Unkept appointments are not covered. The Centers for Medicare and Medicaid Services (CMS) interpret federal law to prohibit a provider from billing/charging an HFS Dental Program member for a missed appointment. In addition, your missed appointment policy for HFS-enrolled members cannot be stricter than that of your private or commercial patients.

Suggestions to decrease the number of missed appointments include:

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

If an HFS member exceeds your office policy for missed appointments, you may choose to terminate the member from your practice. The provider should notify the member of that decision and encourage him/her to contact DentaQuest for a referral to a new dentist.

6.0 Clinical Services

6.01 Diagnostic Services

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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 member's oral health.

For children entering or in kindergarten, second grade, sixth grade, and ninth grade completion of a mandated [IDPH Proof of School Dental Examination 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 determined the number to be redundant, excessive or not in keeping with federal policies relating to radiation exposure, X-ray systems, etc. The total allowed amount for radiographs performed on a member on a single date of service shall not exceed allowed amount for procedure code D0210 (Complete Series).

Oral Exams (D0120) are limited to one every 6 months per child ages 0-20 and one every 12 months per adult over 21 years of age in an office setting. HFS also allows one D0120 per school year period in a school setting.

A periodic examination (D0120) 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 comprehensive examination (D0150) is performed on a new or established patient. 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 complete Early Periodic Screening, Diagnosis and Treatment (EPSDT) examination (D0150 or D0120) 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. Any dental service that is deemed medically necessary by the dentist should be submitted for prior authorization to be covered. It is strongly recommended that the Dental Periodicity

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Schedule (Attachment J) be used as a guide for the provision of services with the understanding that services may be provided more frequently as medically indicated. If a non-covered service or a service that has reached the stated benefit limitations is deemed medically necessary, a request for prior authorization due to medical necessity must be submitted marking “EPSDT” on Box 1 of the [ADA claim form](#). Supporting documentation including narrative and diagnostic X-rays must be submitted for appropriate review. The service may not be rendered until after the request for prior authorization has been approved. Claims submitted for EPSDT coverage prior to authorization will be denied.

Covered Diagnostic codes include:

- Children under the age of 21 - D0120, D0140, D0150, D0210, D0220, D0230, D0270, D0272, D0274, D0277, D0330, D0601, D0602, D0603
- Adult 21 and older - D0120, D0140, D0150, D0210, D0220, D0230, D0270, D0272, D0274, D0277, D0330

6.02 Preventive Services

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

Routine prophylaxis may be completed in an office and school setting. Prophylaxis is covered for members age 0 through 20, once every 6 months. Prophylaxis includes necessary scaling and polishing. One prophylaxis (D1110) may be completed for an adult once per year.

Topical Application of Fluoride (D1208) or Fluoride Varnish (D1206) is limited to three applications per 12 months per child ages 0 – 2 years in an office setting.

Topical Application of Fluoride (D1208) or Fluoride Varnish (D1206) is limited to one every 6 months per child ages 3 – 20 in either an office or school setting.

Interim Caries Medicament (D1354), mostly commonly known as Silver Diamine, may be administered for both children and adults in an office setting. Providers may treat a maximum of four teeth per day, providing participant has no history of any prior or same day billing of CDT category D2000 (Restorative codes) or CDT category D3000 (Endodontic codes) on the same tooth. In addition, providers can provide a maximum of two applications a year per tooth with a lifetime maximum of six applications of medicament per tooth.

Dental Sealants (D1351) are limited to one per lifetime per tooth per child ages 0-20 regardless of place of service. Sealants are covered for members 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

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all 7 and 12-year olds. Sealants will not be covered when they are placed over restorations. Each provider must provide any follow up sealants in addition to the exam, cleaning, and fluoride treatment when needed.

Space maintainers are a covered service for members age 1 through 20 when determined by the dentist to be indicated due to the premature loss of a posterior primary tooth. Space maintainers will not be covered if premolar eruption is imminent and may be completed once per lifetime per quadrant per child.

Covered Diagnostic codes include:

- Children under the age of 21 - D1120, D1206, D1208, D1351, D1354, D1510, D1516, D1517, D1520, D1526, D1527, D1551, D1552, D1553
- Adult 21 and older - D1110, D1354

6.03 Restorative Services

Restorative services available include amalgams, resins, crowns and other restorative services. Restorative services 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. Implants are not a covered service.

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

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date.

Restorations are expected to last a reasonable amount of time. Restorations replaced within 12 months of the date of the completion of the original restoration will not be allowed to the same provider or provider group. Repeated unexplained failures will result in review by Peer Review.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is **disallowed**.

Covered Restorative codes include:

- **Children under the age of 21** – D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753,

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D2790, D2791, D2792, D2910, D2915, D2920, D2930, D2931, D2932, D2933, D2934, D2940, D2950, D2951, D2954

- **Adults age 21 and older** – D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2910, D2915, D2920, D2931, D2932, D2940, D2950, D2951, D2954

6.04 Endodontics

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

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 dental industry or ADA treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped.

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 if 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, the tooth does not demonstrate 50% bone support or if the tooth demonstrates active untreated periodontal disease.

Pulpotomies will be covered on primary teeth only with no evidence of internal resorption, furcation or periapical pathologic involvement and is limited to children ages 0 – 20.

Endodontic Therapy is limited to anterior teeth for adults ages 21 and over.

Apexification/Recalcification Procedures are limited to children ages 0 – 20.

Apicoectomy/Periradicular Services are limited to children ages 0 – 20.

Covered Endodontic codes include:

- **Children under the age of 21** – D3220, D3222, D3230, D3310, D3320, D3330, D3351, D3352, D3353, D3410

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- **Adults age 21 and older – D3310**

6.05 Periodontics

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.

Periodontic services available include surgical and non-surgical procedures for both children and adults.

Covered periodontic codes include:

- **Children under the age of 21** – D4210, D4211, D4240, D4241, D4249, D4260, D4261, D4263, D4264, D4270, D4273, D4274, D4277, D4278, D4320, D4321, D4341, D4342, D4355, D4910
- **Adults age 21 and older** – D4210, D4211, D4240, D4241, D4249, D4260, D4261, D4263, D4264, D4270, D4273, D4274, D4277, D4278, D4320, D4321, D4341, D4342, D4355

6.06 Prosthodontics

A.) Removable Prosthodontic Services

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. The billed date of service for dentures must be the “seat date”/date of insertion.

Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. Extractions and other procedures necessary prior to denture placement must be rendered 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

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that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Fabrication of a removable prosthetic includes multiple steps (appointments). These multiple steps (impressions, try-in appointments, delivery, etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Complete dentures are available to both children and adults every 5 years. Partial dentures are only available to children.

If denture replacement is requested before the benefit limitation expires and is because of theft, vandalism, or fire, a police or fire department report is needed for prior authorization to be approved.

A partial denture that replaces only posterior permanent teeth must include three or more teeth on the denture that are anatomically correct (natural size, shape and color). Partial dentures must include one anterior tooth and/or 3 posterior teeth (including third molars).

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 who could not function with dentures
- Patients who do not desire dentures
- Advanced terminally ill patients

Certain covered codes for claim submission require the applicable Arch to be use which is either/or: 01 or LA, 02 or UA.

Covered Removable Prosthodontic codes include:

- **Children under the age of 21** – D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761
- **Adults age 21 and older** - D5110, D5120, D5130, D5140, D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

B.) Fixed Prosthodontic Services

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Fixed Prosthodontic services (otherwise known as fixed bridge or bridgework) are covered for children ages 0 - 20 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 only be considered for the replacement of permanent anterior teeth and will not be allowed in conjunction with the replacement 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.

Covered Fixed Prosthodontic codes include:

- **Children under the age of 21** –D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6930, D6999
- **Adults age 21 and older** - D6930

6.07 Oral and Maxillofacial Surgery

Oral and maxillofacial services include extractions, surgical extractions, other surgical procedures, alveoloplasty, surgical excision of intra-osseous lesions, surgical incisions, treatment of simple and compound fractures, reduction of dislocation and management of other temporomandibular joint dysfunctions and other repair procedures.

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.

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.

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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).

Covered Oral and Maxillofacial Surgery codes include:

- **Children under the age of 21** – D7140, D7210, D7220, D7230, D7240, D7250, D7270, D7280, D7283, D7310, D7311, D7320, D7321, D7450, D7451, D7460, D7461, D7510, D7511, D7610, D7620, D7630, D7640, D7710, D7720, D7730, D7740, D7810, D7820, D7960, D7963, D7999
- **Adults age 21 and older** - D7140, D7210, D7220, D7230, D7240, D7250, D7270, D7310, D7311, D7320, D7321, D7450, D7451, D7460, D7461, D7510, D7511, D7610, D7620, D7630, D7640, D7710, D7720, D7730, D7740, D7810, D7820, D7999

6.08 Orthodontics

Children under the age of 21 may qualify for orthodontic care.

All orthodontic treatment requires prior authorization. Claims will not be reimbursed unless prior authorization was obtained before the date of service.

Members are required to either score a minimum of 28 points on the HLD or automatically qualify to be eligible to receive medically necessary orthodontia services.

For cleft palate cases, please contact the Division of Specialized Care for Children (DSCC) at (800) 322-3722.

Covered Orthodontic codes include:

- **Children under the age of 21** – D8080, D8660, D8670, D8680, D8999

See Section 15.0 for more information and instructions for requesting prior authorization.

6.09 Adjunctive General Services

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, various drugs and medicaments and emergency services provided for relief of dental pain.

Palliative (emergency) treatment (D9110) is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph.

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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 who 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 members with physical or mental health problems of such severity that treatment cannot 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 member'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.

DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment.

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.

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A consultation (D9310) should 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.

In accordance with the Illinois Dental Practice Act and implementing rules at [68 Ill. Admin. Code Part 1220](#), dentists require a dental sedation permit A or dental sedation permit B in order to perform procedure codes D9239, D9243, and D9248.

Dentists require a dental sedation permit B in order to perform procedure codes D9222 and D9223.

Covered Adjunctive General Service codes include:

- **Children under the age of 21** – D9110, D9222, D9223, D9230, D9239, D9243, D9248, D9310, D9610, D9630, D9999
- **Adults age 21 and older** – D9110, D9222, D9223, D9230, D9239, D9243, D9248, D9310, D9610, D9630, D9999

7.0 Clinical Criteria

The criteria and policies outlined in this manual are based on procedure codes as defined in the American Dental Association’s Code Manuals and will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review to meet and satisfy specific State requirements. Therefore, it is essential that providers review Section 4.0 “Covered Services and Coverage Limitations” in this manual, Exhibit A, Exhibit B and Exhibit C before providing any treatment.

Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Prior authorization is required for some dental codes.

HFS Dental Program providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to Section 9 “Record Requirement” in this manual for additional detail.

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

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Multistage procedures are reported and may be reimbursed upon completion. The completion date for immediate dentures is the date the remaining teeth are removed, and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

7.01 Dental Extractions

Not all dental extractions require prior authorization.

Documentation needed for those procedures requiring authorization:

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

Criteria

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

7.02 Cast Crowns

Documentation needed for authorization of procedure:

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

Criteria

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

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- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.

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

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

Authorizations for crowns will not meet criteria if:

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

7.03 Endodontics

Not all endodontic procedures require authorization. Documentation needed for procedures requiring authorization:

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

Criteria

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

Root canal therapy must meet the following criteria:

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

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

- Gross periapical or periodontal pathosis is demonstrated radiographically (decay subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.
- Root resorption has started and exfoliation is imminent.
- Tooth demonstrates active untreated periodontal disease.

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph. The fee does not include the final restoration.
- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

7.04 Stainless Steel Crowns

In most cases, authorization is not required. Documentation needed for those procedures requiring authorization:

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

Criteria

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

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

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

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

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

7.05 Operating Room (OR) Cases

Criteria

- Young children and/or patients with special needs requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment is not appropriate, and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or member's convenience.

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

7.06 Removable Prosthodontics

Documentation needed for authorization of procedure:

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

Criteria

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

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for children under the age of 21 with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least five years old and unserviceable to qualify for replacement.

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- Dentures are only appropriate for patients who can reasonably be expected to coordinate use of prosthesis (i.e. not for those who are comatose or severely handicapped).
- Fabrication of a removable prosthetic includes multiple steps (appointments). These multiple steps (impressions, try-in appointments, delivery, etc.) are inclusive in the fee for the removable prosthetic and as such are not eligible for additional compensation.

Authorizations for removable prosthesis will **not** meet criteria:

- If there is a pre-existing prosthesis which is not at least five years old and unserviceable.
- If poor oral health and hygiene, poor periodontal health, and an unfavorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the member cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the member has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the member. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional criteria.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new Denture.
- All prosthetic appliances shall be inserted in the mouth before a claim is submitted for payment.

7.07 Non-Restorable Tooth

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

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

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.

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

7.08 General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

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

Criteria

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

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

7.09 Periodontal Treatment

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

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.

A narrative of medical necessity may be required if the submitted documentation does not support the need for the requested treatment.

Periodontal scaling and root planning (D4341/D4342), per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue

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removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

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

Providers can refer to the [American Academy of Periodontology](#) (AAP) for their Policy on Scaling and Root Planing.

Criteria

- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, at least one of the following must be present:
 1. Radiographic evidence of root surface calculus.
 2. Radiographic evidence of noticeable loss of bone support.
- Other periodontal procedures will be reviewed for medical necessity and appropriateness of care according to the ADA definitions of code terminology.

7.10 Medical Immobilization (including Papoose Boards)

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

The patient's record must include:

- Written consent;
- Type of immobilization used;
- Indication for immobilization;
- Duration of application.
- Indication of whether a lesser means of restraint will be possible at the next visit.

Indications

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

Contraindications

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Use of this method must not be used:

- With cooperative patients;
- On patients who, due to their medical or systemic condition, cannot be immobilized safely;
- As punishment;
- For the convenience of the dentist and/or dental staff; or
- Without a prior attempt to manage the patient without the use of immobilization.

Goals of Behavior Management

- Establish communication;
 - Alleviate fear and anxiety;
 - Deliver quality dental care;
 - Build a trusting relationship between the dentist and the child and parent; and
 - Promote the child's positive attitude towards oral/dental health.
1. Routine use of restraining devices to immobilize young children in order to complete their routine dental care is not acceptable practice and violates the standard of care.
 2. Dentists without formal training in medical immobilization must not restrain children during treatment.
 3. General dentists without training in immobilization should consider referring to dental specialties those patients who they consider to be candidates for immobilization.
 4. Dental auxiliaries must only use medical immobilization devices to immobilize children with direct supervision of a general dentist.

8.0 Prior Authorization Process

Prior authorization is a utilization that requires providers to submit documentation associated with certain dental services for a member. The Department requires prior authorization on certain dental services.

8.01 Procedures Requiring Prior Authorization

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 member, the State of Illinois or any agents, and/or DentaQuest.

Requests for prior authorization are granted or denied based upon whether the item or service is medically necessary, whether a less expensive service would

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adequately meet the member’s needs and whether the proposed item or service conforms to commonly accepted standards in the dental community.

Prior authorizations will be honored for 120 days from the date they are issued. An approval does not guarantee payment. The member must be eligible at the time the services are rendered.

DentaQuest must make a decision on a request for prior authorization within thirty (30) days from the date DentaQuest receives this request, provided all information is complete. If DentaQuest does not decide on this request and does not send the Provider written notice of its decision on the services requested within thirty (30) days, the request will automatically be approved.

Within fourteen (14) days of receipt of a prior authorization or a retrospective review request that in the opinion of DentaQuest requires additional information, DentaQuest will notify the submitting provider for the additional information. This additional information\documentation must be received within 30 days or the authorization request is denied.

If DentaQuest denies the approval for some or all of the services requested, DentaQuest will send the member a written notice of the reason(s) for the denial(s) and give member information on how to appeal the decision. Providers are not paid if this documentation is not approved by DentaQuest.

8.02 Documentation Requirements

Requests for prior authorization should be sent with the appropriate documentation on the standard [ADA claim form](#).

The tables of covered services (Exhibits A, B and C) contain a column marked “Prior Authorization Required.” A “Yes” in this column indicates the service requires prior authorization to be considered for reimbursement.

The “Documentation Required” column lists the information required for submission with the prior authorization request.

Examples of documentation requirements include:

- X-rays;
- Narrative of Medical Necessity;
- Photographs (digital); and
- Electronic Models (OrthoCAD)

8.03 Retrospective Review

Services that normally require a prior authorization, but are performed in an emergency situation, are subject to a Retrospective Review. These claims should be

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submitted to the same address used for submitting services for prior authorization, along with any required documentation. Any claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.

After the DentaQuest consultant reviews the documentation, an authorization number is provided to the submitting office for tracking purposes and to maintain in the member's record. For emergency services submitted for retrospective review, the claim is forwarded for processing. The office will receive a prior authorization Determination document, but no further submission is necessary for payment.

8.04 Electronic Attachments

Enrolled participating providers may use one of the following to transfer information electronically to DentaQuest:

- **DentaQuest Provider Web Portal** – DentaQuest accepts radiographs and other attachments electronically via the DentaQuest Provider Web Portal. This is a free service to providers and is accessible on the DentaQuest Provider Web site. The portal allows transmissions via secure internet lines for radiographs, periodontal charts, intraoral pictures, narratives, and EOB's.
- **FastAttach™** - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests and claims submissions. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA) Powered by Vyne, allows Enrolled Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs. FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouses or practice management systems. For more information or to sign up for FastAttach go to the [NEA Powered by Vyne website](#) or call NEA Powered by Vyne at (800) 782-5150.
- **OrthoCAD™** - DentaQuest accepts orthodontic models electronically via OrthoCAD™ for authorization requests. DentaQuest 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 clearinghouses or practice management systems. To ensure your orthodontic authorizations are processed efficiently and timely, all orthodontia prior authorization submissions through email with OrthoCAD™ require an OrthoCAD™ submission form. If a request is received without the

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OrthoCAD™ submission form it will be returned to your office. A copy of the OrthoCAD™ submission form is included as Attachment F. For more information or to sign up for OrthoCAD™, visit the [OrthoCAD™ website](#).

8.05 Radiographs and Photos

Effective January 1, 2018, any radiograph or photos that does not meet the following requirements listed below will cause a claim submission or prior authorization request to deny.

- Member's full name
- Date film was taken (MM/DD/YYYY)
- Identify member's left and right side

8.06 Illinois Dental Schools – Gold Card Status

The students and post-graduate residents at Illinois Dental Schools render services under the direct supervision of attending dentists. The attending dentist is responsible for ensuring services performed under his/her direct supervision are medically necessary and appropriate for each patient. Because of the close supervision required by dental students and residents, Illinois Dental Schools are granted Gold Card status by the HFS Dental Program.

Dental Schools with Gold Card status are not required to submit requests for authorization for any service, except Orthodontics. Prior authorizations are still required for all orthodontic treatment in a dental school.

9.0 Record Requirements

HFS dental providers are required to maintain comprehensive treatment records that meet professional standards for risk management.

The requirements apply to both paper and electronic records and must be kept for a minimum of 10 years, and records pertaining to the most recent 12 months must be available on-site. All dental services performed must be recorded and signed by the rendering provider in the patient record and all records must be available as required by your Participating Provider Agreement.

9.01 Organization

The patient's record must have the following information identified in the Organization section:

- Registration data including a complete health history Medical alert predominantly displayed
- Initial examination data
- Radiographs
- Periodontal and Occlusal status

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- Treatment plan/Alternative treatment plan
- Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
- Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

The design of the record must provide the capability for periodic update, without the loss of documentation of the previous status, of the following information:

- Health history
- Medical alert
- Examination/Recall data
- Periodontal status
- Treatment plan

The design of the record must ensure that all permanent components of the record are attached or secured within the record.

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).

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

9.02 Content

The member record should contain adequate documentation of registration information, which requires entry of these items:

- Patient's first and last name
- Date of birth
- Sex
- Address
- Telephone number
- Name and telephone number of the person to contact in case of emergency.
- Personal representative information, if applicable ([HFS 3806E](#))

An adequate health history that documents:

- Current medical treatment
- Significant past illnesses
- Current medications
- Drug allergies
- Hematologic disorders
- Cardiovascular disorders
- Respiratory disorders

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- Endocrine disorders
- Communicable diseases
- Neurologic disorders
- Signature and date by patient
- Signature and date by reviewing dentist
- History of alcohol and tobacco usage including smokeless tobacco.

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

- Significant changes in health status
- Current medical treatment
- Current medications
- Dental problems/concerns
- Signature and date by reviewing dentist

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

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

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

- Blood pressure (Recommended)
- Head/neck examination
- Soft tissue examination
- Periodontal assessment
- Occlusal classification
- Dentition charting

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

- Blood pressure (Recommended)
- Head/neck examination
- Soft tissue examination
- Periodontal assessment
- Dentition charting

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Radiographs, which are:

- Identified by patient name
- Dated
- Designated by patient's left and right side
- Mounted (if intraoral films)

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

Adequate documentation of the treatment plan (including any alternate treatment options) which is signed and dated by the rendering provider, that specifically describes all the services planned for the patient by entry of these items:

- Procedure
- Localization (area of mouth, tooth number, surface)

Adequate documentation of the periodontal status, if necessary, which is signed and dated by the rendering provider and requires charting of location and severity of these items:

- Periodontal pocket depth
- Furcation involvement
- Mobility
- Recession
- Adequacy of attached gingiva
- Missing teeth

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

- Gingival status
- Amount of plaque
- Amount of calculus
- Education provided to the patient
- Patient receptiveness/compliance
- Recall interval
- Date

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

- Provider to whom consultation is directed
- Information/services requested
- Consultant's response

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

- Date of service/procedure.
- Description of service, procedure and observation.
- Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors.
- Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
- Type and dosage of anesthetics and medications given or prescribed.
- Localization of procedure/observation (tooth #, quadrant etc.)
- Signature of the Provider who rendered the service.

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

- Patient examination
- Treatment plan
- Treatment status

9.03 Compliance

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity for all procedures rendered.

The patient's record must have the following information included to be compliant:

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

10.0 Encounter Clinic Services

Just as any other provider, Encounter clinics must provide services in full compliance with the general provisions contained in the [Handbook for Providers of Medical Services](#), as well as the [Encounter Clinic Services Handbook](#).

The three categories of encounter clinics include:

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- **Federally Qualified Health Center (FQHC)** – A health care provider that receives a grant under Section 330 of the Public Health Service Act (Public Law 78-410) (42 USC 1395x(aa)(3)) or has been determined to meet the requirements for receiving such a grant by the Health Resources and Service Administration, U.S. Department of Health and Human Services.
- **Rural Health Clinic (RHC)** – An RHC can be either a freestanding health care provider that has been designated by the Public Health Service, U.S. Department of Health and Human Services, or by the Governor and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) (42 USC 1395x (aa)(2)) to be an RHC, **or**; a provider based health care provider that is an integral part of a hospital that is participating in the Medicare program and is licensed, governed and supervised with other Departments within the hospital.
- **Encounter Rate Clinic (ERC)** – A health care provider that was actively participating in the Department’s Medical Assistance Program as an Encounter Rate Clinic as of July 1, 1998.

10.01 Allowable Billing

Criteria to qualify for an encounter rate to be reimbursed:

- Must be a billable dental encounter, which is defined as a face-to-face visit with a dentist, dental hygienist under the supervision of dentist or a public health dental hygienist.
- Rendered in a clinic or school.
- Only one dental encounter per patient per day is eligible for reimbursement.
- **All dental encounters must have D0999 on the first line of the claim** or the claim will reject, and no encounter rate will be paid to the FQHC.
- Submit codes for every procedure performed on the encounter claim
- Ensure every code includes corresponding tooth numbers, quads, arches and any other required identifiers.
- X-ray services may not be billed as an encounter.
- Dental encounter claims must be submitted to the Department’s dental contractor, DentaQuest.
- Include applicable authorization numbers, as prior authorizations are required for all dental services indicated in Exhibits A and B.
- Include all documentation requirements.

10.02 Dental Hygienists

Services provided by a licensed Dental Hygienist are covered only when performed under the supervision of a licensed dentist. A dental hygienist is a person licensed by the Department who has met the following qualifications: (1) graduate of high school or its equivalent; (2) satisfactory completed a 2 academic years of credits at a dental hygiene program accredited by the Commission on Dental Accreditation of

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the American Dental Association; (3) holds a valid certification to perform cardiopulmonary resuscitation; (4) passed the National Board Dental Hygiene Examination administered by the Joint Commission on National Dental Examinations and has successfully completed an examination conducted by one of the following regional testing services: the Central Regional Dental Testing Service, Inc. (CRDTS), the Southern Regional Testing Agency, Inc. (SRTA), the Western Regional Examining Board (WREB), or the North East Regional Board (NERB).

A public health dental hygienist is a hygienist with 2 years of full-time clinical experience or an equivalent of 4,000 hours of additional structured courses in dental education in advanced areas specific to public health dentistry, including, but not limited to, emergency procedures for medically compromised patients, pharmacology, medical recordkeeping procedures, geriatric dentistry, pediatric dentistry, pathology, and other areas of study as determined by the Department, and works in a public health setting pursuant to a written public health supervision agreement as defined by rule by the Department with a dentist working in or contracted with a local or State government agency or institution or who is providing services as part of a certified school-based program or school-based oral health program.

Further information regarding the duties of each type of hygienist can be found in section 18 and 18.1 of the Dental Practice Act.

10.03 Denture Billing at Encounter Clinics

Partial dentures are limited to children age 2 through 20 only. Complete dentures are allowed for both children and adults.

All encounter clinics dental claims should have CDT code D0999 on the first line.

Encounter clinics should bill dentures in the following manner:

One Arch

A total of 4 encounters for the denture/partial process **after** the initial visit has been completed.

- 1 encounter visit- insertion of denture/partial - this would be the one of the following codes - D5110, D5120, D5211, D5212, D5213, D5214
- Additional encounter visits - code D5899 - appropriate visit remarks allowed for D5899 below
- If it is assumed that the average encounter rate is \$100 this would allow for approximately \$400 total payment for one arch

Two Arches

A total of 7 encounters for the denture/partial process **after** the initial visit has been completed.

- 1 encounter visit - insertion of denture/partial - this would be the one of the following codes - D5110, D5120, D5211, D5212, D5213, D5214 - both arches should be delivered at the same visit which provides one encounter for the delivery of both prosthetics
- additional encounter visits (3 per arch) - code D5899 - appropriate visit remarks allowed for D5899 below
- If it is assumed that the average encounter rate is \$100 this would allow for approximately \$700 total payment for two arches.

The HFS Dental Program has established CDT code D5899 to be used when an encounter clinic provides dentures services to members. In each case, a narrative of the service performed must be provided at the time procedure code D5899 is billed.

Appropriate Visits for Procedure Code D5899

1. Initial denture impressions
2. Final denture impressions
3. Vertical dimension of occlusion visits
4. Wax try in visits
5. Necessary adjustments post insertion
6. Repairs or relines during the six (6) month period following the insertion of the new prosthesis

Example for Two Arch Treatment

Appointment	Services Provided	Possible Procedure Codes Billed
First	Initial Exam and X-Rays	D0120/D0150, D0210/D0330
Second	Denture Impressions	D5899
Third	Denture Placement	D5110, D5120, D5211, D5212, D5213, D5214
Fourth	Denture Adjustment	D5899
Fifth	Denture Adjustment	D5899
Sixth	Denture Reline	D5899
Seventh	Denture Reline	D5899
Eight	Denture Adjustment	D5899

11.0 Dental Services in a Hospital Setting

Dental providers do not have to obtain prior approval for dental procedures performed in an enrolled hospital outpatient setting or an Ambulatory Surgical Treatment Center (ASTC).

All dental procedures performed in these outpatient settings are subject to post payment review.

11.01 Patient Criteria

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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 member requires general anesthesia or conscious sedation;
- The member has a medical condition that places the member 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 member cannot safely be managed in an office setting because of a behavioral, developmental or mental disorder.

11.02 Dental Hospital Billing Procedures

Claims must include documentation to support the medical necessity for performing the procedure in the outpatient setting including a narrative specifying the medical necessity, supporting X-rays and any other explanation necessary to make a determination.

Dentists must record a narrative of the dental procedure performed and the corresponding CDT dental codes in the member's medical record at the outpatient setting.

Claims must be submitted to DentaQuest for the covered professional services in the same format and manner as all standard dental procedures.

Claims for services performed in a hospital must be sent to:

DentaQuest of Illinois, LLC
Attn: Hospital Claims
P. O. Box 2906
Milwaukee, WI 53201-2906

The hospital must bill HFS to be paid for the facility services. Providers should refer to the [Hospital Handbook](#) or contact the Bureau of Hospital and Provider Services toll-free at 877-782-5565 for hospital billing information.

Only facility bills for services performed in the outpatient setting should be forwarded to:

Illinois Department of Healthcare and Family Services
P.O. Box 19132
Springfield, Illinois 62794-9132

12.0 All Kids School-Based Dental Program

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

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School-Based Dental Program. The All Kids School-Based Dental Program’s school year is recognized as August 1st – July 31st. Recognizing the unique qualities of the All Kids School-Based Dental Program, specific protocols have been developed to assist All Kids School-Based Dental Program Providers. Providers who do not adhere to the requirements for participation are not eligible for reimbursement.

12.01 Participation Guidelines

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

1. Be enrolled as a participating Provider in the HFS Dental Program and completing an All Kids School-Based Dental Program Registration Form Attachment I. Each entity (corporation, partnership, etc.) must register all 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.
2. Be able to render the full scope of preventive All Kids School-Based Dental Program services for an out-of-office setting.
 - D0120 – Periodic Oral Examination
 - D1120 – Prophylaxis – Child
 - D1206 – Topical Application of Fluoride Varnish
 - D1208 – Topical Application of Fluoride (excluding prophylaxis)
 - D1351 – Sealant – Per Tooth
3. A Caries Risk Assessment Code (D0601 – D0603) is required on all claims with a place-of-service “School.”

The CRA codes are as follows:

- D0601 – Caries Risk Assessment and documentation, with a finding of low risk (Equates to Oral Health Score 1)
 - D0602 – Caries Risk Assessment and documentation, with a finding of medium risk (Equates to Oral Health Score 2)
 - D0603 – Caries Risk Assessment and documentation, with a finding of high risk (Equates to Oral Health Score 3)
4. Create a Google Calendar account and provide the username and password to the DentaQuest Outreach Coordinator. Please ensure that the account information is unique for the purpose of the school program, as this information is shared with HFS and the Department of Public Health (IDPH). It is imperative that all calendars are updated to reflect changes or additions to scheduled events. This information is utilized in the scheduling of site visits. Events should be placed on the calendar at least three weeks in advance of each event.
 5. Provide a completed copy of the [Illinois Department of Public Health \(IDPH\) Proof of School Dental Exam Form](#), found under Oral Health, for every child

- seen to the school staff member (secretary, principal, school nurse, counselor, etc.) who is responsible for maintaining the completed forms at the school. The State Board of Education requires that all Illinois children in kindergarten, second, sixth and ninth grades have an oral health examination performed by a licensed dentist. Requiring the completion of an IDPH school exam form for every child treated in the All Kids School-Based Dental Program ensures consistency in completion, eliminates confusion on the part of the parent and relieves the parent from scheduling another dental exam solely for completion of the form.
6. Proof of School Dental Exam Form shall be completed by the Provider and given to school personnel to communicate with the member's parent/guardian regarding the student's oral health and the need for follow-up care. The form must provide the Member's Caries Risk Assessment and the appropriate Referral Plan to provide restorative follow-up care to the member (if follow-up care is required).
 7. Completed Referral Plan for each location where All Kids School-Based Dental Program services are provided. Each entity is responsible for selecting, implementing and providing a referral plan for each location, and each child with urgent treatment needs. Each entity/provider must select at least one of the three approved choices on the Referral Plan to ensure that each member receives necessary follow-up care. It is no longer acceptable to simply provide the parent/guardian with the DentaQuest customer service number or a referral list to community dentists for parents/guardians to locate a provider on his/her own. Each member who requires follow-up care must be provided the opportunity for treatment through one of the three options:
 - Option 1:** Please call to schedule an appointment with my office for follow-up care.
Name
Address
Phone Number
 - Option 2:** [Insert your entity name] will be returning to this location on [insert date] to provide follow-up treatment. Please call [insert phone number] to schedule an appointment.
 - Option 3:** The case manager for [Insert your entity name] will be contacting you for follow-up care information. If you don't receive a call from us, please contact us at [insert phone number here].
 8. Complete and maintain a dental record for each member receiving All Kids School-Based Dental Program services. This record must include relevant components of the Patient Record. The All Kids School-Based Dental Provider is responsible for ensuring HIPAA compliant record retention and the location of record retention storage must be provided at the request of HFS.

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9. Obtain a signed Consent Form from each member prior to providing services. The Consent Form must provide information regarding each of the All Kids School-Based Dental Program preventive services and must be signed and dated by the member's parent/guardian. An additional consent form must be utilized for those providers who perform mobile restorative care to children in the All Kids School-Based Dental Program. In accordance with HFS policy, signed Consent Forms are valid for 365 days from the date of parent/guardian signature and must also grant permission for IDPH oral health consultants to perform sealant rechecks up to a year after the sealant is placed.

12.02 Site Visits

On behalf of HFS, the Illinois Department of Public Health (IDPH) performs periodic site visits to providers enrolled as an All Kids School-Based Dental Program Provider.

12.03 Place of Service (POS) Definition

All Kids School-Based Dental Program services coded as a POS of school are limited to the eight (8) preventive codes.

- D0120 - Periodic Oral Examination
- D1120 - Prophylaxis – Child
- D1206 - Topical Application of Fluoride Varnish
- D1208 - Topical Application of Fluoride (excluding prophylaxis)
- D1351 - Sealant – Per Tooth
- D0601 – Caries risk assessment and documentation, with a finding of low risk (Equates to Oral Health Score 1)
- D0602 – Caries risk assessment and documentation, with a finding of moderate risk (Equates to Oral Health Score 2)
- D0603 – Caries risk assessment and documentation, with a finding of high risk (Equates to Oral Health Score 3)

Please note that a Toothbrush Prophy should only be used as a last resort.

12.04 School Claims

When filing a claim for **preventive services** performed in a school setting, designate the place of service as follows:

- For paper claims, mark the 'other' box in the place of service field, #38 and, write "school" in the remarks field, #35.
- For electronic claims, use place of service 03 for school.

When filing a claim for **restorative services** performed in a school setting, designate the place of service as follows:

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- For paper claims, mark the Extended Care Facility (ECF) or Other (If Other note Mobile in remark Box #35) box in the place of service field, #38 and, if applicable, put the name of the location where services were performed in the remarks field of #35.
- For electronic claims, use place of service 15 if service taking place at the school.

If claims for services, other than the eight (8) preventive services, are submitted with a POS of school, all services on the claim are denied.

13.0 Inquiries, Complaints and Appeals

All members have the opportunity to exercise their rights to a fair and expeditious resolution to any and all inquiries, complaints and appeals.

13.01 Inquiries

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

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

13.02 Complaints

Members may submit complaints to DentaQuest telephonically or in writing on any HFS Dental Program issue other than decisions that deny, delay, reduce, or terminate dental services.

Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or administrative issues.

DentaQuest must resolve and respond to all member complaints within 30 days.

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

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

(888) 281-2076

The address to file a complaint is:

DentaQuest of Illinois, LLC

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Complaint Representative
P. O. Box 2906
Milwaukee, WI 53201-2906

13.03 Member Appeals

Members have the right to appeal any adverse decision DentaQuest has made to deny or reduce dental services.

The member has a right to appeal the restriction decision. The member must notify the Department in writing within 60 days after the Date of Notice that is on the member's denial letter or through the [ABE Appeals portal](#). If an appeal is filed with the Department within ten (10) days of the Date of Notice, the member will not be restricted until a fair hearing appeal decision has been made.

Members may request a hearing by calling the HFS Fair Hearings Section at 855-418-4421, by fax at 312-793-2005 or by writing to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 West Washington Street, 4th Floor
Chicago, IL 60602

13.04 Provider Appeals

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

DentaQuest of Illinois, LLC
P. O. Box 2906
Milwaukee, WI 53201-2906
(888) 281-2076
Fax (262) 241-7401

Provider appeals should be submitted on the form found in Attachment D. DentaQuest must respond to all provider appeals, in writing, within 30 days.

14.0 Program Integrity

14.01 Fraud and Abuse

Providers are expected to obey all laws, civil and criminal, state and federal regulations, and Department policies pertaining to delivery of and payment for health care. The Department and DentaQuest both monitor all claims to identify suspicious

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activities and providers suspected of fraud will be criminally investigated and, when appropriate, prosecuted in state or federal court.

Title XIX of the Social Security Act, under which the Medical Assistance Program is administered, provides federal penalties for fraudulent acts and false reporting. In addition to administrative and civil remedies, providers are subject to State and federal laws pertaining to penalties for provider fraud and kickbacks ([Illinois Public Aid Code 305 ILCS 5/8A-3](#)). Program members, providers or other individuals who have information regarding possible fraud or abuse should call the Medicaid/Welfare Fraud Hotline, at (844) 453-7283/(844)-ILFRAUD.

Providers suspected of fraud, waste, or abuse shall be subject to the Department's sanction authority, including but not limited to payment suspension, payment denial, monetary penalties, and termination or exclusion from participation in the program. See Illinois Public Aid Code at [305 ILCS 5/12-4.25](#) and [89 Illinois Administrative Code, Part 140, Subpart B](#).

14.02 Audits

Every provider enrolled in the HFS dental program is subject to random chart and treatment audits. Providers are required to comply with any requests of records requested by the Office of the Inspector General (OIG) and DentaQuest.

The OIG has statutory authority to oversee the integrity of the Illinois Medical Assistance Program (Program) for HFS, in order to prevent, detect and eliminate fraud, waste and abuse. Pursuant to this authority, the OIG performs pre-payment and post-payment audits of providers to ensure that appropriate payments are made for services rendered and to prevent and recover overpayments. Through these audits, the OIG ensures compliance with State and federal law and Department policy. See [Sections 134 and 135 of the Handbook for Providers of Medical Services](#) for more information about what to expect if you are involved in an audit.

Failure to provide the requested documentation may result in sanctions, including, but not limited to, recoupment of benefits on paid claims, follow up audits or removal of the provider from the HFS Dental Program.

DentaQuest is contractually obligated to report suspected fraud, abuse or misuse by members and providers to the HFS OIG.

14.03 Random Chart Audits

DentaQuest takes an audit sample of claims submitted and requests that the office location provide all dental records for the audit sample. These records will be reviewed to ensure compliance with the member record protocols and to detect possible billing irregularities. The office may either make copies of the dental record or arrange with a DentaQuest representative to review at the office location.

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15.0 Orthodontics

Pursuant to 89 Ill. Admin. Code [Section 140.421](#), medically necessary orthodontic treatment is approved only for patients under the age of 21 presenting with a fully erupted set of permanent teeth and is defined as:

- Treatment necessary to correct a condition that scores 28 points or more on the Handicapping Labio-Lingual Deviation Index (HLD); or
- Treatment necessary to correct the following conditions:
 - Cleft Palate
 - Deep impinging bite with signs of tissue damage (not just touching palate)
 - Anterior crossbite with gingival recession
 - Severe traumatic deviation (i.e., accidents, tumors, etc.)
 - Impacted Maxillary Central Incisor

Orthodontia benefits are limited to one treatment per lifetime. HFS does not allow for multi-phase treatments.

Cosmetic dentistry is not a covered service.

For cleft palate cases, please contact the Division of Specialized Care for Children (DSCC) at 1-800-322-3722.

15.01 Criteria for Orthodontic Services

When a member is believed to have a condition that may require orthodontic treatment, the attending dentist should refer the member to a qualified enrolled dentist or orthodontist for a preliminary examination. After the initial exam, if the provider believes the member requires such treatment, the following is required:

- The member must have good oral hygiene and have all dental work up to date. Both should be noted in narrative.
- The member must be under 21 years of age.
- The member must have permanent dentition, presenting a fully erupted set of permanent teeth. At least $\frac{1}{2}$ to $\frac{3}{4}$ of the clinical crown should be exposed.
- Prior approval must be requested, and documentation must be submitted with the completed HLD scoring tool. To request prior approval, the member must obtain a score of 28 on the HLD or automatically qualify. When received, dental consultants will review and make determination.

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- The member must be eligible in MEDI system to qualify for orthodontia treatment. Provider must always check to ensure eligibility of the member throughout treatment as eligibility may change.

15.02 Handicapping Labio-Lingual Deviation (HLD) Index – HFS 3365

The HFS 3365 Handicapping Labio-Lingual Deviation (HLD) Index is the Orthodontia Scoring Tool HFS currently uses to determine whether or not a member will be approved for orthodontic services. The member must be initially screened using the HLD Index and the HLD Index must be fully completed in accordance with the instructions.

The HLD scoring tool HFS 3365 and instructions can be found on the [Medical Forms](#) page of the HFS website.

15.03 Prior Authorization for Orthodontics

Orthodontia treatment is an example of a procedure that always requires prior authorization. Claims will not be reimbursed unless prior authorization was obtained before the date of service.

Requests for prior authorization should be sent with the appropriate documentation on the standard [ADA claim form](#), along with:

- Completed Handicapping Labio-Lingual Deviation Index (HLD).
- X-rays, photographs, plaster or digital models.
- A written narrative of medical necessity.

15.04 Diagnostic Records

Orthodontic records consist of a cephalometric X-ray; panoramic X-ray or full-mouth survey; external facial photographs (both frontal and profile); intraoral photographs (both sides of the dental arches in occlusion and a frontal view in occlusion); and dental study models (if submitting plaster or plastic molds they must be properly occluded and trimmed so that the models simulate centric occlusion of the patient when the models are placed on their heels).

If the X-rays are unusable, they are rejected, and new records must be submitted prior to authorization of treatment.

The orthodontic examination and preparation of orthodontic records are not separately reimbursable and are considered to be a part of the comprehensive treatment fee.

Providers are required to retain copies of the member history, cephalometric X-rays, panoramic X-rays, facial photographs and study models for a minimum of ten (10) years.

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15.05 Submission

In addition to the photographs, plaster models or digital models, authorization for orthodontia services requires a claim form listing the requested services, the Handicapping Labio-Lingual Deviation (HLD) Index scoring sheet and any other documentation that supports medical necessity.

Prior approval requests may be submitted by the enrolled evaluating provider through OrthoCad or mailed to:

DentaQuest of Illinois, LLC
 Prior Authorizations
 P. O. Box 2906
 Milwaukee, WI 53201-2906

A decision will be based upon the information provided. It is of utmost importance that prior approval requests contain adequate information upon which to make an informed decision. Regardless of the mode of transmission, submitting a complete and accurate prior approval request as well as any other pertinent information, at the time of request will prevent delays in reviewing the prior approval request.

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

Authorizations are valid for three years. If additional time is needed to complete an orthodontic case, an extension must be requested. Patients should not be charged for the continuation of services so long as the patient remains eligible. Providers who accept the individual as a Medicaid patient cannot ask that individual for additional payment.

Prior Authorization requests must be approved before banding a member.

15.06 Member Eligibility for Orthodontic Treatment

Upon receipt of an approved Prior Authorization Request, the enrolled provider must verify the member's eligibility prior to beginning orthodontic treatment.

Even though a service is prior authorized, providers must verify a member's Medicaid eligibility during the entire course of treatment as eligibility may change during the course of treatment. Members must be eligible on the date each service is rendered. It is imperative that providers check MEDI on the date of each service to determine if the individual is eligible for services, as well as participating in fee-for-service or enrolled in an MCO health plan.

The member should not be charged for the continuation of orthodontia services as long as the member is Medicaid eligible.

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15.07 Comprehensive Orthodontic Treatment

Comprehensive orthodontic treatment includes, but is not limited to:

- Initial exam.
- Complete diagnostic records and written narrative.
- Placement of all necessary appliances to properly treat the member (both removable and fixed appliances).
- All adjustments (even if over the 11 allowable)
- Broken brackets.
- Removal of appliances at the completion of the active phase of treatment.
- Placement of retainers or necessary retention techniques.

See the HFS [Dental Fee Schedule](#) for maximum allowable rates.

15.08 Orthodontic Billing

Billing for orthodontic pre-treatment including initial exam (consultation), X-ray/radiograph charges, models and fees for other required documentation, can only be submitted after the determination. For approved orthodontic cases, submit using code D8660. For denied orthodontic cases, submit using D8999.

The date of service for orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the member's mouth. 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 orthodontic adjustments, provider must bill for each date of service treatment was rendered. Only one D8670 is allowed per 45 days. If a member fails to keep an appointment for two consecutive appointments, the dental office must notify DentaQuest. The Department allows for 11 adjustments to be billed (D8670). If treatment extends beyond the 11 adjustments, the provider must continue to treat without additional reimbursement from Department or without any charge to the member.

Payment for orthodontics includes all appliances which includes broken brackets, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

If a member's eligibility ends before the conclusion of treatment, it is acceptable for an enrolled orthodontist to charge the member their private rate for the remaining adjustment visits and debanding, as long as the provider has a signed patient agreement stating that he/she would pay if they become ineligible.

**Attachment A
Contact Information****DentaQuest Customer Service**

P.O. Box 2906
Milwaukee, WI 53201-2906
888-286-2447
Fax: 262-834-3450
TTY 800-466-7566

HFS Provider Hotline

800-842-1461

Provider Relations

P.O. Box 2906
Milwaukee, WI 53201-2906
888-281-2076
Fax: 262-241-7379
Email: denclaims@dentaquest.com

HFS Member Hotline

800-226-0768
TTY 877-204-1012

Information Systems

P.O. Box 2906
Milwaukee, WI 53201-2906
888-875-7482

HFS Fair Hearings (Appeals)

Bureau of Administrative Hearings
69 West Washington, 4th Floor
Chicago, IL 60602
855-418-4421
Email: HFS.FairHearings@illinois.gov

**Prior Authorization/Retrospective
Review**

P.O. Box 2906
Milwaukee, WI 53201-2906
888-875-7482

Fraud Hotline

800-252-8903
TTY 800-447-6404

Dental Claims

DentaQuest of Illinois, LLC
P.O. Box 2906
Milwaukee, WI 53201-2906

Dental Program Manager

Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
607 East Adams
Springfield, IL 62701
217-524-7112

Hospital Dental Service Claims

DentaQuest of Illinois, LLC
Attn: Hospital Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

AVRS Eligibility System

800-842-1461

**Department of Specialized Care for
Children**

2815 West Washington
Suite 300, Box 19481
Springfield, IL 62794-9481
800-322-3722

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Attachment B

None

Attachment C

Authorization to Honor Direct Automated Clearing House (ACH) Credits Disbursed by DentaQuest Of Illinois, LLC

INSTRUCTIONS

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

Maintenance Type:

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

Account Holder Information:

Account Number: _____

Account Type: _____ Checking
 _____ Personal _____ Business (choose one)

Bank Routing Number:

Bank Name: _____

Account Holder Name: _____

Effective Start Date: _____

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

This authorization will remain in effect until revoked by me in writing. I agree you shall be fully protected in honoring any such credit entry. I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

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

Date Print Name

Phone Number Signature of Depositor(s) as shown on bank records for the account for which this authorization is applicable.

Legal Business/Entity Name as appears on W-9 submitted to DentaQuest

Tax ID as appears on W-9 submitted to DentaQuest

**Attachment D
Provider Appeal Form**

Mail completed forms to:
DentaQuest
Attn: Provider Appeals
P. O. Box
Milwaukee, WI 53201-2906
Fax (262) 834-3452

Member Name: _____

Member Identification Number: _____

Date of Service: _____

Date EOB was received: _____

Authorization Number: _____

Date Authorization was received: _____

Provider Name: _____

Location Number: _____

Name of Office Contact: _____

Office Phone Number: _____

Reason for Appeal: _____

Requested Outcome: _____

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Attachment E

None

**Attachment F
OrthoCAD Submission Form**

Date: _____

Patient Information

Name (First & Last)

Date of Birth:

SS or ID#

Address:

City, State, Zip

Area code & Phone number:

Group Name:

Plan Type:

Provider Information

Dentist Name:

Provider NPI #

Location ID #

Address:

City, State, Zip

Area code & Phone number:

Treatment Requested

Code:

Description of request:

**Attachment G
Agreement to Pay for Non-Covered Services Form**

Patient Name: _____
 Recipient (Medicaid) ID: _____
 Guarantor Name: _____
 Relationship to Patient: _____

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

Non-Covered Services

Code	Description

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

 Guarantor Signature Date

 Guarantor Address: Guarantor Phone:

 Street, Apt. # Home:

 City, State, ZIP Cell:

 Work:

Attachment H
Covered Services Comparison for Children and Adults

	Children (< age 21)	Adults (> age 20)	Pregnant Women	Requires Prior Approval
Diagnostic Services				
Oral Exams for Children, limited to one every 6 months per patient in an office setting, and one every 12 months in a school setting.	X			
Oral Exam for Adults, limited to one every 12 months		X	X	
X-rays	X	X	X	
1 Preventive Services				
Prophylaxis – Cleanings (Once every 6 months)	X		X	
Prophylaxis – Cleanings (Once every 12 months)		X	X	
Topical Fluoride Child ages 0-2 – (3 per 12 months)	X			
Topical Fluoride – (Once every 6 months)	X			
Sealants	X			
Space Maintenance	X			
Silver Diamine Fluoride	X	X	X	
2 Restorative Services				
Amalgams	X	X	X	
Resins	X	X	X	
Crowns	X	X	X	Y
Protective Restoration	X	X	X	
3 Endodontic Services				
Pulpotomy	X			
Root Canals	X	X	X	
4 Periodontal Services				
Gingivectomy	X	X	X	Y
Scaling and Root Planing	X	X	X	Y
5 Removable Prosthodontic Services				
Complete Denture (upper and lower)	X	X	X	Y
Partial Denture (upper and lower)	X			Y
Denture Reline	X	X	X	Y
Maxillofacial Prosthetics	X	X	X	Y
6 Fixed Prosthodontic Services				
Bridge	X			Y
7 Oral and Maxillofacial Services				
Extractions	X	X	X	
Surgical Extractions	X	X	X	Y
Alveoloplasty	X	X	X	Y
8 Orthodontic Services				
Orthodontia (Coverage limited to children meeting or exceeding a score of 28 points on the Handicapping Labio-Lingual Deviation Index (HLD) or automatic qualifier.)	X			Y
9 Adjunctive General Services				
General Anesthesia	X	X	X	Y
IV Sedation	X	X	X	Y
Nitrous Oxide	X	X	X	
Conscious Sedation	X	X	X	Y

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**Attachment I
All Kids School-Based Dental Program
Provider Registration**

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

- ___ 1. A **completed** and signed All Kids School-Based Dental Program Provider Registration Application making sure that a Referral Plan has been identified for each location and setup of google calendar.
- ___ 2. Attend any mandatory school provider training teleconference, as requested by HFS.

The following items are **required** on an on-going basis upon completion of school-based exams:

- ___ 1. **The Google Events Calendar must be complete and current at all times; must provide access to HFS or it's designee.**
- ___ 2. A **completed** Dental Record.
- ___ 3. A **completed** IDPH Proof of School Dental Examination Form.
- ___ 4. A **completed** School Exam Follow-Up Care Form, which includes the Referral Plan information, to be sent home with the student.
- ___ 4. All Kids School-Based Dental Program Provider can only **receive payment** for a dental services provider in the school if the claim has a Caries Risk Assessment Code (CRA) (D0601, D0602 or D0603). **No CRA, the entire claim will deny.**

Please remember:

Providers cannot be paid for All Kids School-Based Dental Program services rendered to members until final approval from DentaQuest is received. This process will take approximately 2-4 weeks.

Audits may be conducted to prove best efforts have been made by the All Kids School-Based Dental Program Provider to ensure that members are receiving necessary follow-up.

Site visits will be conducted by the Illinois Department of Public Health on behalf of the Department of Healthcare and Family Services.

****Incomplete Applications Will Delay the Approval Process****

Attachment J

Illinois Department of HealthCare and Family Services Dental Periodicity Schedule Birth to Age 21

Service	Birth – 12 Months	12-24 Months	24 Months to 3 Years	3-6 Years	6-12 Years	12 Years & Older
Anticipatory Guidance/Counseling	•	•	•	•	•	•
Oral Health Screening by PCP (at physical exam)	•	•	•	•	•	•
Clinical Oral Examination			•	•	•	•
Assess oral growth and development	•	•	•	•	•	•
Caries-risk assessment	•	•	•	•	•	•
Fluoride Supplementation/ Topical Fluoride Varnish	•	•	•	•	•	•
Referral to a Dental Home by the PCP			•	•	•	•
Radiographic Assessment			•	•	•	•
Pit & Fissure Sealants				•	•	•
Assessment and possible removal of 3 rd molars						•

Note: While some services are not noted in a certain age category (e.g., birth to 12 months), those services are available, as medically necessary, to those children.