

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



DENTAL SERVICES PROVIDER MANUAL

JANUARY 1, 2024

South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

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

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

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

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

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

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Medicaid Beneficiaries Eligible for Dental Benefits

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

Children

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

Intellectual Disability and Related Disabilities (ID/RD) Waiver Members

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

Adults

This group includes beneficiaries ages 21 years and older.

Medicaid Beneficiaries Ineligible for Dental Benefits

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

Verifying Beneficiary's Eligibility for Dental Benefits

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

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

DentaQuest Web Portal

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

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

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

DentaQuest Customer Service Center

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

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

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

Documenting Beneficiary Eligibility

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

If a participating provider has documentation that a beneficiary was verified as eligible on the date of service and yet the claim is denied due to a possible change in eligibility status after the date of service, the provider will be paid for the services rendered. Providers must document the date and time that the beneficiary eligibility was verified via IVR or by the Web Portal by printing a copy of the

verification and keeping it in the beneficiaries' record. The date of verification must match the date of service. This will serve as proof that eligibility was verified.

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

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

An eligible provider is an individual dental professional, firm, corporation, association or an institution practicing as one business entity that has a written participation agreement in effect with SCDHHS to provide dental services to beneficiaries enrolled in the **Healthy Connections** program.

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

According to 42 CFR 440.100 dental services are defined as:

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

Dental Provider Medicaid Enrollment and Participation Requirements

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

Additionally, a dental provider must meet the following requirements:

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

- Licensure by the appropriate licensing body, certification by the standard-setting agency and/or other pre-contractual approval processes established by SCDHHS.
- All individuals and entities that deliver dental services to Medicaid beneficiaries must be enrolled with the Department as Qualified Medicaid Providers. For specific requirements on Provider enrollment refer to the Department's website at: <https://www.scdhhs.gov/providers/become-provider>
- Enrolled providers are prohibited from using their NPI to bill Medicaid for services rendered by a non-enrolled, terminated or excluded dentist.

Participating dental providers are expected to meet minimum standards with regard to appointment availability. These standards are:

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

VALUE-ADDED PROVIDER BENEFITS

Dedicated Call Center for Providers

DentaQuest offers participating providers access to call center representatives who specialize in areas such as:

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

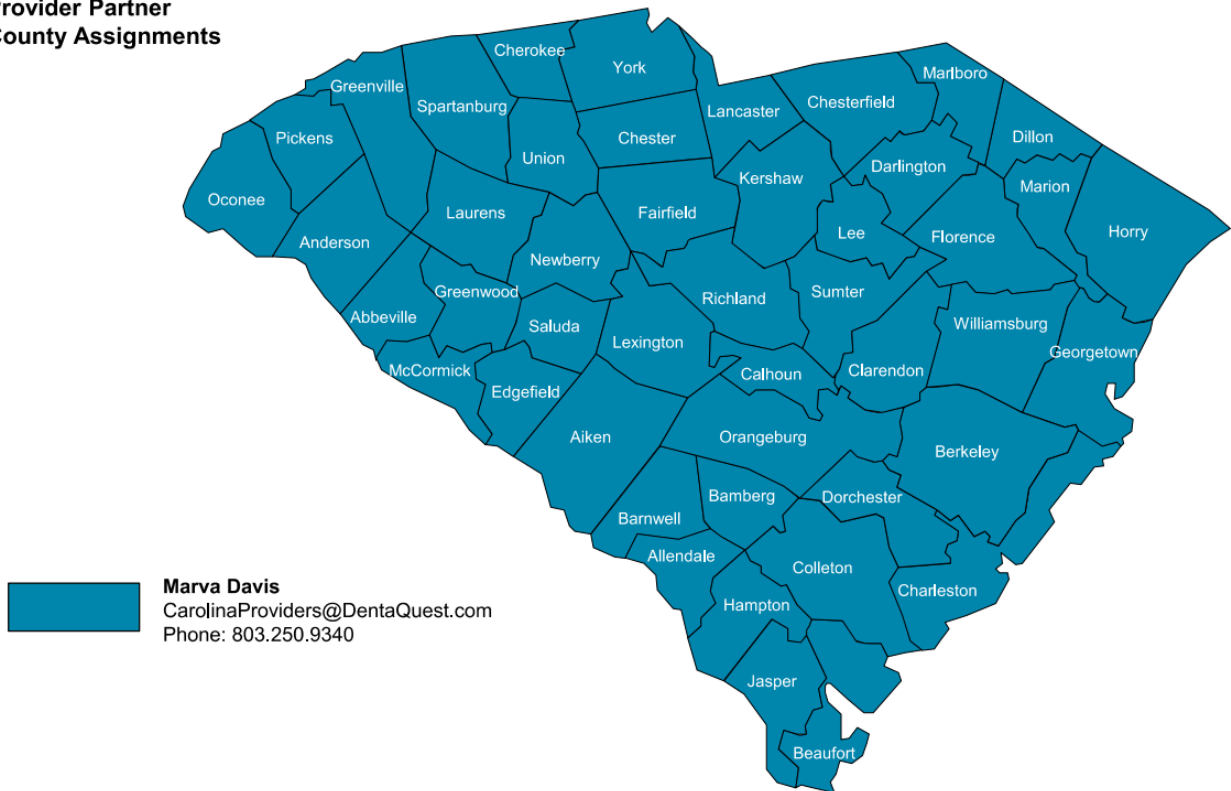
You can reach these representatives by calling (888) 307-6553 from 8:00 a.m. – 6:00 p.m. Monday–Friday, except on stated holidays.

Provider Training

DentaQuest offers free provider training sessions periodically throughout the State of South Carolina. These sessions include important information such as: claims submission procedures, pre-payment and prior authorization (PA) criteria, how to access DentaQuest's clinical personnel, etc. In addition, providers can contact the South Carolina Provider Partners and Outreach Coordinator for assistance. Providers may also request a personal, in-person or virtual office visit by contacting the Provider Partner, Marva Davis at (803) 250-9340 carolinaproviders@dentaquest.com. *Virtual visits can be conducted via phone or webinar. These visits will follow the same guidelines as an in-person visit. DentaQuest provider partner is available to schedule a visit or provide assistance at carolinaproviders@dentaquest.com*

County assignments for Provider Partner are shown on the map below:

DentaQuest
South Carolina
Provider Partner
County Assignments



Provider Newsletters

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

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

DentaQuest Website

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

- Beneficiary Eligibility Verification

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

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

Other Value-Added Provider Benefits

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

- Dedicated South Carolina Project Director, Local Provider Partners and Local Dental Consultants

- Defined PA Requirements for Place of Service (POS)
- Peer-to-Peer Review Process
- Satisfaction Surveys (provider and beneficiary)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

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

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

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

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

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COVERED SERVICES AND DEFINITIONS

DEFINITIONS

1. “*Dental Services*” are defined as any covered diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of:
 - The teeth and associated structures of the oral cavity, and
 - disease, injury or impairment that may affect the oral or general health of the beneficiary.
2. “*Covered Services*” means a dental or medical service, including those services coverable through the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) program that satisfies all the following criteria:
 - A. Is medically necessary.
 - B. Is provided to an eligible beneficiary by a participating provider.
 - C. Is the most appropriate supply or level of care that is consistent with professionally recognized standards of dental practice within the service area and applicable policies and procedures.
 - D. Is not rendered for convenience, cosmetic or experimental purposes.
3. “*DentaQuest*” shall refer to DentaQuest, LLC
4. “*Emergency Services*” means covered dental services that are needed to evaluate or stabilize an emergency medical condition and are furnished in the appropriate setting by a dental provider that is qualified to furnish these services.
5. “*Emergency*” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention will place the health of the individual in serious jeopardy or will cause serious impairment of bodily functions, or will cause serious dysfunction of any bodily organ or part.
6. “*EPSDT*” means the Early and Periodic Screening, Diagnostic, and Treatment program for persons under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)43, 1396d(a)(4)(B) and 1396d(r) and 42 C.F.R. Part 441, Subpart B to ascertain children’s individual physical and mental

illness and conditions discovered by the screening services, whether or not such services are covered.

7. **“Healthy Connections”** is the name of the program provided to South Carolina Medicaid beneficiaries under the direction of SCDHHS.
8. **“Medically Necessary”** (Medically Reasonable and Necessary) means procedures, treatment, medications or supplies, (the provision of which may be limited by specific provisions, bulletins and other directives [42 CFR 440.230 (d) and SC Code of Regulations 126-300 (D)]), ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury which per [S.C. Code of Regulations 126-425(9)]:
 - A. Must be provided at appropriate facilities, at the appropriate levels of care and in the least costly setting required by the patient’s condition.
 - B. Must be administered in accordance with recognized and acceptable standards of dental, medical and/or surgical discipline at the time the patient receives the service.
 - C. Must be in compliance with standards of dental care and not for the patient’s convenience, experimental or cosmetic purposes.
 - D. Medical necessity or any referral information must be documented in the beneficiary’s medical/ dental record and must include a detailed description of services rendered. The fact that a provider prescribed a service or supply does not deem it medically necessary.
9. **“SCDDSN”** is the South Carolina Department of Disabilities and Special Needs, who are responsible for the enrollment of beneficiaries in the ID/RD Waiver program.

COVERED SERVICES

Medical necessity for all covered services will be determined by the agency through established utilization management policies based on the application of industry standards of medical and dental practice, and through applications of reasonable limitations and criteria, as defined in Appendix B of this manual.

Full benefits Healthy Connections beneficiaries are eligible for the following covered dental benefits:

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

Preventive Dental Benefit

Children’s Preventive Dental Benefit (age <21 years):

Medically necessary diagnostic; preventive; restorative; endodontic; prosthodontics (removable); dental extractions; and adjunctive services with specific policy limitations documented in Appendix B of this manual. The policy limitations follow the SCDHHS Dental Periodicity Schedule.

Note: SCDHHS has developed a Dental Periodicity Schedule that generally follows the American Academy of Pediatric Dentistry recommendations on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment for Infants, Children and Adolescents. This schedule is accessible at: <https://www.scdhhs.gov/resources/programs-and-initiatives/epsdt/providers/periodicity-schedule>

ID/RD Waiver Members Preventive Dental Benefit (age >21 years):

Medically necessary diagnostic; preventive; restorative; endodontic; prosthodontics (removable); dental extractions; and adjunctive services with specific policy limitations documented in Appendix B.

Adult Preventive Dental Benefit (age >21 years):

Medically necessary diagnostic; preventive; restorative; dental extractions; and adjunctive services with specific policy limitations documented in Appendix B. These services, except diagnostic and adjunctive, are subject to a maximum of One Thousand dollars (\$1,000) per state fiscal year (SFY).

Emergency & Exceptional Medical Conditions (EMC)

Eligible beneficiaries may receive medically necessary diagnostic, preventive, or corrective procedures of the oral & maxillofacial area, adjacent or associated structures, including the head and neck region, delivered in accordance with sections 1902(a)(10)(A) & 1905(a)(5)(B) of the Social Security Act, for the following:

- Diagnostic and/or maxillofacial prosthetic services delivered for the diagnosis, repair, rehabilitation, reconstruction and /or treatment of facial deformities due to cancer or trauma.
- Diagnostic and/or oral & maxillofacial surgical services for diagnosis and /or treatment of infections, malignancies, injury or trauma, emergency, or stabilization of emergency conditions, that may affect a beneficiary's oral or general health.
- Dental services necessary for the proper fabrication and/or maintenance of the maxillofacial prosthetics and/or oral & maxillofacial surgical service(s), for the conditions listed above, will be allowed with submission of documentation justifying the medical necessity for the additional dental service(s).
- Delivery of dental services in preparation for or during the course of treatment for a) organ transplants; b) radiation of the head or neck for cancer treatment; c) chemotherapy for cancer treatment; d) total joint replacement; e) heart valve replacement. Dental services must be directly related to one or more of the conditions listed above and require a referral by the treating medical provider.

EPSDT Services

Children under the age of twenty-one (21) are eligible for medically necessary dental services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Federal law at [42 U.S.C. § 1396d(r) [§1905(r) of the Social Security Act (SSA)] requires state Medicaid programs to provide EPSDT for recipients under 21 years of age. The scope of EPSDT benefits under the federal

law covers services that are medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the State Plan. The EPSDT benefit includes medically necessary orthodontic services. EPSDT dental benefit includes services provided at intervals that meet reasonable standards of dental practice and at intervals necessary to determine the existence of a suspected illness or condition. EPSDT benefit is detailed on the SCDHHS EPSDT website at: [Covered Services | SCDHHS](#). SCDHHS has developed a Dental Periodicity Schedule that generally follows the American Academy of Pediatric Dentistry recommendations on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment for Infants, Children and Adolescents. This schedule is accessible at: <https://www.scdhhs.gov/resources/programs-and-initiatives/epsdt/providers/periodicity-schedule>. The EPSDT benefit includes medically necessary State Plan covered dental services or medically necessary dental services not otherwise listed as a State Plan covered service. For program operational purposes, these services will be labeled “EPSDT Dental Services”, which also includes services delivered outside of the SCDHHS established policies or the Dental Periodicity Schedule intervals.

Benefits Summary:

Benefit Name	Benefit Description	Age Groups		
		Child age 0-20	ID/RD Age 21+	Adult age 21+
Preventive Dental Benefit	Medically necessary diagnostic, preventive, restorative, endodontic, prosthodontic (removable), extractions, and adjunctive services with limitations through established policies.	Yes	Yes	Yes <i>(Subject to an annual maximum)</i>
Emergency & Exceptional Medical Conditions	Eligible beneficiaries may receive medically necessary dental services of the oral & maxillofacial area, adjacent or associated structures, including the head and neck region for: <ul style="list-style-type: none"> • Diagnosis and /or treatment of infections, malignancies, injury or trauma, emergency, or stabilization of emergency conditions, that affect a beneficiary’s oral or general health. • Delivery of dental services in preparation for, or during the course of treatment for organ transplants; radiation of the head or neck for cancer treatment; chemotherapy for cancer treatment; total joint replacement; and heart valve replacement. 	Yes	Yes	Yes <i>(Annual maximum does not apply)</i>
EPSDT Services	Medically necessary dental services not otherwise listed as a State Plan covered service or when delivered outside of the SCDHHS established policies.	Yes	No	No
Co-Pay of \$3.40	Non-emergency services.	No ¹	No ²	Yes ³
Annual Maximum	July 1 - June 30	No Limit	No Limit	\$1,000 ⁴

REIMBURSEMENT AND CHARGE LIMITS

For general policies regarding charge limits and reimbursements, providers must refer to the Provider Administrative and Billing Manual. Reimbursement and Charge limits specific to dental providers and dental services are addressed in this section of the Dental Services Provider Manual.

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

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

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

⁴ Diagnostic and Adjunctive services of the Adult Preventive Dental Benefit are not included in the \$1,000 annual maximum.

- Reimbursement fees for covered dental services are documented in the SCDHHS dental fee schedule accessible at: <https://www.scdhhs.gov/providers/fee-schedules>. Reimbursement for dental services delivered for exceptional medical conditions, or EPSDT services will be by report, unless the procedure has an established fee listed on the dental fee schedule. Payment for all approved services must be accepted as payment in full.
- The reimbursement fee for a dental procedure is inclusive of any items or related activities/services that are considered necessary to accomplish the procedure, which may include, but are not limited to: materials, supplies, trays, surgical trays, equipment, topical or local anesthesia and post-operative care. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.
- Providers should always check the beneficiary's eligibility and service history for all beneficiaries. For adult beneficiaries ages 21 years and older, the provider must also verify the available balance of the allowed \$1,000 annual maximum prior to rendering services. The covered service that exhausts the maximum allowance will be paid based on the remaining dollars available. The remaining amount paid will be considered payment in full. SCDHHS will not reimburse for any service after the beneficiary's \$1,000 annual maximum has been reached.
- Providers should bill their usual charges and not the Medicaid reimbursement rate. Medicaid will generally pay the established Medicaid reimbursement rate, determined by the program or the provider's charges, whichever is lower.
- Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. *In addition, providers may not charge the patient for the primary insurance carrier's co-payment.*
- Billing covered procedures prior to the date of service is prohibited. For Medicaid reimbursement purposes, services requiring multiple appointments to be completed, must be billed at the delivery/ completion date.
- Providers are prohibited from billing the beneficiary for any service that beneficiary is eligible to receive under the **Healthy Connections** Medicaid program, except of co-payments when applicable. Medicaid payments may be made only to a provider, a provider's employer or an authorized billing entity. Payments will not be reimbursed to a beneficiary. Therefore, seeking payment from a beneficiary is prohibited except where a co-payment is applicable. For services and beneficiaries that are exempt from co-pay, refer to the Copayment Schedule.
- Providers are prohibited from billing a beneficiary for coverable services denied due to the following:

- Provider’s untimely filing.
 - Provider’s insufficient /lack of medical necessity documentation.
 - Provider’s claims filed with clinical and/or administrative errors.
 - Provider’s claims or PAs not indicating EPSDT for services filed under the EPSDT benefit.
 - Provider’s failure to obtain prior authorization (when applicable).
- Providers are prohibited from billing a beneficiary while the prior authorization process or Pre-payment review process is on-going.
 - Providers are prohibited from billing a beneficiary during an appeals process. All beneficiaries have the right to appeal any decision that delays, denies, or reduces a dental benefit.
 - Provider must inform the beneficiary if services requested through prior authorization were deemed by SCDHHS as not medically necessary, therefore:
 - no claim will be filed with Medicaid and no reimbursement is expected from Medicaid for the service(s), and
 - provider and beneficiary may agree to forego with the service delivery, or
 - provider and beneficiary agree to proceed with the service delivery without Medicaid reimbursement. In this case, provider may proceed as follows:
 - › Provide the service to the beneficiary free-of-charge, or
 - › Prior to the provision of the service the provider must obtain written agreement from the beneficiary indicating their willingness to assume financial responsibility for the non-medically necessary service(s). The agreement must detail the service(s) and the respective amount(s) that beneficiary is willing to assume responsibility for. If the beneficiary assumes financial responsibility for the service, the provider may deliver the service and bill the beneficiary based on the provider’s usual and customary charges.

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UTILIZATION MANAGEMENT

GENERAL INFORMATION

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

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

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

SERVICES REQUIRING AUTHORIZATION

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

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

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

Pre-Payment Review

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

The submission of “documentation” should include:

- Radiographs, diagnostic images, pathology reports (when applicable), detailed narrative, or other information where requested.
- Code on Dental Procedures and Nomenclature (CDT) codes on the ADA dental claim form (year 2012 or newer).
- Section 6: Reporting/Documentation and Appendix B: Documentation Required sections of this manual describe the necessary information to be submitted with the claim for PPR and/or to be maintained in the patient dental records.

Prior Authorization

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

Providers can submit PA requests via the following routes:

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

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

Services that require PAs under the Health Connections benefits are:

- EPSDT services: authorization for these services is issued by DentaQuest.

- Planned/scheduled services delivered in an Operating Room (OR) and Ambulatory Surgical Center (ASC): authorization for these services is issued by DentaQuest.
- Inpatient services: authorization for these services is issued by KEPRO or MCO.

Expedited Prior Authorizations

For services requiring PA, there may be times when an Expedited Prior Authorization (EPA) is needed. The request for an EPA should indicate the urgent need and the providers must enter the full word “EXPEDITE” in the “Notes” field on the ADA Claim Form (field #35). PA requests made in urgent situations will be reviewed and the medical necessity determination will be made within 72 business hours of receipt. The request must also include a narrative describing the urgent need for the service. Dental services requested through an expedited authorization must be listed on the ADA claim form and be submitted with appropriate documentation that supports the medical necessity. DentaQuest will verify the member’s eligibility if the service is covered and determine if your narrative supports the proposed treatment. Your request will then be considered “approved – pending.” This means the service is approved based on the information you provided but does not guarantee payment. In order to receive payment, you must submit the claim and supporting documentation (please refer to Section 6: Reporting/Documentation and Appendix B: Documentation Required sections of this manual to verify required documentation for the submitted code). If the required documentation supports your initial PA submission, the service will be fully approved and eligible for payment.

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

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

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

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

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

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

Prior Authorization for EPSDT Services

Providers must obtain a PA for medically necessary EPSDT services for eligible children under the age of 21. DentaQuest will review all EPSDT PA submissions. Providers filing PAs for medically necessary services under the EPSDT benefit, which includes orthodontic services, must indicate the “EPSDT” field on the claim forms.

All PAs submitted for EPSDT services will be systematically denied if the EPSDT indicator is not selected.

The authorization must have attached all documentation that supports the determination of medical necessity. Payment for approved EPSDT services must be accepted as payment in full.

EPSDT services exempt from PA are as follows:

- Service is delivered as an emergency, or
- Service is medically necessary to be delivered on the same day of diagnosis, or
- Service is part of the Initial Dental Encounter for the Foster Care Program

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

Prior Authorization for Orthodontic Services

Authorizations for medically necessary orthodontic services will be issued by DentaQuest. Provider must indicate the “EPSDT” field on the PA form. PA request must include all appropriate documentation such as the HLD Assessment form, a detailed narrative of medical necessity, diagnostic images and/or other supporting documentation that will assist in the determination of medical necessity.

For transfer cases, the provider continuing the orthodontic treatment must file the PA indicating the remaining visits for treatment completion and include the Orthodontic Continuation of Care form, a copy of the approved PA for orthodontic treatment issued by the SCDHHS or other state’s Medicaid program, beneficiary’s current orthodontic history status, photographic and diagnostic images, treatment plan with the anticipated length of the remaining treatment, and orthodontic treatment records from the previous provider including records that indicate Medicaid payment up to the point of transfer.

For limited or comprehensive orthodontic treatment, only one PA will be issued per case (regardless of number of visits needed to complete treatment). The PA form must include the procedure code that reflects the initial treatment (banding) appointment for limited or comprehensive cases. For details, refer to Appendix B, Orthodontic Services Criteria in this manual.

Authorization for Planned/Scheduled Services Delivered in an Ambulatory Surgical Center (ASC) or Hospital Operating Room (OR)

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

- Services delivered in the Emergency Department are exempt from PA requirements.

Authorization for Inpatient Services

DentaQuest will not issue and will deny any authorization requests for inpatient services. Authorization for inpatient services will be issued only by QIO or the beneficiary's MCO. Dental provider must coordinate with the hospital, where these services will be rendered, to obtain the appropriate authorization.

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

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

REASONS FOR DENIALS

A claim processed through PPR or an EPA / PA will be denied for one of the following reasons:

1. Medical Necessity Has Not Been Demonstrated

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

2. Medical Necessity Documentation Missing or Incomplete

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

3. Service Not Filed Under EPSDT

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

CLAIMS RECONSIDERATION

Request for Reconsideration

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

DentaQuest, LLC

Attention: Utilization Management/Provider Appeals

PO Box 2906

Milwaukee, WI 53201-2906

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

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

PEER-TO-PEER REVIEW

Participating providers that disagree with the clinical determination made by DentaQuest may request a Peer-to-Peer review. Only prior authorizations or claims denied for clinical reasons (not meeting the medical necessity) will be considered for the Peer-to-Peer review process.

Providers may request the Peer-to-Peer via the following routes:

1. Email: Provider Engagement team or the local Provider Partner at: CarolinaProviders@DentaQuest.com or Marva.Davis@dentaquest.com
2. Phone: contact the DentaQuest provider call center at 1-888-307-6553
3. File an electronic submission on the provider portal at: <https://govservices.dentaquest.com>

Providers can request **for a specific timeframe (i.e. 10:00-11:00am CST). The call is to be completed within 1 business day of the request being submitted.**

BENEFICIARY GRIEVANCES AND APPEALS

Beneficiary Complaints (Grievances)

Beneficiaries may submit complaints to DentaQuest telephonically or in writing on any **Healthy Connections** dental program issues other than decisions that deny, delay or reduce dental services.

Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or administrative issues. DentaQuest will respond to beneficiary complaints immediately, if possible, however, each complaint will be addressed no later than 14 calendar days from the date the complaint (grievance) is received.

Beneficiary Appeals

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

Beneficiary complaints and/or appeals should be directed to:

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

FRAUD AND ABUSE

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

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

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

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

Beneficiary Fraud: If a provider suspects a beneficiary of ID fraud, drug-seeking behavior, or any other fraudulent behavior they should report it to SCDHHS.

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

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

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REPORTING/DOCUMENTATION

General policies for Medicaid beneficiaries' health records requirements and documentation are detailed in the Provider Administrative and Billing Manual. In addition to the general policies, dental providers must comply with specific policies for dental records requirements and documentation detailed below.

DENTAL RECORD

Retention and Documentation policy

In addition to providers' compliance with state and federal laws and regulations regarding dental record retention requirements [S.C. Code Ann. 40-15-83; S.C Code of Regulations 39-11.1-B] and [Social Security Act 1902(a)(27) and 42 CFR 431.107], SCDHHS requires dental providers to retain *on site*, all dental and fiscal records pertaining to Medicaid beneficiaries for a minimum period of four (4) years after last payment was made for services rendered, to facilitate audits and reviews of the patient's dental record.

No other documentation (except for hospital records) will be accepted in lieu of a treatment record. This includes PA forms, ledger cards, claim forms, computer records, etc. ***Medicaid services that are not properly documented in the progress notes are subject to denial or recoupment.***

All required documentation must be present in the dental record before the provider files claims for reimbursement.

The design and organization of the required documentation in the dental records may vary by provider; however, the content of the dental record (per the SC Board of Dentistry Dental Record Policy and Procedure at: <https://lir.sc.gov/bod/PDF/Policy/PatientRecordsPolicy.pdf>), must be present, properly labeled, legible, signed and dated.

A beneficiary's dental record is considered maintained when it **complies with the following requirements:**

- Must document the rationale and justification of the medical necessity for the services, including all findings, diagnosis and supporting information.
- Must detail the extent of the service performed to ensure the service is billed with the correct and appropriate level of the procedure code, as defined in the American Dental Association (ADA) Current Dental Terminology (CDT) nomenclatures and descriptors, or as indicated in the SCDHHS policy.
- Must be signed and dated at the time of service, or the rendering provider must attest to the date and time as appropriate to the media; and information, including rendering provider, date, and time of the service, must be verifiable.

1. Progress Notes Policy

An entry must be made in the progress notes that accurately and objectively summarizes each visit or encounter including the patient's experience. The entry must minimally contain the following information:

- a. Date of service/procedure
- b. Reason for the visit/chief complaint.
- c. Radiographic exposures and interpretation, (if any).
- d. Description of service rendered including but not limited to: teeth treated; materials used; technique performed; the type and dosage of anesthetic agents, medications, materials, and/or nitrous oxide/oxygen; type/duration of the protective stabilization; treatment complications and adverse outcomes (when applicable).
- e. Localization of procedure, and observation (tooth number, quadrant, etc.). Documentation in progress notes must contain information to support the level of ADA CDT code billed as detailed in the code's nomenclature and descriptor or as defined in the SCDHHS policy. Documentation must be written on a tooth-by-tooth basis for a per tooth code (including tooth surface), on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
- f. Findings and observation during treatment or visit; patient's response or behavior to treatment.
- g. Post-operative instructions and prescriptions given including the type and dosage (when applicable).
- h. Provider's signature (see signature policy below for details)

2. Signature Policy

The signature of the provider rendering or authorizing the services may be handwritten, electronic or digital. Stamped signatures are unacceptable. For acceptable electronic signatures, refer to the SCDHHS Provider Administrative and Billing Manual, section "Electronic Signatures".

- Dental services rendered by the treating provider: signature or initials of the treating dental provider must be documented in the progress notes.
- Dental services authorized to be delivered under direct supervision: signature or initials of the authorizing or supervising dental provider must be documented in the progress notes along with the signature or initials of the qualified healthcare professional performing the services. This includes services performed by dental students or dental residents under the direct supervision of a teaching dentist.
- Dental sedation services authorized by the treating dental provider, but administered by another qualified provider, such as a dental anesthesiologist, certified registered nurse anesthesiologist, or an anesthesiologist: signature of the administering provider must be documented in the progress notes.
- Dental services authorized to be delivered under general supervision: signature of the qualified healthcare professional performing the services under general supervision, must be documented in the progress notes. Additionally, a valid authorization or standing order form must be included and maintained in the patient's records. The authorization or standing order form is considered valid when **all** the following are met:
 - The form is dated and signed by both the supervising dentist and the qualified healthcare personnel performing the services under general supervision prior to services being performed.
 - The form identifies the services that the supervising dentist is authorizing prior to the services being performed by the qualified healthcare personnel under the dentist's

general supervision. The form identifies the timeframe for which the healthcare personnel is authorized to perform services under general supervision. The timeframe must not exceed twelve (12) months.

3. Documentation

Documentation in the dental record must justify the medical necessity for all procedures rendered. Appropriate diagnostic pre-treatment radiographs clearly showing the affected tooth, the adjacent and opposing teeth if applicable, substantiating any pathology or caries present, are required for treatment record.

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

When applicable, post-treatment radiographs are also required for the dental record (Refer to Appendix B of this manual for when post-treatment radiographs are required).

Healthy Connections providers are required to maintain comprehensive and accurate dental records that meet professional standards for risk management. Please refer to the Dental Record section within the Reporting/Documentation section of this manual for additional details.

Every participating provider in the **Healthy Connections** program is subject to random chart/treatment audits. Providers are required to comply with any request for records. The provider will be notified in writing of the results and findings of the audit.

4. Documenting and Reporting of Procedure Codes

- Tooth Indicators

SCDHHS follows the ADA's CDT manual definitions, designations and indicators for tooth numbering, tooth surfaces, quadrants and arches for the primary, permanent and supernumerary teeth.

- Procedure Codes

The DentaQuest claim system can only recognize dental services described using the current ADA CDT code list, specifically those defined as an SCDHHS Healthy Connections covered dental benefit. To purchase copies of the CDT code manual please refer to the Provider Administrative and Billing Manual Appendices section.

- Code definitions and descriptors

Furthermore, DentaQuest subscribes to the definition of services performed as described in the CDT code manual, unless otherwise indicated in Appendix B of this manual.

All the tooth indicators and the approved procedure codes must be referenced in the patient's record for retention and review purposes.

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

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BILLING GUIDANCE

GENERAL INFORMATION

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

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

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

FILING CLAIMS

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

Filing Options

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

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

Paper Format

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

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

- Mail it to the attention of:

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

Electronic Format

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

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

- Via Clearinghouse
 - Participating providers may submit their claims to DentaQuest through:
 - › Emdeon: +1 888 255 1293
 - › Tesia: +1 800 724 7040
 - › EDI Health Group: +1 800 576 6412

- › Secure EDI: +1 877 466 9656
- › Mercury Data Exchange: +1 866 633 1090

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

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

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

- Via HIPAA Compliant 837D File

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

Electronic Attachments

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

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

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

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

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

CLAIM COMPLETION INSTRUCTIONS

- ADA Claim Form (2019) Completion Instructions:
 - American Dental Association provides general instructions for completing the ADA Claim Form 2019. Those instructions can be accessed at: [General Instructions \(ada.org\)](http://ada.org)
- Additionally, SCDHHS requires that a claim form filed by a dental provider must:
 - Contain the beneficiary’s name, identification number and date of birth. If the beneficiary identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting provider office, causing a delay in payment. Contain the valid provider NPI numbers, which must be entered properly and in their entirety in order for claims to be accepted and processed accurately. For claims with a Group NPI as the “Billing” provider, the claim must be submitted with both the Group (Type 2) NPI under “Billing Provider and Individual (Type 1) NPI under “Treating Provider.” These numbers are not interchangeable and could cause the claim to be returned as non-compliant.
 - Contain an acceptable provider signature. Refer to the Provider Administrative and Billing Manual for a list of acceptable signatures; “Signature on File” is acceptable. DentaQuest requires that dental services provided will be authenticated by the provider. Acceptable method used for authentication shall be handwritten, signed initials and/or rubber stamp signatures.
 - Contain the billing and/ or treating provider’s name, billing entity and treatment location address clearly identified and legible on the claim. Frequently, if only the dentist signature is used for identification, the dentist’s name cannot be clearly identified.
 - › Treating Dentist Information (Section 53-55 and 56a of the claim)
 - » Services rendered by dental provider: Must enter the name, NPI, license number and specialty of the provider who rendered the treatment.
 - » Dental Sedation services administered by a qualified provider, other than the treating dentist: Must enter the name, NPI, license number and specialty of the provider who rendered the dental treatment and authorized the dental sedation services.
 - » Services rendered by a qualified dental healthcare professional under direct supervision (this includes services rendered in a teaching facility): Must enter the

- name, NPI, license number and specialty of the supervising provider/ teaching dental faculty.
- » Services rendered by a qualified dental healthcare professional under general supervision: Must enter the name, NPI, license number and specialty of the supervising/ authorizing provider.
- › Treatment Location Information (Section 56 of the claim)
- » Services rendered in the dental office: Must enter the address of the office where services were delivered, regardless of the business address (if different)
 - Services rendered in any location, other than the office: Must enter the address of the location where services were rendered (such as the hospital, ambulatory surgical center, schools, nursing homes etc.). This should coincide with a valid Place of Service Code (POS) as indicated by Centers for Medicare and Medicaid Services (CMS). POS codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The SCDHHS requires POS codes for all submitted ADA Claim Forms. Field 38 on the ADA claim form allows for the POS entry.
 - For a complete listing of POS codes please visit the CMS website.
https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
 - Contain the date of service for each service line submitted.
 - Identify all services by either an approved and valid ADA dental codes as published in current CDT book.
 - List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification. Missing tooth, surface, quadrant or arch identification codes may result in the delay or denial of the claim.

CLAIM FILING INSTRUCTIONS BY PLACE OF SERVICE OR BENEFIT

Claim Submission for Emergency & Exceptional Medical Conditions

Medically necessary dental services rendered for diagnosis and treatment of emergency & exceptional medical conditions will not consume the \$1,000 annual maximum allowed for adult beneficiaries under the Preventive Dental Benefit as long as claims for treatment under this category is appropriately submitted. Please refer to Appendix B, Benefit Limitations of the Emergency & Exceptional Medical Conditions for details on services covered, criteria, and documentation required for review for these services.

When filing claims for the provision of dental services in preparation for or during the treatment of emergency & exceptional medical conditions, providers must indicate on the claim the keyword:

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

Claim Submission for EPSDT Services

Planned EPSDT Services

When filing a claim for the provision of medically necessary services rendered under the EPSDT benefit, which includes orthodontic services, providers must indicate the “EPSDT” field on the claim forms.

- EPSDT Box in Field 1 — for ADA Claim Forms
- The approved PA number issued by DentaQuest
- All claims submitted for EPSDT services will be systematically denied if the EPSDT indicator is not selected.

EPSDT Services Delivered as an Emergency

Claims filed for EPSDT services delivered when medically necessary as an emergency, will be processed through PPR. The claim filed for the provision of medically necessary services rendered under the EPSDT benefit in these cases, must indicate the following on the ADA Claim form (2012 version or newer):

- EPSDT Box in Field 1, and
- The word “EMERGENCY” in the Remarks field # 35 of the ADA paper claim form or Notes Field if filed electronically,

All claims submitted for the EPSDT Services will be systemically denied if the EPSDT indicator is not selected.

EPSDT Services Delivered Necessarily on the Same Day as Diagnosis

Claims filed for EPSDT services delivered necessarily on the same day as diagnosis will be processed through PPR. The claim filed for the provision of medically necessary services rendered under the EPSDT benefit in these cases must indicate the following on the ADA Claim form (2012 version or newer):

- EPSDT Box in Field 1, and
- The word “EMERGENCY” in the Remarks field # 35 of the ADA paper claim form or Notes Field if filed electronically,

All claims submitted for the EPSDT Services will be systemically denied if the EPSDT indicator is not selected.

EPSDT Services — Initial Dental Encounter for Foster Children

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

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

All claims submitted for the EPSDT Services will be systemically denied if the EPSDT indicator is not selected.

Claim Submission for Planned/Scheduled Services Performed in an ASC or OR

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

Claims for Inpatient Services

The authorizations for these services will only be issued by KEPRO or the beneficiary's MCO. DentaQuest will not reimburse for inpatient services. All services rendered during an inpatient stay are included in the Diagnosis Related Group (DRG) reimbursement. Outpatient services that result in an inpatient admission are deemed to be inpatient services and are included in the DRG payment. Outpatient services rendered on the day of admission are included in the DRG payment regardless of relation to the inpatient admission. All outpatient services rendered during an inpatient stay are included in the DRG payment.

Claim Submission with Standard Coordination of Benefits (COB)

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

- For paper claim submission:
 - The South Carolina three-digit carrier code or codes in Field 9;
 - The policy number or numbers in Field 8; and,
 - The amount paid or amounts paid in Field 11.
- For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field.

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

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

ADJUSTMENTS

Void Only and Void/Replacement Claims

Dental providers must use DHHS Form 130 to submit claim-level adjustments. (A sample DHHS Form 130 can be found in the Forms Link of this manual.) Once a provider has determined that a claim-level adjustment is warranted, there are two options:

- Submitting a Void Only claim will generate an account debit for the amount that was reimbursed. A Void Only claim should be used to retract a claim that was paid in error. To initiate a Void Only claim, complete DHHS Form 130 and attach a copy of the original Remittance Advice.
- Submitting a Void/Replacement claim will generate an account debit for the entire original claim. The new Replacement claim re-filed with the corrected information will replace the original one. A Void/Replacement claim should be used to:
 - Correct a keying or billing error on a paid claim
 - Add new or additional information to a claim
 - Add information about a third-party insurer or payment

To initiate a Void/Replacement claim, complete DHHS Form 130 and attach a copy of the original Remittance Advice, as well as the new Replacement claim with the corrected information. Attach any documentation relevant to the claim.

Instructions on how to complete the SCDHHS Form 130 are listed in the Administrative and Billing Manual; however, dental providers must enter DentaQuest's assigned Claim Number under the CCN entry and mail the form along with documentation required directly to DentaQuest at:

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

ELECTRONIC REMITTANCE STATEMENTS

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

Providers may access their remittance statements by following these steps:

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

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

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

APPENDIX A

ADDRESS AND TELEPHONE NUMBERS

DentaQuest's South Carolina Office

1333 Main Street, Suite 603
Columbia, SC 29201

Provider Call Center

Phone: +1 888 307 6553

Fax: +1 262 834 3589

IVR: +1 888 307 6553

Email:

Claims Questions: denclaims@dentaquest.com

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

Beneficiary Call Center

Phone: +1 888 307 6552

TDD (Hearing Impaired): +1 800 466 7566

Special Needs Beneficiary Services: +1 800 660 3397

SCDHHS Fraud and Abuse Hotline

Phone: +1 888 364 3224

Email: fraudres@scdhhs.gov

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

P.O. Box 2136

Columbia, SC 29202-2136

Electronic Claims should be sent:

Via the web: www.dentaquest.com

Via Clearinghouse

DentaQuest Systems Corporation

P.O. Box 2906

Milwaukee, WI 53201-2906

Authorization requests should be sent to:

DentaQuest, LLC — Authorizations

P.O. Box 2136

Columbia, SC 29202-2136

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

DentaQuest, LLC — Authorizations

P.O. Box 2136

Columbia, SC 29202-2136

Requests for Reconsideration Should Be Sent to:

DentaQuest, LLC

Utilization Management/Provider Appeals

P.O. Box 2906

Milwaukee, WI 53201-2906

or faxed to +1 262 834 3452

Beneficiary Grievance and Appeals

DentaQuest, LLC

Complaints and Appeals

P.O. Box 2906

Milwaukee, WI 53201-290

APPENDIX B

BENEFITS CRITERIA AND LIMITATIONS

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

The criteria outlined in SCDHHS’ Dental Services Provider Manual are based around procedure codes as defined in the American Dental Association CDT Manual.

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

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

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

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

The **Healthy Connections** Coverable Dental Services are defined as follows:

- State Plan-Covered Services:
 - Preventive Dental Benefit
 - Emergency & Exceptional Medical Conditions
- EPSDT Services (Non-State Plan Covered Services)

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

STATE PLAN COVERED SERVICES

Preventive Dental Benefit

Diagnostic Services

Criteria

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

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

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

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

Medically necessary diagnostic services are not subject to the annual maximum of \$1,000 for the Adult Dental Benefit. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Documentation Required

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

Benefit Limitations

Diagnostic						
Code	Description	Beneficiary Subgroup	Benefit Limitations		Pre-Payment Review	Prior Authorization
			Age (Years)	Frequency/Timespan		
D0120	Periodic evaluation-established patient	Child	3-20	One D0120, per 6 months per patient. Not allowed within 6 months of D0145 or D0150.	No	No
		ID/RD Waiver	21+	One D0120 per 6 months per patient. Not allowed within 6 months of D0145 or D0150.	No	No
		Adult	21+	One D0120, per 12 months per patient. Not allowed within 12 months of D0150.	No	No
D0140	Limited oral evaluation-problem focused	Child	0-20	Two D0140 per 12 months per patient.	No	No
		ID/RD Waiver	21+	Two D0140 per 12 months per patient.	No	No
		Adult	21+	Two D0140 per 12 months per patient.	No	No
D0145	Oral evaluation for children under 3 years of age and counseling with primary caregiver	Child	0-2	One D0145 per 6 months per patient.	No	No
		ID/RD Waiver	Not applicable			
		Adult	Not applicable			
D0150	Comprehensive Oral Evaluation-new or established patient	Child	3-20	One D0150 per 36 Month(s) per provider, provider location or billing entity. Not allowed within 6 months of service history of D0120, D0145 or D0150.	No	No
		ID/RD Waiver	21+	One D0150 per 36 month(s) per provider, provider location or billing entity. Not allowed within 6 months of service history of D0120 or D0150.	No	No
		Adult	21+	One D0150 per 36 months per provider, provider location or billing entity. Not allowed within 12 months of service history of D0120 or D0150.	No	No
D0160	Detailed and Extensive oral evaluation-problem focused	Child	0-20	One D0160 per treatment plan of oral surgeons only, per provider, provider location or billing entity. Not allowed on the same day as D0120, D0140, D0145, D0150, D0170 or D9310 by same provider, provider location or billing entity. Not allowed within 30 days of D0140, D0160, D0170 or D9310 by the same provider, provider location or billing entity.	No	No
		ID/RD Waiver	21+			
		Adult	21+			

Diagnostic							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D0210	Intraoral - comprehensive series of radiographic images	Child	2-20		One of (D0210 or D0372) per 36 months per provider, provider location or billing entity. Not allowed to be billed within 6 months of patient service history of (D0210, D0240, D0272, D0274, D0330, D0372 or D0373). Not allowed to be billed on the same day of (D0220, D0230, D0240, D0272, D0274, D0330, D0372, D0373 or D0374).	No	No
		ID/RD Waiver	21+				
		Adult	21+		One of (D0210 or D0372) per 36 months per provider, provider location or billing entity. Not allowed to be billed within 12 months of patient service history of (D0210, D0272, D0274, D0330, D0372 or D0373). Not allowed to be billed on the same day of (D0220, D0230, D0272, D0274, D0330, D0372, D0373 or D0374).	No	No
D0220	Intraoral - periapical first radiographic image	Child	0-20		One of (D0220) per one (1) day(s) per patient. Must be billed with one of (D0120, D0140, D0145, D0150, D0160, D0170, D9310) on the same date of service. Not allowed to be billed on the same day of (D0210, D0372 or D0374) by same provider, provider location or billing entity.	No	No
		ID/RD Waiver	21+				
		Adult	21+				
D0230	Intraoral – periapical each additional radiographic image	Child	0-20		Three (3) of D0230 per one (1) day(s) per patient. Must be billed with one of (D0120, D0140, D0145, D0150, D0160, D0170, D9310) on the same date of service. Not allowed to be billed on the same day of (D0210, D0372 or D0374) by same provider, provider location or billing entity.	No	No
		ID/RD Waiver	21+				
		Adult	21+		One (1) of D0230 per one (1) day(s) per patient. Must be billed with one of (D0120, D0140, D0150, D0160, D0170, D9310) on the same date of service. Not allowed to be billed on the same day of (D0210, D0372 or D0374) by same provider, provider location or billing entity.	No	No
D0240	Intraoral-occlusal radiographic image	Child	0-20		Two of (D0240) per 12 Month(s) per patient. Not allowed to be billed on the same day or within 6 months of service history of D0210, D0272, D0274, D0330, D0372 or D0373.	No	No
		ID/RD Waiver	21+				
		Adult	21+		<i>Not a covered service</i>		

Diagnostic							
Code	Description	Beneficiary Subgroup	Benefit Limitation			Pre-Payment Review	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D0270	Bitewing - single radiographic image	Child	2-20		One D0270 per 1 day(s) per patient. Not allowed to be billed on the same day as (D0210, D0272, D0274, D0372 or D0373). Must be billed with one of (D0120, D0140, D0145, D0150, D0160, D0170, D9310) on the same date of service	No	No
		ID/RD Waiver	21+				
		Adult	21+	Not a covered service			
D0272	Bitewings - two Radiographic images	Child	2-20		One of D0272 per 6 month(s) per patient. Not allowed to be billed on the same day as D0210, D0240, D0270, D0274, D0372, or D0373. Not allowed to be billed within 6 months of service history of D0210, D0240, D0272, D0274, D0330, D0372 or D0373.	No	No
		ID/RD Waiver	21+				
		Adult	21+		One of (D0272,) per 12 month(s) per patient. Not allowed to be billed on the same day as D0210, D0270, D0274, D0372 or D0373. Not allowed to be billed within 12 months of service history of D0210, D0272, D0274, D0330, D0372 or D0373.	No	No
D0274	Bitewings - four radiographic images	Child	8-20		One D0274 per 6 month(s) per patient. Not allowed to be billed on the same day as D0210, D0240, D0270, D0272, D0372 or D0373. Not allowed to be billed within 6 months of service history of D0210, D0240, D0272, D0274, D0330, D0372 or D0373.	No	No
		ID/RD Waiver	21+				
		Adult	21+		One D0274 per 12 month(s) per patient. Not allowed to be billed on the same day as D0210, D0270, D0272, D0372, or D0373. Not allowed to be billed within 12 months of service history of D0210, D0272, D0274, D0330, D0372 or D0373.	No	No
D0330	Panoramic radiographic image	Child	6-20		One D0330 per 36 Month(s) per provider, provider location or billing entity. Not allowed to be billed on the same day as D0210, D0240 or D0372. Not allowed to be billed within 6 months of service history of D0210, D0240, D0272, D0274, D0330, D0372 or D0373. Oral surgeons are allowed two (2) D0330 per 36 months per patient.	No	No
		ID/RD Waiver	21+				
		Adult	21+		One D0330 per 36 month(s) per provider, provider location or billing entity. Not allowed to be billed on the same day as D0210 or D0372. Not allowed to be billed within 12 months of service history of D0210, D0272, D0274, D0330, D0372 or D0373. Oral surgeons are allowed two (2) D0330 per 36 months per patient.	No	No

Diagnostic							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/ Timespan		
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	Child	2-20		One of (D0210 or D0372) per 36 months per provider, provider location or billing entity. Not allowed to be billed within 6 months of service history of (D0210, D0240, D0272, D0274, D0330, D0372 or D0373). Not allowed to be billed on the same day of (D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0373 or D0374).	No	No
		ID/RD Waiver	21+				
		Adult	21+		One of (D0210 or D0372) per 36 months per provider, provider location or billing entity. Not allowed to be billed within 12 months of service history of (D0210, D0272, D0274, D0330 D0372 or D0373). Not allowed to be billed on the same day of (D0220, D0230, D0272, D0274, D0330, D0373 or D0374)	No	No
D0373	intraoral tomosynthesis – bitewing radiographic image	Child	2-20		One D0373 per 6 month(s) per patient. Not allowed to be billed on the same day as D0210, D0240, D0270, D0272, D0274 or D0372. Not allowed to be billed within 6 months of service history of D0210, D0240, D0272, D0274, D0330, D0372 or D0373.	No	No
		ID/RD Waiver	21+				
		Adult	21+		One D0373 per 12 month(s) per patient. Not allowed to be billed on the same day as D0210, D0272, D0274 or D0372. Not allowed to be billed within 12 months of service history of D0210, D0272, D0274, D0330, D0372 or D0373.	No	No
D0374	intraoral tomosynthesis – periapical radiographic image	Child	0-20		Up to four (4) of D0374 per one (1) day(s) per patient. Must be billed with one of (D0120, D0140, D0145, D0150, D0160, D0170, D9310) on the same date of service. Not allowed to be billed on the same day of (D0210, D0220, D0230 or D0372) by same provider, provider location or billing entity.	No	No
		ID/RD Waiver	21+				
		Adult	21+		Up to two (2) of D0374 per one (1) day(s) per patient. Must be billed with one of (D0120, D0140, D0145, D0150, D0160, D0170, D9310) on the same date of service. Not allowed to be billed on the same day of (D0210, D0220, D0230 or D0372) by same provider, provider location or billing entity.	No	No

Preventive Services

Criteria

Reimbursement fee for the preventive dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays, or equipment. None of these items or related activities/services

are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative. Multistage procedures are reported and may be reimbursed upon completion. The completion date for fixed space maintainers is the cementation date regardless of the type of cement utilized.

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

Space Maintainers

- Space maintainers are performed to prevent tooth movement and maintain the space for eruption of a permanent tooth when the deciduous tooth has been lost prematurely.
- The procedure is reimbursable once per lifetime and includes any follow-up care and/or re-cementing, if necessary. The space maintainer must be cemented prior to submitting a claim for reimbursement.
- Space maintainers are not reimbursable when the eruption of the permanent tooth is imminent.

A bilateral fixed space maintainer (D1516 or D1517) is allowed and reimbursable when there is no service history of any space maintainers for the same arch. Additionally, the bilateral fixed space maintainer (D1516 or D1517) placed on the same arch with a service history of one unilateral fixed space maintainer (D1510) will be allowed and reimbursed at the D1510 rate. Reimbursement for a bilateral fixed space maintainer placed on the same arch with a service history of two unilateral fixed space maintainers is not allowed.

Application of Caries Arresting Medicament

The caries arresting medicament allowed for use and billing of the CDT D1354, is Silver Diamine Fluoride (SDF) 38%.

- Application of caries arresting medicament is allowed on primary or permanent teeth of Medicaid eligible beneficiaries under the age of twenty-one (21) or members of the ID/RD waiver.
- The frequency of application of caries arresting medicament per patient is allowed on a per "date of application" basis. Date of application is a date of service during which the provider applies caries arresting medicament on at least one tooth. Providers may apply caries arresting medicament to as many teeth as necessary during the date of application. Reimbursement for caries arresting medicament will be on a per tooth basis not to exceed \$60 per date of application.

The first and second date of application of caries arresting medicament must be billed in conjunction with or within 6 months of a periodic, comprehensive, or a consultation performed by the same provider, provider location or billing entity.

The subsequent dates of application of caries arresting medicament must be either in conjunction with a periodic, comprehensive or a consultation, or at least 6 months apart.

- Reimbursement for subsequent treatment (extraction) performed within six (6) months of application of caries arresting medicament on the same tooth by the same provider, provider location or billing entity will be adjusted based on the initial service.
- Application of caries arresting medicament for tooth sensitivity or as an adjunctive procedure will not be reimbursed.
- Application of caries arresting medicament within 36 months subsequent to a restorative or endodontic procedure on the same tooth by the same provider, provider location, or billing entity is not reimbursable.
-
- Documentation in the patient’s record must include **all** the following:
 - Appropriate pre-treatment diagnostic radiographic images such as bitewings, periapicals or panorex that clearly show the affected tooth/teeth with decay;
 - A detailed narrative demonstrating the medical necessity for the service;
 - Parent/patient written informed consent prior to providing the service. The provider must inform the parent/patient of expected permanent staining on the application site;
 - Documentation of patient/parent education and/or anticipatory guidance;
 - Documentation of oral hygiene instructions;
 - Patient’s Caries Management Plan tied to the treatment plan (SDF application must be based on the ongoing patient’s caries management plan); and,
 - Documentation supporting **all** the following *clinical criteria*:
 - › Tooth has an active, non-symptomatic cavitated lesion on any coronal tooth surface;
 - › Tooth has no clinical signs of pulpal inflammation or reports of unsolicited/spontaneous pain;
 - › Cavitated lesions are not encroaching on the pulp;
 - › Cavitated lesions are accessible for application of the SDF; and,

- › Tooth is not expected to exfoliate within the next twelve (12) months and/or tooth prognosis is good.

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

- Provider Training

SCDHHS recommends provider training for proficiency in the SDF application protocols and clinical guidelines. Two available resources for SDF application guidelines are:

- Protocol for Caries Arrest Using Silver Diamine Fluoride: Rationale, Indications and Consent, developed by the University of California San Francisco (UCSF) School of Dentistry, published in 2016 and available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4778976/>.
- Chairside Guide: Silver Diamine Fluoride in the Management of Dental Caries Lesions, developed by American Academy of Pediatric Dentistry, published in 2018 and available at: https://www.aapd.org/media/Policies_Guidelines/R_ChairsideGuide.pdf.

Documentation Required

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

Benefit Limitations

Preventive								
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review	Prior Authorization	
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan			
D1110	Prophylaxis adult	Child	12-20		One of (D1110) per 6 month(s) per patient. Not allowed within 6 months of D1120.	No	No	
		ID/RD Waiver	21+		One of (D1110) per 6 month(s) per patient	No	No	
		Adult	21+		One of (D1110) per 12 month(s) per patient	No	No	
D1120	Prophylaxis child	Child	0-11		One of (D1110, D1120) per 6 month(s) per patient	No	No	
		ID/RD Waiver	21+	Not applicable				
		Adult	21+	Not applicable				
D1206	Topical Fluoride Varnish	Child	0-20		One of (D1206, D1208) per 6 month(s) per patient	No	No	
		ID/RD Waiver	21+		One of (D1206, D1208) per 6 month(s) per patient	No	No	

Preventive							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
		Adult	21+	Not a covered service			
D1208	Topical Fluoride-excluding varnish	Child	0-20		One of (D1206, D1208) per 6 month(s) per patient	No	No
		ID/RD Waiver	21+		One of (D1206, D1208) per 6 month(s) per patient	No	No
		Adult	21+	Not a covered service			
D1351	Sealant- per tooth	Child	5-14	2, 3, 14, 15, 18, 19, 30, 31	One (D1351) per 36 month(s) per patient, per tooth. Not allowed on the same date or after placement of any (D2000- D2999) on the same tooth.	No	No
		ID/RD Waiver	21+	Not applicable			
		Adult	21+	Not a covered service			
D1354	Caries arresting medicament application	Child	0-20	1-32; A-T	See limitation described under the Criteria section	No	No
		ID/RD Waiver	21+	1-32		No	No
		Adult	21+	Not a covered service			
D1510	Space maintainer-fixed, unilateral	Child	0-20	Per Quad 10, 20, 30, 40	One of (D1510) per lifetime per patient per quadrant. Not allowed on the same day as D1516 or D1517 on the same arch. Not allowed with a history of D1516 or D1517 on the same arch	No	No
		ID/RD Waiver	21+	Not applicable			
		Adult	21+	Not a covered service			
D1516	Space maintainer-fixed, bilateral maxillary	Child	0-20		One of (D1516) per lifetime per patient. Not allowed on the same day as D1510 on the same arch. Allowed with history of ONLY one D1510 on the same arch but reimbursed at the D1510 rate.	No	No
		ID/RD Waiver	21+	Not applicable			
		Adult	21+	Not a covered service			
D1517	Space maintainer-fixed, bilateral mandibular	Child	0-20		One of (D1517) per lifetime per patient. Not allowed on the same day as D1510 on the same arch. Allowed with history of ONLY one D1510 on the same arch but reimbursed at the D1510 rate.	No	No
		ID/RD Waiver	21+	Not applicable			
		Adult	21+	Not a covered service			

Restorative Services

Criteria

Reimbursement fee for the restorative procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: tooth

preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, temporary or protective restorations, direct and indirect pulp caps, curing, polishing, supplies, trays, equipment, topical/local anesthesia and post-operative care up to 30 days from the date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Restorative Fillings

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

- Children:
 - Reimbursement for restoration on the same surface of the same tooth (primary or permanent tooth) is allowed once per 36 months per same provider, provider location or billing entity.
 - Reimbursement for restoration on a tooth will be made based on surface combinations following the frequency listed below:
 - › Reimbursement for restoration of a tooth involving at least one of the surfaces (F, I, L for primary or permanent anterior teeth) or (B, L for primary or permanent posterior teeth) performed within (less than) a 36-month period of a restoration of that tooth by same provider, provider location or billing entity, regardless of tooth surface involvement or configuration, is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.
 - › Reimbursement for restoration of a tooth involving at least one of the (M, O, D surfaces of primary or permanent anterior or posterior teeth) performed within (less than) a 12-month period of a restoration of that tooth by same provider, provider location or billing entity, regardless of tooth surface involvement or configuration, is subject to payment adjustment based on the initial service.
 - Reimbursement for a tooth restored within (less than) a 12-month period after the placement of a dental sealant by the same provider, provider location or billing entity is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.
- ID/RD Waiver:
 - Reimbursement for restoration on the same surface of the same tooth (retained primary or permanent tooth) is allowed once per 36 months per same provider, provider location or billing entity.

- Reimbursement for restoration on a tooth will be made based on surface combinations following the frequency listed below:
 - › Reimbursement for restoration of a tooth involving at least one of the surfaces (F, I, L for primary or permanent anterior teeth) or (B, L for primary or permanent posterior teeth) performed within (less than) a 36-month period of a restoration of that tooth by same provider, provider location or billing entity, regardless of tooth surface involvement or configuration, is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.
 - › Reimbursement for restoration of a tooth involving at least one of the (M, O, D surfaces of primary or permanent anterior or posterior teeth) performed within (less than) a 12-month period of a restoration of that tooth by same provider, provider location or billing entity, regardless of tooth surface involvement or configuration, is subject to payment adjustment based on the initial service.
- Reimbursement for a tooth restored within (less than) a 12-month period after the placement of a dental sealant by the same provider, provider location or billing entity is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.
- Adults:
 - Reimbursement for restoration on the same surface of the same tooth (retained primary or permanent tooth) is allowed once per 36 months per patient.
 - Reimbursement for a tooth restored within (less than) a 12-month period after the placement of a dental sealant is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.
 -

Additionally:

- Supernumerary teeth, both primary and permanent, are subject to the same policy limitations. Reimbursement for restorative treatment of retained primary teeth for beneficiaries ages 21 years and older will require PPR. Providers must submit radiographic images and supporting documentation to justify the need for the procedure for the treatment to be reimbursed by SCDHHS.

Prefabricated Crowns

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

authorization. *(Includes all prefabricated crowns: stainless steel/esthetic coated stainless steel, resin and porcelain/ceramic).* Additionally, reimbursement for a tooth restored with a crown within (less than) a 12-month period after the placement of a dental sealant or a restoration, or within (less than) six-month period of the application of caries arresting medicament by the same provider, provider location or billing entity, is subject to payment adjustment based on the initial service. Supernumerary teeth, both primary and permanent, are subject to the same policy limitations.

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

- Primary teeth (anterior and posterior):
 - Tooth is expected to have more than 12 months of life prior to exfoliation, based on the child's eruption pattern, and
 - Tooth needs an extensive restoration when other restorative materials have a poor prognosis, and the restoration is due to any of the following:
 - › Substantial decay or trauma
 - › Cervical decalcification and/or developmental defects
 - › Following pulpal therapy
- Permanent teeth (anterior, bicuspid, molar):
 - Tooth needs an extensive restoration when other restorative materials have a poor prognosis, and the restoration is due to any of the following:
 - › Substantial decay or trauma
 - › Cervical decalcification and/or developmental defects
 - › Following pulpal therapy

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

- Tooth has sub-osseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- PRIMARY tooth root is surrounded by severe pathologic destruction of bone.
- PERMANENT tooth apex is surrounded by untreated pathologic destruction of bone.
- Crown is being planned to alter vertical dimension.

- Crown is used as a temporizing treatment while a permanent restoration is being fabricated.

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

Documentation Required

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

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

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

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

Benefits Limitations

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2140	Amalgam - one surface, Primary or permanent	Child	0-20	Teeth 1-32; A-T; 51-82; AS-TS	One of (D2140, D2330, D2391) per 36 month(s) per provider or location per tooth, per surface.	No	No
		ID/RD Waiver	21+		One of (D2140, D2330, D2391) per 36 month(s) per provider or location per tooth, per surface	No	No
		Adult	21+		One of (D2140, D2330, D2391) per 36 month(s) per patient, per tooth, per surface	No Yes - Retained Primary	No
D2150	Amalgam - two surfaces, primary or permanent	Child	0-20	Teeth 1-32; A-T; 51-82; AS-TS	One of (D2150, D2331, D2392) per 36 month(s) per provider or location per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2150, D2331, D2392) per 36 month(s) per provider or location per tooth, per surface	No	No
		Adult	21+		One of (D2150, D2331, D2392) per 36 month(s) per patient, per tooth, per surface	No Yes - Retained Primary	No

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2160	Amalgam - three surfaces, primary or permanent	Child	0-20	Teeth 1-32; A-T; 51-82; AS-TS	One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2160, D2332, D2393) per 36 month(s) per patient per tooth, per surface	No Yes - Retained Primary	No
D2161	Amalgam - four or more surfaces, primary or permanent	Child	0-20	Teeth 1-32; A-T; 51-82; AS-TS	One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2161, D2335, D2394) per 36 month(s) per patient per tooth, per surface	No Yes - Retained Primary	No

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2330	Resin-based composite - one surface, anterior	Child	0-20	Teeth 6-11; 22-27; C-H; M-R; 56-61; 72-77; CS-HS; MS-RS	One of (D2140, D2330, D2391) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2140, D2330, D2391) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2140, D2330, D2391) per 36 month(s) per patient per tooth, per surface	No Yes - Retained Primary	No
D2331	Resin-based composite - two surfaces, anterior	Child	0-20	Teeth 6-11; 22-27; C-H; M-R; 56-61; 72-77; CS-HS; MS-RS	One of (D2150, D2331, D2392) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2150, D2331, D2392) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2150, D2331, D2392) per 36 month(s) per patient per tooth, per surface	No Yes - Retained Primary	No

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2332	Resin-based composite - three surfaces, anterior	Child	0-20	Teeth 6-11; 22-27; C-H; M-R; 56-61; 72-77; CS-HS; MS-RS	One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2160, D2332, D2393) per 36 month(s) per patient per tooth, per surface	No Yes - Retained Primary	No
D2335	Resin-based composite four or more surfaces (anterior)	Child	0-20	Teeth 6-11; 22-27; C-H; M-R; 56-61; 72-77; CS-HS; MS-RS	One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2161, D2335, D2394) per 36 month(s) per patient per tooth, per surface	No Yes - Retained Primary	No

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2390	Resin based composite crown-anterior	Child	0-20	6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS; MS-RS	One (D2390, D2929, D2930, D2931, D2932, D2934) per 36 months per patient per tooth	No	No
		ID/RD Waiver	21+		One (D2390, D2929, D2930, D2931, D2932, D2934) per 36 months per patient per tooth	No	No
		Adult	21+		<i>Not a covered service</i>		
D2391	Resin-based composite - one surface, posterior	Child	0-20	Teeth 1-5; 12-21; 28-32; A-B; I-L; S-T; 51-55; 62-71; 78-82; AS-BS; IS-LS; SS-TS	One of (D2140, D2330, D2391) per 36 month(s) per provider or location per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2140, D2330, D2391) per 36 month(s) per provider or location per tooth, per surface	No	No
		Adult	21+		One of (D2140, D2330, D2391) per 36 month(s) per patient per tooth, per surface	No Yes - Retained Primary	No

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2392	Resin-based composite - two surface, posterior	Child	0-20	Teeth 1-5; 12-21; 28-32; A-B; I-L; S-T; 51-55; 62-71; 78-82; AS-BS; IS-LS; SS-TS	One of (D2150, D2331, D2392) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2150, D2331, D2392) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2150, D2331, D2392) per 36 month(s) per patient, per tooth, per surface	No Yes - Retained Primary	No
D2393	Resin-based composite - three surface, posterior	Child	0-20	Teeth 1-5; 12-21; 28-32; A-B; I-L; S-T; 51-55; 62-71; 78-82; AS-BS; IS-LS; SS-TS	One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2160, D2332, D2393) per 36 month(s) per patient, per tooth, per surface	No Yes - Retained Primary	No
D2394	Resin-based composite – four or more surface, posterior	Child	0-20	Teeth 1-5; 12-21; 28-32; A-B; I-L; S-T51-55; 62-71; 78-82; AS-BS; IS-LS; SS-TS	One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2161, D2335, D2394) per 36 month(s) per patient, per tooth, per surface	No Yes - Retained Primary	No

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2929	Prefabricated porcelain/ceramic crown - primary tooth	Child	0-20	Teeth C-H, M-R	One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No
		ID/RD Waiver	21+		One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No
		Adult	21+		<i>Not a covered service</i>		
D2930	Prefabricated stainless	Child	0-20	Teeth A-T	One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No

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

Endodontic Services

Criteria

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

these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

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

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

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

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

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

- Root Canal therapy will not meet criteria if:
 - Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
 - The general oral condition does not justify root canal therapy due to loss of arch integrity.
 - Root canal therapy is for third molars, unless they are an abutment for a partial denture.
 - Tooth does not demonstrate 50% bone support.
 - Root canal therapy is in anticipation of placement of an overdenture.
 - A filling material not accepted by the Federal Food and Drug Administration (e.g., Sargenti filling material) is used.

Documentation Required

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

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

- Detailed narrative of medical necessity, and
- Sufficient and appropriate pre-treatment radiographic images clearly showing the pathology of the affected tooth/teeth, and
- A dated post-operative radiographic image clearly showing treatment completion as defined in the “Criteria” section of this manual.

Benefit Limitations

Endodontics							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D3220	Therapeutic pulpotomy (excluding final restoration)	Child	0-20	Teeth 2-15, 18-31, A-T	One D3220 per lifetime per patient per tooth. Not allowed in conjunction with one of (D3310, D3320, or D3330) on the same tooth, on the same day.	No	No
		ID/RD Waiver	21+	Teeth 2-15, 18-31, A-T	One D3220 per lifetime per patient per tooth. Not allowed in conjunction with one of (D3310, D3320, or D3330) on the same tooth, on the same day.	No	No
		Adult	21+	<i>Not a covered service</i>			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Child	0-20	Teeth 6-11, 22-27	One D3310 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		ID/RD Waiver	21+	Teeth 6-11, 22-27	One D3310 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		Adult	21+	<i>Not a covered service</i>			
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Child	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	One D3320 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		ID/RD Waiver	21+	Teeth 4, 5, 12, 13, 20, 21, 28, 29	One D3320 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No

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

Prosthodontic (removable) Services

Criteria

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

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

Provision for removable prostheses must meet the following clinical criteria:

- Full Dentures:
 - As an initial placement:
 - › The masticatory function must be impaired.
- Note:** A denture is determined to be an initial placement if the beneficiary has never worn a prosthesis. Initial placement does not refer to the first time a beneficiary is seen and treated by a given provider.
- As a replacement of an existing prostheses:
 - › The existing prosthesis is unserviceable, and
 - › The evidence submitted indicates that the masticatory insufficiencies are likely to impair the general health of the member, and

- › The existing prosthesis is at least three years old.
- Partial Dentures:
 - As an initial placement:
 - › The masticatory function must be impaired, and
 - Note:** A denture is determined to be an initial placement if the beneficiary has never worn a prosthesis. Initial placement does not refer to the first time a beneficiary is seen and treated by a given provider.
 - › Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone, and
 - › Partial dentures are covered only for beneficiaries with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- For replacement of an existing prosthesis:
 - › The existing prosthesis is unserviceable, and
 - › The evidence submitted indicates that the masticatory insufficiencies are likely to impair the general health of the member, and
 - › The existing prosthesis is at least three years old, and
 - › Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone, and
 - › The replacement teeth should be anatomically full-sized teeth.

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

Removable prosthesis will not meet criteria for the following reasons:

- Partial dentures are not a covered benefit when eight or more posterior teeth are in occlusion.
- Partial dentures not allowed for closing a space gap without missing teeth.
- If there is a pre-existing prosthesis which is not at least three years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.

- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the beneficiary cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the beneficiary has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If repair, relining or rebasing of the patient's present dentures will make them serviceable.
- If a partial denture, less than three years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the beneficiary. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the partial denture meet functional criteria.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

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

- All prosthetic appliances shall be seated in the mouth before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service.
- Beneficiaries must be eligible on that date for the denture service to be covered. In addition, there may be coverage for dentures in cases where extractions are performed in conjunction with an authorized denture or final impression while the beneficiary is still eligible.

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

Documentation Required

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

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

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

Benefit Limitations

Prosthodontics (Removable)							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D5110	Complete denture - maxillary	Child	14-20		One D5110 per 60 month(s) per patient	Yes	No
		ID/RD Waiver	21+		One D5110 per 60 month(s) per patient	Yes	No
		Adult	21+	Not a covered service			
D5120	Complete denture - mandibular	Child	14-20		One D5120 per 60 month(s) per patient	Yes	No
		ID/RD Waiver	21+		One D5120 per 60 month(s) per patient	Yes	No
		Adult	21+	Not a covered service			
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	Child	14-20		One D5211 per 60 month(s) per patient	Yes	No
		ID/RD Waiver	21+		One D5211 per 60 month(s) per patient	Yes	No
		Adult	21+	Not a covered service			
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	Child	14-20		One D5212 per 60 month(s) per patient	Yes	No
		ID/RD Waiver	21+		One D5212 per 60 month(s) per patient	Yes	No
		Adult	21+	Not a covered service			
D5511	Repair broken complete denture base, mandibular	Child	14-20			No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			
D5512	Repair broken complete denture base, maxillary	Child	14-20			No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			

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

Dental Surgery (Extractions)

Criteria

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

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

Reimbursement for a tooth extracted within (less than) a 12-month period after the placement of a dental sealant, a restoration or endodontic treatment, or within 6 months of application of caries arresting medicament by the same provider or provider location, is subject to payment adjustment based on the initial service.

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

- Tooth is determined to be non-restorable; a tooth may be deemed non-restorable if one or more of the following criteria are present:
 - The tooth presents with greater than a 75% loss of the clinical crown.

- The tooth has less than 50% bone support.
 - The tooth has sub-osseous and/or furcation caries.
 - The tooth is a primary tooth with exfoliation imminent.
 - The tooth apex is surrounded by severe pathologic destruction of the bone.
 - The overall dental condition (i.e., periodontal) of the beneficiary is such that an alternative treatment plan would be better suited to meet the beneficiary’s needs.
- Tooth is compromising the patient’s dental health and/or overall health and development.
 - Provider’s clinical judgement determines that there is no other alternative treatment option.

SCDHHS will follow the American Dental Association (ADA) published age-based eruption and exfoliation patterns for reimbursement of extractions of primary teeth. Providers must maintain appropriate pre-treatment radiographic images of the primary teeth to support the level of extraction procedure code billed on the claim. SCDHHS will not reimburse for the removal of primary teeth whose exfoliation is imminent.

Documentation Required

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

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

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

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

Benefit Limitations

Dental Extractions							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/ Quad/ Arch	Frequency/ Timespan		
D7111		Child	0-20	Teeth		No	No

	Extraction, coronal remnants - primary tooth	ID/RD Waiver	21+	A-T; AS-TS		No	No
		Adult	21+	Not a covered service			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Child	0-20	Teeth 1-32; 51-82; A-T; AS-TS		No	No
		ID/RD Waiver	21+			No	No
		Adult	21+			No	No
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Child	0-20	Teeth 1-32; 51-82; ; AS-TS		No	No
		ID/RD Waiver	21+			No	No
		Adult	21+			No	No
D7220	Removal of impacted tooth-soft tissue	Child	0-20	Teeth 1-32; 51-82; A-T; AS-TS		No – for third molars (1,16,17,32) Yes- for all others	No
		ID/RD Waiver	21+				
		Adult	21+			Yes	No
D7230	Removal of impacted tooth-partially bony	Child	0-20	1-32; 51-82; A-T; AS-TS		No- for third molars (1,16,17,32) Yes-for all others	No
		ID/RD Waiver	21+				
		Adult	21+			Yes	No
D7240	Removal of impacted tooth-completely bony	Child	0-20	1-32; 51-82; A-T; AS-TS		Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	Child	0-20	1-32; 51-82; A-T; AS-TS		Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D7250	Removal of residual tooth roots (cutting procedure)	Child	0-20	1-32; 51-82; A-T; AS-TS	Not allowed by same office or provider who performed original extraction.	No	No
		ID/RD Waiver	21+			No	No
		Adult	21+			No	No

Adjunctive Services

Criteria

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

Claims filed for adjunctive services must also include the procedure code(s) rendered in conjunction with the adjunctive service(s). Adjunctive services will be considered for review and reimbursement

only when accompanied by a covered service or by an approved EPSDT service and when the medical necessity for the service is established through supporting documentation (refer to documents required and clinical criteria for each specific procedure/procedure category).

Use of sedation for beneficiaries ages 21 years and older may be allowable if authorized through PA or PPR ONLY when medically necessary for treatment of an adult with a special needs' diagnosis or ONLY when medically necessary for treatment by an oral surgeon. Medically necessary adjunctive services are not subject to the \$1,000 Adult Dental Benefit annual maximum.

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

Dental Sedation Services in Dental Office

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

The administration of sedation and/or anesthesia by or under the direction of an authorized dental provider shall be medically necessary.

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

A dental provider in agreement with the patient after informed consent, may consider the individual a Medicaid patient or a private-pay patient. A dental provider accepting the individual as a Medicaid patient must comply with all Medicaid rules and policies.

The beneficiary's status as a Medicaid patient applies to all services rendered as part of the course of treatment and the beneficiary's status cannot be changed during the course of that treatment. This policy applies to the dental treatment delivered under sedation or anesthesia in a dental office by any qualified provider who is acting within their scope of practice according to South Carolina

law. The dental provider's treatment plan which includes services being delivered under sedation or anesthesia in their office setting, is considered one treatment plan.

The reimbursement fee for sedation or anesthesia includes but is not limited to any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, drugs and biologicals, trays, or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative. There is no facility fee associated with sedation or anesthesia services performed in a dental office and no such fee shall be billed to SCDHHS, the beneficiary or to the beneficiary's representative.

Sedation or anesthesia services administered by a dental anesthesiologist, a licensed physician, or a Certified Registered Nurse Anesthetist (CRNA) under the direction of the treating dentist who holds the sedation permit for the dental office, must be billed on a dental claim under the treating dental provider's National Provider Identification (NPI) number. Providers must comply with the South Carolina 2014 Dental Sedation Act 222 (South Carolina Code of Laws 40-15-450) requirements for patient's record keeping. SCDHHS also requires that both the authorized office location and administering provider must be clearly documented in the patient's record. If there is no sedation documentation in the treatment record that meets these requirements for a billed service, then the service is subject to recoupment by SCDHHS.

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

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

- Required Documentation must be submitted with the claim for PPR, and
- Clinical criteria must include one of the following:
 - Treatment is comprised of complex oral surgical procedure such as: impacted wisdom teeth, surgical root recovery from maxillary antrum, surgical exposure of impacted or unerupted cuspids, radical excision of lesions in excess of 1.25 cm, or
 - Beneficiary has a medical condition(s) which requires monitoring (e.g., cardiac problems, severe hypertension), or
 - Beneficiary has an underlying hazardous medical condition or mental or physical disability which would render the beneficiary non-compliant during treatment, or

- Beneficiary has a documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective, or
- Children requiring operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures and the documentation justifies that in-office general/IV sedation is appropriate and is not sought solely based on provider or beneficiary convenience, or
- Cognitively disabled individuals requiring dental procedures whose prior history indicates that in-office general anesthesia/IV sedation is appropriate.

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

Planned, non-emergent dental services delivered in an outpatient OR, or ASC must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR/ASC. The authorization request for the use of the ASC/OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment.

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

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

- Beneficiaries requiring extensive dental procedures with a medical history or complex medical condition that renders in-office treatment not medically appropriate.
- Beneficiaries requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates outpatient setting is appropriate.

Behavioral Management

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

- Required documentation must be submitted with the claim for PPR, and
- Clinical criteria for the use of behavior management must include ALL the following:
 - Child beneficiary presenting with disabilities and/or special health care needs or beneficiary is a member of the ID/RD Waiver program and need for behavior management is documented in the patient's dental record, and
 - Documentation supplied for adjudication of the claim and recorded in the dental record is unique to that visit and includes a description of the known condition of the patient and additional time requirement to provide treatment.

The behavioral management services are not allowed in conjunction with sedation services (Nitrous Oxide, deep sedation/general anesthesia, IV or non-IV moderate sedation).

Documentation Required

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

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

- Detailed narrative describing medical necessity of the services to be delivered in conjunction with the adjunctive service, and
- Necessary documentation as required for each procedure/ procedure category to support the medical necessity.
- When sedation or general anesthesia is employed, additional documentation on a time-based record is required.

Benefits Limitation

Adjunctive General Services							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D9222	Deep sedation/ general anesthesia - first 15 minutes	Child	0-20		Allowed 1 unit of D9222 per 1 day per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920. <i>For adult beneficiaries, this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D9223	Deep sedation/ general anesthesia - each subsequent 15-minute increment	Child	0-20		Allowed up to five (5)units of D9223 per 1 day per patient. Allowed with D9222 only. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920. <i>For adult beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis	Child	0-20		One D9230 per 1 day per patient. Not allowed in conjunction with D9222, D9223, D9239, D9243 or D9920. <i>For adult beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	No	No
		ID/RD Waiver	21+			No	No
		Adult	21+			Yes	No
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	Child	0-20		Allowed 1 unit of D9239 per 1 day per patient. Not allowed in conjunction with D9222, D9223, D9230, D9248 or D9920. <i>For adult beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D9243	Intravenous moderate (conscious) sedation/ analgesia - each subsequent 15-minute increment	Child	0-20		Allowed up to five (5) units of D9243 per 1 day per patient. Allowed with D9239 only. Not allowed in conjunction with D9230, D9222, D9223, D9248 or D9920. <i>For adult beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D9248	Non-intravenous	Child	0-20		One of D9248 per 1 day per patient. Not allowed in conjunction with D9222, D9223, D9239, D9243 or D9920.	No	No

	moderate (conscious) sedation	ID/RD Waiver	21+		For adult beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.	No	No
		Adult	21+			Yes	No
D9310	Consultation from Referral	Child	0-20		One D9310 per 1 day per patient per referral. Allowed to be billed only by specialty dental providers (except orthodontists). Not allowed on the same day as D0120, D0140, D0145, D0150, D0160 or D0170 billed by same provider, provider location, or provider billing entity. Not allowed when referred within the same provider, provider location or provider's billing entity regardless of specialty.	No	No
		ID/RD Waiver	21+			No	No
		Adult	21+			No	No

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

Services for Emergency & Exceptional Medical Conditions

Criteria

Reimbursement fee for dental services delivered for the Emergency & Exceptional Medical Conditions includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/local anesthesia, and post-operative care up to 30 days from date of service.

None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Dental services delivered for Emergency & Exceptional Medical Conditions will be processed through prepayment review. Prior authorization is optional. Reimbursement for these dental services will be by report, unless the procedure already has an established fee listed in the dental fee schedule. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Dental services delivered for the Emergency & Exceptional Medical Conditions will be allowed only when services have met the medical necessity and are delivered in the most efficient and effective way following standard clinical guidelines and practices.

Reimbursement for some or multiple diagnostic images of the same tooth or area may be denied if SCDHHS determines the number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure. Reimbursement for diagnostic images is limited to those images required for proper treatment and/or diagnosis. All diagnostic images must be of good diagnostic quality, properly mounted, dated and identified with the recipient's name and date of birth. Diagnostic images that do not fit the policy description will not be reimbursed for, or if already paid for, SCDHHS will recoup the funds previously paid. SCDHHS utilizes the guidelines published by the U.S. Department of Health and Human Services (DHHS), Center for Devices and Radiological Health (CDRH). Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Eligible beneficiaries may receive medically necessary diagnostic, preventive, or corrective procedures of the oral & maxillofacial area, adjacent or associated structures, including the head and neck region, delivered in accordance with sections 1902(a)(10)(A) & 1905(a)(5)(B) of the Social Security Act as follows:

- Diagnostic and/or maxillofacial prosthetic services delivered for the diagnosis, repair, rehabilitation, reconstruction and /or treatment of facial deformities due to cancer or trauma.
- Diagnostic, and/or oral & maxillofacial surgical services delivered for the diagnosis, repair, rehabilitation, reconstruction and /or treatment of infections, malignancies, injury or trauma, emergency, or stabilization of emergency conditions, that may affect a beneficiary's oral or general health.
- Dental services necessary for the proper fabrication and maintenance of the maxillofacial prosthetics and/or oral & maxillofacial surgical service(s), for the conditions listed above, will be allowed with submission of documentation justifying the medical necessity for the additional dental service(s).
- Dental services delivered in preparation for, or during the course of treatment for: a) organ transplants; b) radiation of the head or neck; c) chemotherapy for cancer treatment; d) total joint

replacement; and e) heart valve replacement. Dental services must be directly related to one or more of these conditions and require a referral by the treating medical provider.

Documentation Required

All claims submitted for the dental services rendered for the exceptional & medical conditions listed above are subject to PPR with submission of appropriate documentation from both dental provider and the referring medical provider; PA is optional. Proper documentation must be maintained in patient’s records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record keeping requirements. Procedures that require PPR can be rendered before determination of Medical Necessity but require submission of the following proper documentation:

- Detailed narrative of medical necessity for the procedure(s) and any additional documentation that would support the medical necessity; and
- Referral from the treating medical doctor or specialist, documentation of diagnosis of the medical condition and treatment plan (when applicable); All referring or ordering providers must be enrolled providers participating in the Healthy Connections Medicaid program pursuant to 42 CFR 455.210. The referring or ordering provider’s individual NPI must be listed on the referral form. SCDHHS reserves the right to deny any dental services when the referring medical professional is not a Healthy Connections Medicaid provider.
- Pre-operative diagnostic images such as radiographs or CT scan;
- Pathology report, post-operative radiographic images, intraoral photographs when applicable.

Benefit Limitations

Services for Emergency & Exceptional Conditions						
Code	Description	Beneficiary Subgroup	Benefit Limitations		Pre-Payment Review	Prior Authorization
			Age (Years)	Frequency/Timespan		
Diagnostic Services						
D0160	Detailed and extensive oral evaluation-problem focused	Child	0-20	One of (D0160) per provider, provider location or billing entity, per treatment plan for evaluation of Emergency & Exceptional Medical Conditions. Not allowed on the same day as D0120, D0140, D0145, D0150, D0170 or D9310 by same provider, provider location or provider’s billing entity. Not allowed within 30 days of D0140, D0160 or D0170 by same provider, provider location or billing entity.	No	No
		ID/RD Waiver	21+		No	No
		Adult	21+		No	No
D0170	Re-evaluation-limited, problem focused (established patient; not post- op visit)	Child	0-20	One of (D0170) per Provider, provider location or billing entity, per treatment plan for re-evaluation of Emergency & Exceptional Medical Conditions. Not allowed on the same day as D0120, D0140, D0145, D0150, D0160 or D9310 by same provider, provider location or provider’s billing entity. Not allowed within 30 days of D0140, D0160 or D0170 by same provider, provider location, billing entity.	No	No
		ID/RD Waiver	21+		No	No
		Adult	21+		No	No

D9310	Consultation from referral	Child	0-20	One D9310 per 1 day per patient per referral. Allowed to be billed only by specialty dental providers (except orthodontists). Not allowed on the same day as D0120, D0140, D0145, D0150, D0160 or D0170 billed by same provider, provider location, or provider billing entity. Not allowed when referred within the same provider, provider location or provider's billing entity regardless of specialty.	No	No
		ID/RD Waiver	21+		No	No
		Adult	21+		No	No
Specialized Diagnostic Services						
D0250; D0251; D0310; D0330; D0364; D0365; D0366; D0367; D0368; D0369; D0370; D0371; D0391; D0801; D0802; D0803; D0804	Specialized Diagnostic images (range)	Child	0-20	One of (D0250, D0251, D0310, D0330, D0364, D0365, D0366, D0367, D0368, D0369, D0370, D0371, D0391, D0801, D0802, D0803, D0804) per 1 day, per treatment Plan per patient.	No	No
		ID/RD Waiver	21+		No	No
		Adult	21+		No	No
Oral Pathology Laboratory Services						
D0472; D0473; D0474; D0475; D0476; D0478; D0486	Oral Pathology Laboratory (range)	Child	0-20	Allowed one of (D0472, D0473, D0474, D0475, D0476, D0478, D0486) per 1 Day, per treatment Plan per patient.	No	No
		ID/RD Waiver	21+		No	No
		Adult	21+		No	No

Maxillofacial Prosthetic Services					
Code	Beneficiary Subgroup	Benefit Limitations		Pre-Payment Review	Prior Authorization
		Age (Years)	Criteria, Frequency/ Timespan		
D5992-D5999	Child	0-20	Maxillofacial prosthetic services delivered to repair or rehabilitate facial disfigurements due to trauma, injury, or cancer.	Yes	No
	ID/RD Waiver	21+		Yes	No
	Adult	21+		Yes	No

Oral & Maxillofacial Surgical Services					
D7260; D7261; D7270; D7272; D7284; D7285; D7286; D7287; D7288; D7295; D7310; D7311; D7320; D7321; D7410; D7411; D7412; D7413; D7414; D7415; D7440; D7441; D7450; D7451; D7460; D7461; D7465; D7471; D7472; D7473; D7485; D7490; D7509; D7510; D7511; D7520; D7521; D7530;	Child	0-20	Oral and Maxillofacial surgical services delivered for repair, rehabilitation, reconstruction and /or treatment of infections, malignancies, injury or trauma, emergency or stabilization of emergency conditions. <ul style="list-style-type: none"> • Tooth reimplantation/ transplantation allowed for permanent teeth only. • Biopsy is not billable with another surgical procedure that is part of the same procedure. • D7530- Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue is allowed only one per 1 day per patient. • D7550- Partial ostectomy/ sequestrectomy per quadrant is not allowed to be billed for treatment of dry socket. 	Yes	No

D7540; D7550; D7560; D7610; D7620; D7630; D7640; D7650; D7660; D7670; D7671; D7680; D7710; D7720; D7730; D7740; D7750; D7760; D7770; D7771; D7780; D7810; D7820; D7910; D7911; D7912; D7920; D7922; D7939; D7941; D7943; D7944; D7945; D7946; D7947; D7948; D7949; D7950; D7955; D7979; D7980; D7981; D7982; D7983; D7990; D7991; D7993; D7994; D7995; D7996; D7997; D7998; D7999.	ID/RD Waiver	21+	<ul style="list-style-type: none"> D7910-Suture of small wound up to 5 cm (single layer) By Report. Excludes closure of surgical incision. One D7910 per day per patient for total length of single layer wound repair up to 5 cm. The length of the single layer wound repair will be evaluated on 1 cm increments. May be billed in conjunction with D7911 on the same date of service only when the combined length of single and multi-layer wound repair is less than or equal to 5 cm. Documentation showing the length of suture repair is required with claim submission. D7911-Complicated suture up to 5 cm (multi-layer). By Report. Excludes closure of surgical incision. One D7911 per day per patient for total length of complicated multi-layer wound repair up to 5 cm. The length of the complicated multi-layer wound repair will be evaluated on 1 cm increments. May be billed in conjunction with D7910 on the same date of service only when the combined length of single and multi-layer wound repair is less than or equal to 5 cm. Documentation showing the length of suture repair is required with claim submission. 	Yes	No
	Adult	21+	<ul style="list-style-type: none"> D7912- Complicated suture greater than 5 cm (single or multi-layer). By Report. Excludes closure of surgical incision. One D7912 per day per patient when the total length of complicated wound repair is greater than 5 cm. The complicated suture greater than 5 cm can be single layer, multi-layer or a combination of both. The length of the complex wound repair will be evaluated on 1 cm increments. Not allowed in conjunction with D7910 or D7911 on the same day. Documentation showing the length of suture repair is required with claim submission. 	Yes	No

Services for Emergency & Exceptional Medical Conditions					
Procedure Code Set	Eligible Beneficiaries	Age (years)	Criteria Description	Pre-Payment Review Required	Prior Authorization Required
Additional Dental Services					
CDT Dental Codes D0120-D9999	Child	0-20	<ul style="list-style-type: none"> Medically necessary dental services for the proper fabrication and maintenance of the maxillofacial prosthetic and/or oral & maxillofacial surgical service(s) done for treatment of infections, malignancies, injury or trauma, Documentation justifying the medical necessity for the additional dental service(s) is required with claim submission. 	Yes	No
	ID/RD Waiver	21+		Yes	No
	Adult	21+	<ul style="list-style-type: none"> Medically necessary dental services delivered in preparation for, or during the course of treatment for: <ul style="list-style-type: none"> ✓ Organ transplants. ✓ Radiation of the head or neck for cancer treatment. ✓ Chemotherapy for cancer treatment. ✓ Total joint replacement. ✓ Heart valve replacement. 	Yes	No

EPSDT Services (Non- State Plan Covered Services)

Criteria

Children ages 0–20, through the month of the 21st birthday, are eligible for medically necessary services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Eligible beneficiaries may receive EPSDT services which are medically necessary dental services not otherwise listed as a State Plan covered service. These services also include those delivered outside of the SCDHHS established policy or Dental Periodicity Schedule intervals.

All EPSDT services require PA, with the exception when the service is delivered as an emergency or service is part of the Initial Dental Encounter for a foster child. Please refer to the Prior Authorization section of this manual.

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

Reimbursement for these dental services will be by Report, unless the procedure already has an established fee listed in the dental fee schedule. Medicaid reimbursement for an approved EPSDT dental service is considered as payment in full. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

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

The DSS Foster Care Program requirements include an initial dental encounter within 30 days upon a child's entry into the program. Medicaid eligible children entering the Foster Care Program are eligible to receive this initial dental encounter under the EPSDT benefit. The initial dental encounter includes a comprehensive oral evaluation, prophylaxis, fluoride application and any medically necessary diagnostic procedures, regardless of the child's prior service history. To bypass the PA required for the EPSDT services, providers who will render the initial dental encounter for foster care members, should follow the process detailed in Filing Claims section 7 of this manual.

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

Orthodontic Services

Beneficiaries eligible to receive medically necessary orthodontic services must meet the following:

- Eligibility criteria:

- The anticipated treatment completion date must occur prior to the loss of benefit eligibility due to age. Only beneficiaries whose treatment plan shows completion before the child reaches the age of 21 years will be considered eligible for orthodontic services.
 - Beneficiary must be Medicaid-eligible on the dates of billable services. Provider must always check to ensure eligibility of the member throughout treatment as eligibility may change.
- Compliance Criteria:
 - Providers must take into consideration the following patient’s ability when selecting the patient for orthodontic treatment:
 - › Tolerate the treatment
 - › Keep multiple appointments over several months and years
 - › Maintain good oral hygiene
 - › Be cooperative and complete all needed dental preventive and treatment visits.
 - › Medicaid will not reimburse for de-banding/ removal if treatment has not been completed due to patient’s poor compliance.
 - Providers must take into consideration their own ability to complete the treatment when selecting the patient for orthodontic care.
 - › Providers are expected to complete treatment for all cases that they started.
 - › Orthodontic Transfer cases for a Medicaid beneficiary due to:
 - » Provider unable to complete treatment due to unforeseen circumstances such as (moving out of state, retiring, death).
 - The beneficiary’s orthodontic treatment must continue and shall be transferred to another qualified Medicaid-enrolled provider. The treating provider who started the case will be responsible to coordinate care for their patient of record for continuation of treatment with another qualified Medicaid provider. Financial arrangements reflecting the care already provided at the point of transfer shall be between the two providers. Medicaid will reimburse only for the remaining billable visits as defined in the EPSDT Orthodontic Services “Benefit Limitations” section below.

- Provider continuing the orthodontic treatment must file a prior authorization indicating the remaining visits for treatment completion and include the following documentation:
 - Orthodontic Continuation of Care Form
 - A copy of the approved authorization for orthodontic treatment issued by the Medicaid program.
- » Beneficiary moved from another state Medicaid program
 - A beneficiary's orthodontic treatment may be completed by a qualified Medicaid provider. Only orthodontic treatment approved by another state's medical assistance/ Medicaid program will be considered for continuation of treatment. Medicaid will reimburse only for the remaining billable visits as defined in the EPSDT Orthodontic Services "Benefit Limitations" section below.
 - Provider continuing the orthodontic treatment must file a prior authorization indicating the remaining visits for treatment completion and include the following documentation:
 - Orthodontic Continuation of Care Form
 - Beneficiary's current orthodontic history status, photographic and diagnostic images, and treatment plan with the anticipated length of the remaining treatment.
 - A copy of the approved orthodontic treatment issued by the other state's Medicaid program.
 - Orthodontic treatment records from the previous provider including records that indicate Medicaid payment up to the point of transfer.
- Providers must provide a consent form to be signed by the patient or parent/guardian, informing them of the following:
 - › The age limit for the orthodontic coverage
 - › Length of treatment
 - › Consequences of excessive breakage of appliance(s) and/ or other behavior that is not conducive of completing treatment in a timely manner, and
 - › The patient's/parent's responsibilities, including financial responsibilities should the eligibility and coverage be lost

- Clinical criteria:
 - Minor Treatment to Control Harmful Habits
 - › Minor treatment can be used for correction of oral habits in any dentition. Prior authorization is required for such treatment when not part of the comprehensive orthodontic cases.
 - › The following documentation must be submitted with the PA and maintained in patient's record:
 - » a narrative of clinical findings justifying the medical necessity for the treatment,
 - » diagnostic images, such as radiographs, photographs, etc.,
 - » a treatment plan, and estimated treatment length with prognosis.
 - › Reimbursement for the appliance to control harmful habits includes all the materials, supplies, equipment, procedures, and appointments necessary for the diagnosis, measurement, fabrication, insertion, adjustments, repairs, removal, retention, and treatment visits.
 - Comprehensive Orthodontic Cases
 - › SCDHHS utilizes the Handicapping Labio-Lingual Deviation Index (HLD) assessment tool to determine the medical necessity for the comprehensive orthodontic treatment. The assessment form and instructions for its completion can be found on the [Forms](#) section of this manual. A beneficiary may be eligible for comprehensive orthodontic treatment when one of the following criteria is met:
 - » At least one of the automatic qualifying conditions are present and documented on the HLD assessment form. Documentation supporting the diagnosis of the qualifying condition is required to be submitted and maintained in patient's record; OR,
 - » The HLD assessment form has a documented score of twenty-five (25) or more. Documentation supporting the score is required to be submitted and maintained in patient's record.
 - › Reimbursement for the comprehensive orthodontic cases includes all the materials, supplies, equipment, procedures, and appointments necessary for the diagnosis, HLD assessment, measurement, fabrication, and banding, adjustments, repairs, removal, retention, and treatment visits. The orthodontic examination and preparation of orthodontic records are not separately reimbursable and are part of the comprehensive treatment fee. Reimbursement for comprehensive orthodontic cases is based on the total amount allowed per case and will be issued in four (4) payments corresponding

with the allowed billable visits as described below. Comprehensive orthodontic cases include:

- » Comprehensive orthodontic treatment includes but not limited to initial clinical evaluation, diagnostic work-up, HLD assessment, orthodontic treatment plan, and banding. Allowed one (1) comprehensive orthodontic treatment per lifetime, per patient. Only the use of the fixed orthodontic systems and braces will be allowed for the comprehensive orthodontic treatment.
 - » Periodic orthodontic treatment visit includes but is not limited to the treatment visits, adjustments, repairs, and any diagnostic services for treatment progress. Allowed to bill two (2) periodic treatment visits per comprehensive case. Not allowed within 5 months of the initial orthodontic visit. Not allowed within 5 months of the periodic orthodontic visit.
 - » Orthodontic retention includes removal of appliances (de-banding), adjustments, fabrication and placement of retainer(s), post-treatment diagnostic services. Allowed one (1) orthodontic retention per comprehensive case. Not allowed within 5 months of the periodic orthodontic visit.
 - › Replacements for maxillary or mandibular retainers allowed one (1) per arch within 12 months of the orthodontic retention visit.
- Limited Orthodontic Cases
- › Medically necessary limited orthodontic treatment may be allowed for special circumstances and will be reviewed on case-by-case basis when a detailed justification is provided to support the necessity for the service. Provider must complete the HLD assessment form and provide justification if scoring is less than twenty-five (25) points. The following clinical circumstances, but not limited to, may be considered for the limited orthodontic cases:
 - » Necessary treatment of primary and transitional dentition for cases involving functionally impairing malocclusions caused by cleft lip and palate or other severe craniofacial developmental anomalies or severe traumatic injuries.
 - › Reimbursement for the limited orthodontic cases includes all the materials, supplies, equipment, procedures, and appointments necessary for the diagnosis, measurement, fabrication, and banding, adjustments, repairs, removal, retention, and treatment visits. The orthodontic examination and preparation of orthodontic records are not separately reimbursable and are part of the limited treatment fee. Reimbursement for limited orthodontic cases is based on the total amount allowed per case and will be issued in three (3) payments corresponding with the allowed billable visits as described below. Limited orthodontic cases include:

- » Limited orthodontic treatment includes but not limited to initial clinical evaluation, diagnostic work-up, HLD assessment, orthodontic treatment plan, and banding. Allowed one (1) limited orthodontic treatment visit per lifetime, per patient. Only the use of the fixed orthodontic systems and braces will be allowed for the limited orthodontic treatment.
 - » Periodic orthodontic treatment visit includes but is not limited to the treatment visits, adjustments, repairs, and any diagnostic services for treatment progress. Allowed to bill one (1) periodic treatment visits per limited treatment case. Not allowed within 5 months of the initial orthodontic visit.
 - » Orthodontic retention includes removal of appliances (de-banding), adjustments, fabrication and placement of retainer(s), post-treatment diagnostic services. Allowed one (1) orthodontic retention per comprehensive case. Not allowed within 5 months of the periodic orthodontic visit.
 - › Replacements for maxillary or mandibular retainers allowed one (1) per arch within 12 months of the orthodontic retention visit.
- Documentation required specifically for orthodontic services:
 - › Documentation required to be submitted with PA and maintained in the patient's record:
 - › The completed HLD assessment form [only forms that have met the clinical criteria with at least one auto-qualifying condition or with a score of twenty-five (25) or more (for comprehensive treatment), will be considered for review]
 - › Narrative of clinical findings for the craniofacial anomalies and/ or dental diagnosis; and medical diagnosis and surgical treatment plan (when applicable).
 - › Treatment plan and estimated treatment length
 - › Diagnostic intraoral and extraoral photographs
 - › Diagnostic radiographs, cephalometric

Documentation Required

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

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

- Detailed narrative of medical necessity and any additional documentation that would support the medical necessity, and

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

Benefit Limitations

Non-State Plan Covered Services — EPSDT Services					
Procedure Codes	Eligible Beneficiaries	Age (years)	Benefit Description	Pre-Payment Review	Prior Authorization
EPSDT Dental Services					
D0120-D7999; D9110-D9999	Child	0-20	Medically necessary dental services delivered outside of the SCDHHS established policy or not otherwise listed as a State Plan covered service.	No	Yes
	ID/RD Waiver	21+	<i>Not a covered service</i>		
	Adult	21+	<i>Not a covered service</i>		
EPSDT Orthodontic Services					
CDT Dental Codes D8010; D8020; D8070; D8080; D8220; D8670; D8680; D8703; D8704;	Child	0-20	<ul style="list-style-type: none"> • D8010- Limited orthodontic treatment of the primary dentition. Allowed one of (D8010 or D8020) per lifetime, per patient • D8020- Limited orthodontic treatment of the transitional dentition. Allowed one of (D8010 or D8020) per lifetime, per patient • D8070- Comprehensive orthodontic treatment of the transitional dentition. Allowed one of (D8070 or D8080) per lifetime, per patient • D8080- Comprehensive orthodontic treatment of the adolescent dentition. Allowed one of (D8070 or D8080) per lifetime, per patient • D8670- Periodic orthodontic treatment visit <ul style="list-style-type: none"> i. Limited treatment- Allowed one (1) D8670 per case (at midpoint of the course of treatment). Not allowed within 5 months of D8010 or D8020. ii. Comprehensive treatment- Allowed two (2) D8670 per case (at one-third and two-thirds through the course of comprehensive treatment). Not allowed within 5 months of D8070 or D8080. Not allowed within 5 months of D8670. • D8680- Orthodontic Retention- Allowed one (1) D8680 per limited treatment and/ or one (1) D8680 for comprehensive treatment. Not allowed within 5 months of D8670. • D8220- Fixed appliance therapy- Allowed one D8220 per lifetime, per patient • D8703- Replacement of lost or broken retainer-maxillary. Allowed one (1) D8703 within 12 months of treatment completion. 	No	Yes

			<ul style="list-style-type: none"> • D8704- Replacement of lost or broken retainer-mandibular. Allowed one (1) D8704 within 12 months of treatment completion. 		
	ID/RD Waiver	21+	<i>Not a covered service</i>		
	Adult	21+	<i>Not a covered service</i>		