Thank You

For Being a Delta Dental Smiles and Delta Dental Smiles for Kids Participating Dentist

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Delta Dental of Arkansas is pleased to present you with this Delta Dental Smiles Provider Manual. This manual will serve as a useful source of information for you and your office staff. Please take the opportunity to review the manual in its entirety. We look forward to serving you.

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1.0 WELCOME

Delta Dental of Arkansas (Delta Dental) is partnering with the Arkansas Department of Human Services to provide services to the Arkansas Medicaid Dental Managed Care Program. Our plan for Enrollees is comprised of two programs:

- **Delta Dental Smiles for Kids:** This is our dental benefits plan for kids which includes ARKids First A and B (CHIP) Enrollees.

- **Delta Dental Smiles:** This is our dental benefits plan for adult Medicaid Enrollees.

As a 501(c)(4) not-for-profit company, Delta Dental's mission is "To improve the Oral Health of Arkansans." We work towards fulfilling this mission every day.

It is for this reason Delta Dental is excited to have the opportunity to encourage and guide individuals in the Medicaid dental program to get the oral health services available to them in the program.

We are appreciative of the Arkansas dental community and dentists like you who play a critical role in ensuring the adults and children in the Medicaid dental program get the diagnostic, preventive, and therapeutic treatment they need. Thank you for your participation!

This manual covers all aspects of your rights and responsibilities as a Participating Dentist, from enrolling and credentialing, to verifying eligibility, requesting Preauthorization, submitting claims, understanding the remittance advice, receiving payment, and submitting Grievances and Appeals.

This manual also details EPSDT requirements, practice guidelines, specific billing codes and procedures, proper claims submission for reimbursement and other information to help you and your office provide services in accordance with program guidelines.

We may need to modify this manual from time to time. Any changes to this manual will be made consistent with the requirements of your Participation Agreement.

Please read this manual carefully and be sure you and your staff are familiar with and understand its contents.

1.1 Important Terms and Definitions

The following is a list of terms and definitions frequently used throughout this manual to assist you in understanding the information provided here and to better understand an Enrollee's dental benefits in the Delta Dental Smiles and Delta Dental Smiles for Kids programs.

Administrative Hearing (State Fair Hearing)

A hearing that takes place outside the judicial process before hearing examiners who have been granted judicial authority specifically for the purposes of conducting such hearings.

There are two types of Administrative Hearings:

- Provider initiated – conducted by administrative law judges from the Arkansas Department of Health and is governed in part by provisions of the Arkansas Medicaid Fairness Act in addition to CMS and Arkansas State Plan policies and regulations.
- Enrollee initiated – conducted by administrative law judges from the Arkansas Department of Human Services and governed by CMS and Arkansas State Plan policies and regulations.

Adverse Benefit Determination

Any of the following:

- The denial or limited authorization of a requested Covered Service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, health care setting, or effectiveness of a Covered Service.
- The reduction, suspension, or termination of a previously authorized Covered Service including but not limited to the down-coding of Preauthorization services.
- The denial, in whole or in part, of payment for a Covered Service.
- The failure to provide Covered Services in a timely manner.
- Delta Dental's failure to act within the timeframes provided under State and federal law regarding the standard disposition of Grievances and standard disposition and resolution of Appeals. Applicable authority includes the State of Arkansas, DHS procedure (see Section 160 of the Arkansas Medicaid Provider Manual), any and all applicable administrative or court orders, and 42 C.F.R. § 438.408(b).
- The denial of a request to dispute financial liability, including cost sharing, co-payments, and Enrollee financial liabilities.
- Any other occurrence which meets the definition of an "Adverse Decision" under § 20-77-1701 of the Arkansas Medicaid Fairness Act.

Appeal
The process used by Delta Dental to review an Adverse Benefit Determination.

Billed Charge
The amount you bill for a specific dental service or procedure.

CMS
The Centers of Medicare and Medicaid Services, an agency within the United States Department of Health and Human Services responsible for overseeing the Medicaid and Children's Health Insurance Program (ARKids First B/CHIP).

Covered Service(s)
Dental services reimbursable under the applicable Delta Dental Smiles Enrollee's plan or policy, provided in accordance with professional standards and appropriately documented.

Denied
Dental services that are not reimbursable under the applicable Delta Dental Smiles Enrollee's plan or policy will be Denied. For example, teeth whitening is considered purely cosmetic and is not reimbursable. If your claim is Denied, you can bill and collect your Billed Charge from the Enrollee only if the Enrollee has agreed to pay for the service(s) as described in Section 7.5 of this manual.

In certain limited circumstances, dental services that are not reimbursable may be allowed as a different Covered Service. For example, posterior composites are not reimbursable, but will be allowed and paid at the amalgam reimbursement rate. Similarly, esthetic crowns are not reimbursable but will be allowed and paid at the stainless steel rate. You cannot collect the difference between your normal Billed Charge and the Maximum Allowed Amount for these services from the Enrollee.

Dental Office Toolkit (DOT)
Our free online portal that allows you and your staff to sign on to our secure, HIPAA compliant online system. This can be accessed at www.deltadentalsmiles.com.

Dental Service Provider
Licensed facilities or professionals providing dental services.

Delta Dental Smiles Fee Schedule
As a Participating Dentist you agree to accept as payment in full the lesser of the Delta Dental Smiles Fee Schedule or the Billed Charge for Covered Services rendered.

DHS
The Arkansas Department of Human Services.

Division of Medical Services (DMS)
A department of DHS that runs the Arkansas Medicaid Program.

Emergency Dental Care (also referred to as "Palliative" care)
Dental services necessary to treat a dental condition of sudden onset and severity which would lead a prudent layperson to conclude the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. The dental procedures will identify the source of the patient's significant pain, extent of trauma, source of infection, with palliative measures, or treat a traumatic clinical condition to the teeth and/or supporting structures.

Enrollee
A person who is eligible to receive services under the Arkansas Medicaid program and who is enrolled in Delta Dental Smiles or Delta Dental Smiles for Kids. Enrollee includes an individual who is in the Spend Down Population.

Enrollee Handbook
A document we provide to Enrollees that contains a general explanation of the benefits and related provisions of our administration of the Arkansas Medicaid dental program.

EPSDT
The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program mandated by 42 U.S.C. §1396d(e) and amended by the Omnibus Budget Reconciliation Act (OBRA) of 1989.

Grievance
An expression of dissatisfaction from or on behalf of an Enrollee or Dental Service Provider about any action taken by Delta Dental or a Dental Service Provider other than an Adverse Benefit Determination. Grievances may include, but are not limited to, expressions of dissatisfaction about the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Dental Service Provider or employee, or failure to respect the Delta Dental Enrollee's rights regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by Delta Dental to make an authorization decision.

Medical Necessity/Medically Necessary

A dental service or Covered Service that satisfies all the following criteria:

- It directly relates to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
- It is consistent with currently accepted standards of good dental practice, including our defined criteria;
- It is the most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
- It is not primarily for the convenience of the patient, family, or Dental Service Provider.

Network

All Participating Dentists who have a contract with Delta Dental for the delivery of Medically Necessary Covered Services to Enrollees.

Participation Agreement

The document that defines the contractual rights and obligations between you as a Participating Dentist and Delta Dental for your participation in the Delta Dental Smiles and Delta Dental Smiles for Kids Network. If you also contract with Delta Dental to participate in its Premier Network, PPO Network and/or other networks (our "Standard Contract"), your Participation Agreement is made up of your Standard Contract and your Delta Dental Smiles-specific Amendment.

Non-Participating Dentist

A dentist who has not entered into a Participation Agreement with Delta Dental for the Delta Dental Smiles and Delta Dental Smiles for Kids Networks.

Non-Restorable Tooth

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

(i) less than 50% bone support remains
(ii) greater than 75% of the clinical crown is missing or decayed
(iii) exfoliation is imminent for primary tooth
(iv) caries extends into subosseous and/or furcation areas
(v) apex is involved in severe pathologic bone destruction and
(vi) overall dental condition of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.
(vii) in general, if a tooth requires a crown build-up (not a covered service in Delta Dental Smiles) to restore.

Not Billable to The Patient

Covered Services may be Not Billable to The Patient in whole or in part for a variety of reasons. In some cases Covered Services cannot be billed to the Enrollee. Examples include the following:

(i) reimbursement for the procedure or service was either included as part of a payment of a more global service provided; and/or

(ii) the procedure or service is still within the time frame for which it should be warranted by you as a Participating Dentist; and/or

(iii) you did not follow rules and regulations of your Participation Agreement.

In other cases, Covered Services otherwise Not Billable to The Patient in whole or in part, can be billed to the Enrollee if the Enrollee agrees in advance to pay for the services in accordance with Section 7.5 of this Manual. For example, a Covered Service may be subject to frequency limitations in which case the entire charge may be Not Billable to The Patient. Likewise, reimbursement for a Covered Service may exceed the Enrollee's Contract Year Maximum Benefit.

The Explanation of Payment (EOP)/ Remittance Advice (RA) will indicate whether a Not Billable to The Patient amount may be billed to the Enrollee, subject to the requirement to obtain an agreement from the Enrollee in advance of the Covered Service being provided.

Participating Dentist

A dentist who holds a current license to practice dentistry, who has entered into a Participation Agreement with Delta Dental for the Delta Dental Smiles and Delta Dental Smiles for Kids Plans. You are a Participating Dentist because of your Participation Agreement with Delta Dental.

Preauthorization

An approval required from Delta Dental before the provision of a particular Covered Service.

See the differences in the definitions of Predetermination Estimate Request versus Preauthorization.

Predetermination Estimate Request
A way for you to get an estimate of reimbursement for treatment prior to performing the treatment. You can elect to have an estimate done prior to treatment or not. There is no requirement for Predetermination Estimate Requests to be completed.

See the differences in the definitions of Predetermination Estimate Request versus Preauthorization.

Primary Care Dentist (PCD)
The principal Dental Service Provider for an Enrollee who is responsible for coordinating and integrating the Enrollee's dental services.

Provider Preventable Condition
A healthcare acquired infection or other preventable condition, as defined by the state, that Medicaid is prohibited from paying for under 42 CFS S 447.26

Routine Care
Care that does not constitute Emergency Dental Care and is designed for preventive or restorative services that may include, but is not limited to, recall examinations, dental cleanings, radiographs or dental restorations.

Specialist
A licensed dentist with advanced training beyond that required for initial licensure, who has demonstrated competency through examination or other evaluative processes, and has been issued a specialty license/certificate in one or more of the State's recognized Specialty Services.

Specialty Services
Dental services generally considered outside standard dental services because of the specialized knowledge required for service delivery and management, including, but not limited to, pediatric dentistry, oral surgery, endodontics, periodontics and orthodontics.

Spend Down Population
The group of individuals eligible for Medicaid coverage only after incurring medical expenses that reduce their incomes to Medicaid eligibility levels.

Stabilization Services
Services to restore basic human function and prevent an existing clinical condition from further deterioration in an immediate time frame to a more serious and costly situation.

State
The State of Arkansas, including the Arkansas Department of Human Services (DHS).

Uniform Requirements
A component of the “Delta Dental of Arkansas Standards” referenced in your Participation Agreement and are incorporated into the Participation Agreement by reference and describe mutual operational rules between you and Delta Dental.

Urgent Care
Dental services that do not constitute Emergency Dental Care but are needed to treat pain. Urgent Care is designed to provide services that minimize the potential for Emergency Dental Care and is needed to treat pain.

Utilization Management (UM)
Evaluation of the Medical Necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities. Utilization Management encompasses prospective, concurrent and retrospective review; it does not include claims review, even if we choose to conduct utilization review on a claims submission, unless a specific request from the claimant for retrospective review accompanies the claims submission. UM is sometimes called "utilization review."

Value Added Services (VAS)
Actual dental services or benefits offered by us as a Covered Service determined by DHS to promote healthy lifestyles and improve dental outcomes among Enrollees.

We, Us, Our
This refers to Delta Dental of Arkansas.

You, Your
This refers to you as a Participating Dentist in the Delta Dental Smiles and Delta Dental Smiles for Kids Network.

2.0 CONTACT INFORMATION

2.1 Delta Dental of Arkansas

Physical Location:

Delta Dental of Arkansas
1513 Country Club Road
Sherwood, AR 72120

Mailing Address:

Delta Dental Smiles
PO Box 6247
Sherwood, AR 72124

Other Important Contact Information:

Customer Service	1-866-864-2499
Professional Relations Phone Number	501-992-1710
Language Translation Service	1-844-648-5669
Email Address	profrelations@deltadentalar.com
Website	www.DeltaDentalSmiles.com

2.2 Arkansas Department of Human Services

Customer Service Line	1-800-482-8988
Complaint Hotline	1-888-987-1200
Complaint Hotline, Telecommunication for the Deaf (TDD)	1-800-285-1131
Fraud Hotline	1-855-527-6644
Website	www.humanservices.arkansas.gov

2.3 Delta Dental Customer Service

Our Customer Service Representatives are available from 7:00 a.m. to 7:00 p.m.

Contact Customer Service for the following:

- Benefits
- Eligiblity
- Filing a claim
- Claim processing
- Claim status
- Report fraud, waste and abuse
- Grievance and Appeals

Any calls where Protected Health Information (PHI) is discussed is authenticated.

Please be prepared with the following:

- Your name
- The dentist or office name
- Dentist tax ID number
- Enrollee ID number
- Enrollee name, date of birth, and address

2.4 Delta Dental Professional Relations

Certain questions should be directed to the Professional Relations staff. Please contact Professional Relations at 501-992-1710 or e-mail profrelations@deltadentalar.com if you:

- Change your office address or phone number
- Have a change in your credentialing information
- Are a new dentist opening an office or have a new associate dentist joining your practice
- Are leaving a practice due to retirement, relocation, etc.
- Change your tax identification number (TIN)
- Have questions about your Participation Agreement, credentialing and processing policies
- Would like to schedule an office visit with a Delta Dental Professional Relations Representative regarding office training needs, Network participation, claims processing guidelines, attachment requirements, or any other area of concern
- Need information regarding your Network participation
- Have questions about DOT or about registering for DOT
- Need to add additional staff access to DOT
- Forgot your DOT password

2.5 Provider Data Accuracy and Validation

It is important for you to make sure Delta Dental has accurate information about you and your practice. Accurate information allows us to better support and serve you, our other Participating Dentists, and our Enrollees.

Medicaid Provider Enrollment with DHS is essential. To ensure information is accurate, please refer to section 3.2 for credentialing requirements for Delta Dental Smiles network.

Our having current information is critical for timely and accurate claims processing. Invalid information can negatively impact Enrollee access to care, PCD assignments (Section 3.8 for a full explanation) and referrals. An Enrollee may request a printed copy of the provider directory at any time.

You should validate our Provider Online Directory information regularly to be sure your information is correct and complete. This directory is available at www.DeltaDentalSmiles.com.

Whenever possible, you should notify us in writing at least thirty (30) days in advance of changes such as, but not limited to:

- Any change in your Arkansas Medicaid Provider Enrollment
- Change in office location(s), office hours, phone, fax or email
- Addition or closure of office location(s)
- Addition or termination of a dentist within an existing clinic/practice
- Change in tax ID and/or NPI number
- Opening or closing your practice to new patients
- Any other information that may impact member access to care

Please email your practice updates to profrelations@deltadentalar.com. You may also contact a Professional Services Representative if your information needs to be updated or corrected at 501-992-1710.

We are required to audit and validate our Network data and provider directories on a routine basis. As part of our validation efforts, we may reach out to you as a Participating Dentist through various methods, such as letters, telephone campaigns, face-to-face contact, fax and fax-back verification, etc. Please provide timely responses to these communications from us.

3.0 PARTICIPATION AND PROVIDER ROLES

3.1 Dentist Participation

As a Participating Dentist with a Participation Agreement, you agree to:

- Abide by your Participation Agreement and Uniform Requirements, the Delta Dental Smiles rules, regulations, and this manual
- Not require Enrollees to prepay any portion of Covered Services
- Accept from us as payment in full for Covered Services the lesser of:
    - The applicable amount set forth in the Delta Dental Smiles Fee Schedule or
    - Your Billed Charge
- Furnish us credentialing information by completing a Confidential Credentialing Information Form when requested
- File claims for completed services to us within 12 months of the date-of-service and include all documentation necessary for us to review, process and finalize the claim. Documentation includes, but is not limited to:
    - Clinical rationale/narrative
    - Radiographs
    - Periodontal chart
    - Patient treatment records
    - Coordination of benefits information, as applicable

  If the claim is not received and finalized within this time period, the claim is Not Billable to The Patient.

- Follow the Delta Dental Smiles and Delta Dental Smiles for Kids processing policies and claim filing guidelines
- When required, provide information and patient office records for the purpose of conducting reviews and/or in-office audits
- Furnish services that meet the criteria for Medical Necessity
- Comply with all applicable State and federal laws and regulations
- Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships. This includes checking the HHS-OIG websites (http://exclusions.oig.hhs.gov/ or https://oig.hhs.gov/exclusions/index.asp) by the name of any individual or entity for their exclusion status before you hire or enter into any contractual relationship with the person or entity. In addition, you agree to check the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. You must report to us any exclusion information discovered through a search.

We are prohibited from paying for any items or services furnished, ordered or prescribed by excluded individuals or entities. This payment ban applies to any items or services reimbursable under Delta Dental Smiles and Delta Dental Smiles for Kids that are furnished by an excluded individual or entity, and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system.
- Payment for administrative or management services not directly related to patient care, but are a necessary component of providing items and services to Enrollees, when those payments are reported on a cost report or are otherwise payable by Delta Dental Smiles and Delta Dental Smiles for Kids.
- Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Delta Dental Smiles and Delta Dental Smiles for Kids.

In addition, no payments can be made for any items or services directed or prescribed by an excluded individual or entity or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion.

This prohibition applies even when Delta Dental's payment is made to another individual, entity, practitioner, or supplier that is not excluded. See 42 C.F.R. §1001.1901(b).

3.2 Credentialing

In order to participate in the Delta Dental Smiles Network, you must be credentialed by Delta Dental of Arkansas and be properly enrolled with DHS as a Medicaid provider.

As a Participating Dentist you agree to accurately and thoroughly complete the Confidential Credentialing Information Form and Provider Facility Profile Form at least every three (3) years for Delta Dental of Arkansas and provide the following credentialing elements as requested:

- Proof of graduation from an accredited dental school and completion of specialty training, as applicable
- A copy of your active State issued dental license and Medicaid Provider ID

- Board certification status
- Clinical privileges in good standing at the hospital designated as the primary admitting facility, if any
- Individual NPI Number (NPI Type 1)
- W-9 Form
- Dentist Authorized Signature Form
- Corporate Authority Form to authorize us to pay the corporation directly for services rendered by the treating provider
- A copy of your Federal DEA license, if applicable
- A copy of your liability declaration page reflecting you have at least the minimum required malpractice liability coverage
- Disclose any licensing board actions, malpractice claims, and other adverse personal or professional background information
- Federally mandated ownership control form
- Work history, including a minimum of the most recent five years of work history as a health professional
- Re-Enrollment with DHS every five (5) years
- Update license information with DHS each time dental license is renewed

There are two options to receive claims payments.

1. Individual SSN: Claim payments can be made under your individual SSN (Social Security Number). This option requires only an individual enrollment with DHS. This choice may have tax implications so you may need to consult with your tax advisor or accountant.

2. Business TIN: Claim payments can be made to your business TIN (Tax Identification Number). This option requires a group enrollment in addition to your individual enrollment. It is a CMS requirement for businesses paid under its TIN to have group enrollment status with DHS. Group enrollment requires obtaining a Type 2 NPI number.

If you need to obtain a Type 2 NPI number, you can apply for one at NPPES: https://nppes.cms.hhs.gov
If you do not currently have group enrollment and choose to receive claims payments to the business TIN you will need to complete and submit an application to achieve group enrollment status with Medicaid. You have the option to complete your application online via the DXC portal:

https://nj.gov/humanservices/ddd/programs/sppp.html

You may contact our Professional Relations Department for assistance with your group enrollment application with Medicaid by emailing: arsmilesquestions@deltadentalar.com.

Network participation may be backdated or adjusted at the discretion of DDAR. A signed Participation Agreement and all required initial credentialing documents must be completed before an effective date can be established.

Please notify our Professional Relations staff immediately of any changes in your credentialing elements at 501-992-1710 or e-mail profrelations@deltadentalar.com.

3.3 Federally Mandated Ownership Control Form

In addition to being contracted and credentialed with us, you will also have to be approved by DHS as a provider in the Arkansas Medicaid program.

CMS and DHS require all Participating Dentists complete and provide a Federally Mandated Ownership Control form.

3.4 Disclosures

As a Participating Dentist you must provide the following disclosures as part of the process of being approved by DHS as a provider in the Arkansas Medicaid program:

- The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity (Participating Dentist practice).
- The address for corporate entities must include as applicable primary business address, every business location and P.O. Box address.
- In the case of an individual, date of birth and social security number are required.
- Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor[1] in which the disclosing entity has a 5 percent or more interest. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling.
- The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- The name, address, date of birth and Social Security number of any managing employee of the disclosing entity.

As a Participating Dentist, you will need to provide information in regard to the disclosing entity at any of the following times:

- Upon completion of the Confidential Credentialing Information Form and executing of the Participation Agreement
- Upon request of DHS during the revalidation of enrollment in the Arkansas Medicaid process
- Within 35 Days after any change in ownership of the disclosing entity (Participating Dentist's practice)

[1] A "subcontractor" as used in this manual means an individual, agency, or organization to whom you have contracted or delegated some of your management function or responsibilities of furnishing health related services. This is a term defined under State and federal law.

As a Participating Dentist, you must disclose information related to the following types of business transactions:

- Within 35 days of the date on a request by the Secretary of Health and Human Services, DHS, or us, full and complete information about the ownership of any subcontractor with whom you have had a business transactions totaling more than $25,000 during the 12-month period ending on the date of the request
- Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor during the 5-year period ending on the date of the request

Participating Dentists Must Disclose Information On Persons Convicted of Crimes.

Before we enter into or renew a Participation Agreement, or at any time upon written request by DHS, you must disclose to us and DHS the identity of any person who:

- Has ownership or control interest in your dental practice or is an agent or managing employee of your practice; and
- Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XIX services program since the inception of those programs.

3.5 Terminations

Your ability and our ability to terminate your Participation Agreement are set out in your Participation Agreement. In the event there is a conflict between the terms of the Participation Agreement and this summary, the Agreement controls.

You must maintain both your Delta Dental Smiles credentialed status and revalidation with AR Medicaid. Failure to recredential and revalidate will result in termination. You will receive termination notification 45 days from the termination date from Delta Dental Smiles network. Delta Dental Smiles Network termination will affect your claims payment.

You Terminate Your Participation Agreement

You can terminate your Participation Agreement by giving us at least sixty (60) days written notice in the manner required by the Participation Agreement. Delta Dental will notify Enrollees of your Network termination. You must also inform Enrollees if there is a termination of your Participation Agreement.

If you are also a participating dentist with Delta Dental in its Premier and/or PPO Network(s), you can terminate your participation in the Delta Dental Smiles and Delta Dental Smiles for Kids Network without terminating your participation status in the other Delta Dental Networks. This option is described more fully in your Participation Agreement.

Delta Dental Terminates Your Participation Agreement

Termination without Cause

We may terminate your Participation Agreement without cause at any time by sending a notice of termination with the termination being effective sixty (60) days after the date of the notice.

Termination for Cause

Delta Dental may terminate your Participation Agreement for cause if you breach or violate any of the provisions of your Participation Agreement, including the Uniform Requirements, your license to practice dentistry issued by the Arkansas Board of Dental Examiners (or the equivalent governing body of the state in which you practice) is suspended or terminated, or your conduct is determined to be unprofessional and/or your conduct could be detrimental to Delta Dental or Enrollees.

Any termination for cause will be effective on the date designated by us in the notice of termination (which may be immediate), as determined by us. The notice will state the reason(s) for the termination and your right to request a hearing on the termination.

Notices of Termination; Other Notices
Any notice of termination or other required or permitted notices will be given to you from us as described in the Participation Agreement.

Termination of a Provider for Administrative Reasons

1. Dentist must maintain their enrollment status with AR Medicaid. Failure to do so will result in a pended and termed status with Delta Dental Smiles participation.

2. Dentist will receive communication via a certified letter explaining their Delta Dental Smiles participation is pended, due to unresolved DHS enrollment issues. Letters will be sent 120 days before the provider is terminated informing about his/her Delta Dental Smiles enrollment status.

3. Claims received during the time the provider has a pended participation status will be denied regardless of date of service. Claims may be eligible for reprocessing once the AR Medicaid Enrollment issue has been resolved as long as that period does not exceed 120 days.

4. If the dentist's enrollment with DHS is unresolved within the 120 calendar days, the dentist will be terminated from Delta Dental Smiles (but eligible to reapply) and claims for dates of service during that 120 calendar period will not be eligible for reprocessing nor will there be beneficiary responsibility.

5. A claim with a date of service that is before the MPF's effective date will not be eligible for reprocessing nor will the beneficiary have financial responsibility.

Appealing a Termination Notice

You may Appeal a termination of participation for cause as set forth in the Uniform Requirements.

3.6 Provider Rights

As a Participating Dentist, you have the following rights:

- Communicate with Enrollees regarding dental treatment options
- Recommend treatment even if the treatment is not a Covered Service or approved under the Delta Dental Smiles or Delta Dental Smiles for Kids plan
    - If recommended treatment is not a Covered Service or approved by Delta Dental, you must notify the Enrollee if you intend to charge the Enrollee for the services. See the Covered Services Section for more information about getting the Enrollee's agreement for you to provide the service.
- Provide correct, pertinent, factual information to an Enrollee when a complaint has been filed by the Enrollee against you
- Receive information from us on Grievances, Appeals, and/or Administrative Hearings
- File an Appeal about an action or decision we make
- Know:
    - How Delta Dental decides whether a service is covered and/or Medically Necessary
    - Who in Delta Dental's office makes the decision
- Advise Enrollees about their:
    - Health status
    - Dental care
    - Treatment, including any alternative treatments that may be self-administered

    - Any information the Enrolled Member needs to decide among all relevant options
    - The risks, benefits, and consequences of treatment or non-treatment.
    - Right to participate in decisions regarding their healthcare, including the right to refuse treatment and the right to express preferences about future treatment options.
- Recommend changes in policies and services under Delta Dental Smiles and Delta Dental Smiles for Kids by writing to us or calling us toll-free at 1-866-864-2499
- Exercise these rights without adversely affecting the way Delta Dental or DHS treats you
- Be notified by us regarding a decision to deny a service or Preauthorization
- Make recommendations about these rights and responsibilities

3.7 Provider Responsibilities

As a Participating Dentist, you have the following responsibilities:

- Emergency Dental Care must be provided within 24 hours
- Urgent Care, including urgent Specialty Services, must be provided in 48 hours
- Therapeutic and diagnostic care must be provided within 14 days
- Non-urgent Specialty Services must be provided within 60 days
- Follow EPSDT guidelines in section 6.4
- Engage in provider education, feedback activities and review of referral patterns as required by DMS
- Provide Medically Necessary Covered Services to Enrollees with the same quality level and practice standards and with the same level of dignity and respect as provided to non-Medicaid patients
- Have on-call coverage after hours, during your absence or unavailability
- Participate in Delta Dental's Grievance program and cooperate in identifying, processing and promptly resolving all Enrollee complaints, Grievances or inquires; refer to the Grievance and Appeals section 12.0 of this manual
- Comply with program integrity activities as set forth in section 13.0 of this manual
- Provide children enrolled in Delta Dental Smiles for Kids with diagnostic and preventive services in accordance with American Academy of Pediatric Dentistry (AAPD) recommendations which can be found on the AAPD website:

http://www.aapd.org/policy_center/state_dental_periodicity_schedules/

- Assess the dental needs of Enrollees for referral to a Specialist and provide referrals as needed
- If a referral is needed, make it on a timely basis based on the urgency of the Enrollee's dental condition, but no later than 30 days
- Provide Covered Services to Enrollees with dignity and respect
- As a Participating Dentist, you must make necessary and appropriate arrangements for Covered Services to be available for Enrollees on a 24 hours per day, 7 days per week basis when Medically Necessary. If your arrangements include the Enrollee seeking treatment from another Dental Service Provider, you must make certain the other provider is a Participating Dentist.
- Maintain facilities (including treatment rooms), equipment, personnel and administrative services:
    - At a level and quality necessary to perform duties and responsibilities to meet all applicable federal, State and local laws
    - In compliance with laws and regulations relating to privacy (HIPAA), waste management (OSHA & EPA), environmental hazards (OSHA & EPA) and the Centers for Disease Control (CDC) infection control and sterilization guidelines
    - In accordance with the principles and ethics of the American Dental Association (ADA), the Dental Practices Act and the Arkansas State Board of Dental Examiners or governing body of the licensing state where services are rendered
    - In compliance with the Americans for Disabilities Act

3.8 Primary Care Dentist

Each Enrollee in Delta Dental Smiles and Delta Dental Smiles for Kids will have a Primary Care Dentist (PCD). The PCD is the principal Dental Services Provider for an Enrollee and is responsible for coordinating and integrating the Enrollee's dental services with the appropriate dental specialty care provider.

As described in your Participation Agreement, you will be chosen or assigned and must serve as a PCD, as applicable. Upon request we will send you a list of those assigned to you.

PCD Selection/Assignment

Once Enrollees are enrolled in Delta Dental Smiles or Delta Dental Smiles for Kids they will have 30 days to select a PCD. If they do not select a PCD, we will assign them to one based on claims history, geographic location, where other members of the family go for dental care, and provider capacity.

We may also decide to assign an Enrollee to a location such as a dental practice group rather than to an individual Participating Provider.

In the event a PCD voluntarily leaves or is terminated from the Network, we will notify the affected Enrollees. These Enrollees will need to select or be assigned a new PCD.

Dismissing an Enrollee

You can dismiss an Enrollee for whom you serve as a PCD if you give us advanced written notice with supporting documentation of that Enrollee's failure to cooperate with you, for example, repeated failure to keep a scheduled appointment. On our receipt of the supporting documentation, we will reassign that Enrollee to another PCD.

3.9 Quality Improvement

Delta Dental maintains an active Quality Assurance and Improvement Program (QAIP). The QAIP establishes procedures based on professionally recognized standards to assess and monitor the appropriateness of dental services delivered to Enrollees, and to assess and resolve issues impacting the availability, accessibility, utilization, continuity, complaints and satisfaction of services. The QAIP implements quality improvement activities based upon the outcome to move the Delta Dental Smiles and Delta Dental Smiles for Kids closer to meeting the goals established by Delta Dental and the Department of Human Services (DHS).

Because quality is important to us, you may be asked to serve on committees, participate in a survey, review guidelines, be asked for education program advice, be asked for feedback on operations or for input in many of our Delta Dental Smiles and Delta Dental Smiles for Kids areas. These activities would all be on a voluntary basis and are meant to help us serve you and our Enrollees better. If you are not asked to serve on a committee or participate, you can still help identify issues or give feedback by contacting our Professional Relations Department with any information.

3.10 Access to Care/ Cultural Competence

In our efforts to overcome barriers in access to care for our Enrollees, we expect you as a Participating Dentist to be responsive to the linguistic, cultural and other unique needs of any minority or disabled Enrollees. This includes the capacity to communicate with Enrollees in a language other than English. We offer free translation services to our Participating Dentists to

assist them with this. See section 9.2 for specific information on how to access these free translation services.

We recognize that cultural and linguistic diversity can create barriers in access to care for our diverse member population. We encourage providers to understand our members' cultures in what they value, beliefs, how they think, act, and live as they vary across our member populations.

The Center for Disease Control (CDC) provides information regarding cultural competency with insight into how diverse communities can create a culture of healthy living. Different cultures may have unique preferences for incorporating healthy changes. This information can be found at: https://npin.cdc.gov/pages/cultural-competence or more information at www.minorityhealth.hhs.gov.

3.11 Quality of Dentures

We allow Participating Dentists the ability to choose the lab from which dentures and partial dentures are fabricated for an Enrollee. The fee we pay you for providing dentures and partial dentures will include the cost of the lab from which you fabricated the prosthesis. You will be responsible for lab costs associated with the prosthesis from the fee we pay you.

In order to ensure the quality of the dentures and partial dentures provided to our Enrollees, we will require the appliances to meet the quality standards described in this section.

Dentures/Partials

You must verify dental coverage and eligibility on each Enrollee prior to completing an order for a denture. The lab must have a system that prevents the lab from processing duplicate orders received on the same Enrollee.

The following materials (or materials with equal or higher quality) must be used:

- Premium heat-cured acrylic comparable to Lucitone 199 or Ivocap Injected.
- Premium denture teeth comparable to Myerson DB or Dentsply IPN.

Full Dentures (ADA Procedure Codes D5110 and D5120) shall include:

- Model work and articulation
- Baseplate / Bite rim
- Setup for try-in
- Premium hardened plastic teeth
- Resetting of teeth (unlimited)

- Process and finish, high impact heat-cured acrylic
- One (1) year unlimited warranty

Partial Dentures (ADA Procedures Code D5211 and D5212) shall include:

- Model work and articulation
- Baseplate / Bite rim
- Duplicate model for processing
- Setup for try-in
- Premium hardened plastic teeth
- Resetting of teeth (unlimited)
- Process and finish, high impact heat-cured acrylic
- Two (2) cast metal clasp standard or up to three (3) wrought wire clasps at doctor request
- One (1) year unlimited warranty

Verification of Quality

We will verify the quality of dentures supplied to Enrollees through periodic and random requests for records from you that must demonstrate the appliances meet the standards described here. If records you supply do not demonstrate an appliance meets these required quality standards, you will be required to refund the fee paid to you for the services and appliance so we can assist the Enrollee obtain a denture that does meet these quality standards; if you do not refund the fee, we will recoup the amount from you from future payments.

Shipping Charges

The Enrollee cannot be charged for shipping associated with providing the services outlined in this manual. This includes shipping charges for the shipment of new dentures, shipping charges for you to send dentures to the lab, and all shipping charges associated with repair and warranty work.

3.12 Appointment Scheduling

As a Participating Dentist, if you are accepting new patients, you must accept all new patients and make appointments equally available regardless of payer source.

Our Customer Service Representatives will assist Enrollees who call our call center with scheduling appointments in an effort to increase utilization and drive Enrollees into our Participating Dentists' offices. Our goal is to help facilitate the relationship between our Enrollees and their PCD.

Missed Appointments

The Enrollee cannot be charged for missed or failed appointments. For assistance with Enrollees that routinely miss appointments, please contact Customer Service.

3.13 Referrals to Non-Participating Dentist

In the event a Medically Necessary service is not available through a Delta Dental Smiles Participating Dentist, we will help the Enrollee get the services from a Non-Participating Dentist.

Delta Dental will review and act upon all requests for a referral to a Non-Participating Dentist within a reasonable timeframe, not to exceed five (5) business days from our receipt of all documentation we need to evaluate the request to cover services from a Non-Participating Dentist. Requests for a referral can be made via telephone or written correspondence. (See section 2.0 for contact information)

4.0 HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and implementing regulations) is a federal law intended to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs. Since electronic transactions are significantly more cost effective than paper for Providers, patients and health plans, HIPAA includes a major provision (Administrative Simplification) that is designed to encourage the use of electronic transactions, while safeguarding patient privacy.

To do so, HIPAA created a universal language or standard for electronic transmissions used in the health care industry.

It also established standards governing the privacy/security of health information, which is an extremely important issue for consumers today. Specific requirements are detailed in rules issued by the federal Department of Health and Human Services (DHHS). Please refer to end of this section for important HIPAA websites.

All health plans, health care clearinghouses and health care Providers who maintain or transmit protected health information in electronic form standardized by DHHS are referred to as **"Covered Entities."** If you file electronic claims, submit electronic attachments or use the Internet to check benefits, eligibility or claims status, you are considered a Covered Entity.

"Health Information" is any information, whether oral or recorded in any form or medium, that:

- Is created or received by a health care Provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse; and
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

"Individually Identifiable Health Information (IIHI)" is information that is a subset of Health Information, including demographic information collected from an individual, and;

- Is created or received by a health care Provider, health plan, employer, or health care clearinghouse;
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual;

or the past, present or future payment for the provision of health care to an individual;
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

"Protected Health Information (PHI)" is Individually Identifiable Health Information maintained or transmitted by electronic media or transmitted or maintained in any other form or medium by a Covered Entity.

A **"Business Associate"** is defined as a person or organization that performs a function or activity on behalf of a Covered Entity and has access to PHI, but is not part of the Covered Entity's work force.

Covered Entities must comply with the HIPAA Transactions and Code Sets Standards. To comply with these standards, you need to ensure that the format you are using for submitting claims electronically is HIPAA compliant. Covered Entities transferring data electronically have to adopt the use of the Current Dental Terminology (CDT), which is periodically updated by the American Dental Association.

The Privacy Standards are intended to streamline the flow of information integral to the operation of the health care system while protecting confidential health information from inappropriate access, disclosure and use.

The Security Standards are intended to provide safeguards for data storage, protection of information transmission systems and the establishment of chain-of-trust agreements between Covered Entities and their business partners.

Dentists who are Covered Entities are required by law to obtain a **National Provider Identifier (NPI)** number and use a National Provider Identifier under 42 CFR part 438 (Medicaid Managed Care Regulations) with which Delta Dental must comply. The NPI is a ten digit unique identifier for health care providers and organizations. There are two basic types of NPIs available: (i) Individual and (ii) Organizational.

Individual NPIs (Type 1) are for health care providers, such as dentists.

Organizational NPIs (Type 2) are for use by incorporated businesses, such as group practices and clinics.

Be sure to notify us of your NPI number(s) by contacting our Professional Relations at 501-992-1710 or e-mail profrelations@deltadentalar.com.

The HITECH Act amends HIPAA and is a part of the American Recovery and Reinvestment Act (Federal Stimulus Package). The HITECH Act required the Department of Health and Human Services (HHS) to issue regulations for breach notification by Covered Entities and their Business Associates subject to HIPAA. HITECH rules require Covered Entities (and their Business Associates) to notify affected individuals, the media and the Secretary of HHS following a breach of unsecured PHI. Consequently, Covered Entities must implement security breach detection and notification programs (or alternatively, ensure that PHI is "secured" in accordance with the guidance.)

Delta Dental maintains a toll-free, HIPAA-compliant customer service call line for Enrollees and dentists. Dentists and their office staff can call this number for assistance with claims submissions or questions about an Enrollee's benefits.

You and your office staff can utilize the Delta Dental online Provider portal called the Dental Office Toolkit (DOT) to easily submit claims with real-time adjudication and to access education-focused materials. By using DOT, you have around-the-clock, HIPAA-compliant access to us. Submission of documentation through the DOT, online portals or the Delta Dental fax line is HIPAA compliant.

This information is for instructional and educational purposes only. It does not constitute legal advice. You are strongly urged to contact legal counsel for advice with respect to the interpretation of HIPAA and its applicability to you.

Visit the official HIPAA website at http://aspe.hhs.gov/admnsimp/.

Access the Office for Civil Rights website at http://www.hhs.gov/ocr/hipaa/.

5.0 ELIGIBILITY AND ENROLLMENT

5.1 Enrollee Eligibility Verification

Delta Dental does not perform enrollment functions for Enrollees. Eligibility information available to and provided by us is the eligibility information we received from DHS or its designee. DHS determines whether an individual is eligible for ARKids First A, ARKids First B, or adult Medicaid benefits.

Because eligibility can vary, your office should confirm eligibility of scheduled Enrollees on the day of the appointment or providing service.

You can access your patients' benefits and verify their eligibility in the following ways:

- You may access Enrollee benefits and eligibility via our Dental Office Toolkit (DOT).
  - Go to www.deltadentalsmiles.com and click Log In/Register in the top right corner
  - Register for an account if you do not already have one
  - Once you have an account, log in to the site and select Patient Benefits on the left side of the screen. Enter the Enrolee's identification number, name and date of birth
  - By using DOT, you can verify Enrollee eligibility 24/7 (See section 9.1 for information about DOT and registering for toolkit access)
- You can also utilize the Fax Back system to verify eligibility or claim status
  - Dial 1-866-864-2499. Press 1, and enter your tax ID
  - Choose 1 for Eligibility and Claim Status or 2 for Claims. Enter the Enrolee's identification number and date of birth
  - Press 1 for a Fax Back
- Our Customer Service Representatives are also available Monday through Friday from 7:00 a.m. to 7:00 p.m. at 1-866-864-2499 to assist you and your staff

Please note that due to possible eligibility status changes, the information provided by us does not guarantee payment. You and your office should confirm eligibility on the day of treatment.

5.2 Renewal/Re-enrollment

Enrollee eligibility is reviewed for renewal every 12 months by DMS. We are not involved in this process. A renewal is a periodic redetermination of eligibility after initial eligibility has been established. Only factors of eligibility which are subject to change (e.g., financial) are redetermined. Factors not subject to change such as age or citizenship are not redetermined at renewal. Depending on the Medicaid eligibility group, a renewal form completed by the individual may or may not be required in order to complete the redetermination of eligibility. Renewals are covered in the DMS Policy Manual, Section I, "Renewals and Changes."

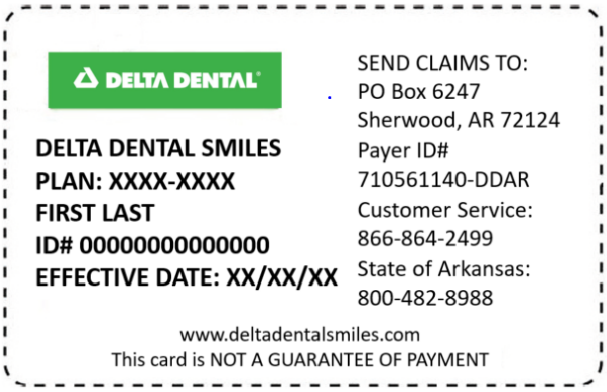
5.3 Enrollee Disenrollment

Enrollees may select to disenroll from the Medicaid dental program. Again, we recommend you verify an Enrollee's eligibility at each dental visit to determine their current status. You may not take retaliatory action against an Enrollee for disenrolling from the program.

5.4 ID Cards

Delta Dental Smiles and Delta Dental Smiles for Kids Enrollees will be issued an ID card in a Welcome Packet upon enrollment with Delta Dental. They will then have a 30-day window to select a Primary Care Dentist (PCD) or they will be assigned one.

The ID Card looks like:



Delta Dental strongly recommends your office require each Enrollee to present their ID card and confirm eligibility at each appointment. We also suggest you keep a copy of each Enrollee's ID card on file in the Enrollee's chart.

6.0 UTILIZATION MANAGEMENT

6.1 General

Delta Dental defines Utilization Management (UM) as the evaluation of Medical Necessity, appropriateness and efficiency of the use of health care services, procedures, and facilities under the provisions of the Delta Dental Smiles and Delta Dental Smiles for Kids Plans.

The primary purpose of Utilization Management is to provide the structure and organization for performing comprehensive review of the access to and appropriateness of care delivered by Participating Dentists. Delta Dental maintains a detailed plan to establish utilization review standards and procedures.

The determination of Medical Necessity is a necessary component of Utilization Management. Our staff includes Dental Consultants who are qualified, clinically trained personnel whose primary duties are to assist in evaluating Medical Necessity for Dental Services on a case-by-case basis, as well as performing clinical reviews. Our Dental Consultants consider all submitted documentation in the final determination of Medical Necessity.

6.2 Decision-Making Criteria

Delta Dental clinical review standards comply with recognized practice standards as they apply to dentistry. The standards and criteria our Dental Consultants use in conducting Utilization Management are based on current scientific evidence, clinical principles and processes, including the following:

- Evidence-based guidelines of leading nationally recognized public health organizations, health research agencies and professional organizations.
- Credible scientific evidence published in peer-reviewed medical and dental literature, including journals and textbooks generally recognized by the relevant medical and dental communities.
- Resources from accredited dental schools.
- The regulatory status of relevant technologies.
- Appropriate cumulative professional expertise and experience, including Providers with current knowledge relevant to the criteria under review.

Delta Dental's Utilization Management plan keeps up with industry trends and new standards, both from a clinical perspective as well as new technology. Nationally recognized criteria and standards are applied when adopting any new guidelines or standards. New standards of care proposed for adoption by Delta Dental are evaluated by appropriately licensed dentists with current

knowledge relevant to the criteria being reviewed. Some of the resources used to evaluate new standards of care are:

- Clinical guidelines published by the American Academy of Pediatric Dentistry. http://www.aapd.org/policy_center/state_dental_periodicity_schedules/
- Guidelines related to the medically complex patient affecting diagnosis and management of medical conditions of the oral and maxillofacial regions by the American Academy of Oral Medicine.
- Clinical guidelines, parameters, positions and statements published by the American Academy of Periodontology.
- Clinical guidelines and positions published by the American Association of Endodontists.
- Clinical guidelines and positions published by the American Association of Orthodontists.
- Parameters of care published by the American Association of Oral and Maxillofacial Surgeons.
- Dental practice parameters and clinical practice guidelines published by the American Dental Association.
- Dental procedure code, nomenclature and descriptor information contained in the current version of the Code on Dental Procedures and Nomenclature published by the American Dental Association.
- Guidelines related to the medically complex patient affecting diagnosis and management of medical conditions of the oral and maxillofacial regions by the American Academy of Oral Medicine.

6.3 Medically Necessary Dental Guidelines

Delta Dental will cover Medically Necessary Covered Services on a timely basis based on the urgency of the Enrollee's dental condition but no longer than 30 days, consistent with appropriate dental guidelines and with generally accepted practice parameters.

Delta Dental will begin covering Medically Necessary Covered Services to Delta Dental Smiles and Delta Dental Smiles for Kids Enrollees beginning on the Enrollee's date of enrollment, regardless of pre-existing conditions. Such date of enrollment may include a retroactive eligibility period.

6.4 Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program

EPSDT is a federally mandated program for children through age 20 which emphasizes the importance of prevention, early detection of dental conditions and timely dental treatment of conditions detected as a result of screening.

EPSDT services should be provided routinely beginning at 12 months of age; however, EPSDT services are allowable as early as six months of age.

EPSDT services also include dental services for relief of pain and infections.

Services an Enrollee who is eligible for EPSDT benefits needs are a Covered Service as long as the services meet administrative and clinical criteria and are determined to be Medically Necessary.

When submitting a claim to us for EPSDT services, include a completed Delta Dental Smiles Supplemental Processing Form. List on this Form all recommended services and procedures, including a complete explanation of the reasons the services in your opinion are Medically Necessary. You can submit this Form to us either (i) prior to treating the Enrollee as a Predetermination Estimate Request or (ii) with the claim after you provide the services. We will use the information provided by you in making a Medical Necessity determination. Because we may determine a service is not Medically Necessary and, therefore, not covered, we recommend requesting a Predetermination Estimate Request by submitting to us the Supplemental Processing Form.

The Supplemental Processing Form is available on DOT.

6.5 Access to Utilization Management Services

Calls related to Utilization Management (UM) are responded to by the Professional Relations (UM) staff within one business day. Outgoing communications related to UM are during business hours, unless otherwise mutually agreed upon. Other than Preauthorization requirements, we do not require any other type of notification by dentists with respect to UM.

7.0 COVERED SERVICES

This section provides in depth details about Delta Dental Smiles for Kids and Delta Dental Smiles Covered Services. Some of these services require Preauthorization, that is, an approval from us before you provide the particular Covered Service. See section 7.2 for Delta Dental Smiles for Kids and 7.4 for Delta Dental Smiles to see Covered Services requiring Preauthorization.

This section also explains when you can bill and collect fees from an Enrollee for services we do not cover and what you must do in order to bill and collect for these fees.

7.1 Delta Dental Smiles for Kids Coverage

The following describes Covered Services for individuals DHS determines are eligible for kids coverage, which includes ARKids First A and ARKids First B.

At the end of this section we provide you with a summary chart of:

- Covered Services, including the applicable billing code and service description
- Current fee
- Whether a co-pay is required for ARKids First B Enrollees
    - ARKids First B enrollees have a $10 co-pay due per office visit if one of the procedures submitted is found to require a copayment as listed in the summary chart below. Only one $10 copayment per visit is required and not intended to be per procedure code submitted.
- Whether Preauthorization is required

Some Covered Services are only covered one time in an Enrollee's life, for example, removable full and partial dentures. If Medicaid has already paid for an Enrollee to have one of these services, the Enrollee may not be able to have the service under our plan. You can call us with your questions about these services.

7.1.1 Diagnostic and Preventive Services

Evaluations (Exams)

- Children are eligible for two periodic evaluations, (D0120), in a calendar year.
- If a comprehensive exam (D0150, D0160) is submitted, the allowance of a periodic evaluation will be given and subject to the time limitation.

- When screening an Enrollee (D0190) is necessary, one screening is payable once per calendar year as long as the same dentist or dental office provides no other procedure on the same date of service with the exception of covered sealants, D1351, and fluoride varnish, D1206. The D0190 will not be covered if the Enrollee has a D0120 in prior history for the treatment year.
- General Policy - Benefits for evaluations (D0120) performed without an intent to provide dental services to meet the patient's dental needs will be processed as D0190.

Periapical X-rays

- Limited to 6 in a calendar year with a limitation of two per office visit.
- Images included in the combination of six per calendar year include all intraoral and extraoral films. (D0220, D0230, D0240, D0250)

Bitewing X-rays

- Limited to 1 set of 2 films, D0272, per office visit with a maximum of 2 sets per calendar year.
- D0273 and D0274 can be submitted and will pay as D0272.
- A single film bitewing (D0270) is a Covered Service limited to 1 per office visit with a maximum of 4 per year. This limit applies to the limits set out above for D0272.

Full Mouth Complete Series and Panoramic Radiographic Images

- Covered Services are limited to only one of a complete full mouth series, D0210, or panoramic image, D0330, in a five consecutive year period.
- If a complete full mouth series, D0210, is performed, no additional images will be benefited and the fee is considered to be included in the total fee of the full mouth procedure.
- A panoramic radiographic image, D0330, with additional images such as periapicals, bitewings, and/or occlusal films, performed on the same date of service, by the same dentist, or dental office, is considered a complete full mouth series, D0210, and benefited as such.
- If multiple images (radiographs) are submitted on the same date of service, they will be combined and given the allowance of a complete full mouth series (D0210) if the total fee is equal or greater than the fee for a full mouth series (D0210). The fee for multiple images (radiographs) should never exceed the allowed fee for a complete full mouth series, D0210.
- Delta Dental utilizes the American Dental Association's Dental Radiographic Examination Guidelines.

Emergency Dental Care

- Limited oral evaluation, problem focused, D0140, is limited to 2 per calendar year.
- Palliative (emergency) treatment of dental pain, (D9110), as needed.
    - Palliative treatment is not a Covered Service when definitive work has been performed on the same date by the same dentist or dental office except for exams and x-rays to diagnose the problem.
    - If a definitive Covered Service is performed by you on the same date the more inclusive procedure will be benefited. The remaining services are Not Billable to The Patient and considered as part of the fee for the more inclusive procedure.
- Delta Dental may request documentation and/or patient's records for Dental Consultant review for multiple submissions of limited, problem focused evaluations and/or Palliative treatment over a period of 6 to 12 months.

Diagnostic Casts

- Diagnostic casts are a Covered Service with Medically Necessary orthodontic services.
- Records may be reimbursed when a case submitted for comprehensive orthodontic treatment is denied if the HLD score determined by our consultants is 20 or higher, or in the cases of limited orthodontic treatment the HLD score is 16 or higher.

Caries Risk Assessment and Documentation is a Value Added Service for children once per calendar year for either low, medium, or high risk findings. You may use any of the standard Caries Risk Assessment forms (ADA, AAPD, CAMBRA, etc.). An online assessment tool is available on the Dental Office Toolkit.

Prophylaxis (cleanings)

- Cleanings are allowed twice in a calendar year.
- Adult cleanings (D1110) are Covered Services for ages 10 and over.
- Child cleanings (D1120) are Covered Services for ages 13 and under.
- One additional cleaning is allowed as a Value Added Service for expectant mothers. The time of eligibility for the additional cleaning is from the beginning of pregnancy through the end of 3 months following the delivery of the child.
- Scaling in the presence of generalized moderate or severe gingival inflammation (D4346) will be payable as a routine cleaning according to

the Enrollee's age. The Maximum Plan Allowable fee and time limitations of a routine cleaning will apply.

Fluoride

- D1206 – Topical application of fluoride varnish.
- D1208 – Topical application of fluoride – excluding varnish.
- Topical application of fluoride is covered 2 times per calendar year.

Sealants

- A sealant, D1351, is a Covered Service only for the first and second permanent molars when applied to a tooth with an unrestored occlusal surface.
- Sealants are Covered Services for Enrollees under age 21.
- Sealants are Covered Services one time per tooth per lifetime.

Interim Caries Arresting Medicament Application (Silver Diamine Fluoride)

Silver diamine fluoride (D1354) is a Value Added Service. It is a topical desensitizing and cariostatic agent. It is used by placing a small amount of the solution directly on the affected tooth. Silver diamine fluoride is a minimally invasive treatment option that is shown to effectively treat and prevent caries and relieve sensitivity of the teeth.

Since its introduction in the U.S., it has been demonstrated to:

- Effectively arrest or reduce the rate of caries progression.
- Prevent further caries.
- Be a non-invasive procedure that makes it particularly helpful in treating young children and children with special needs and patients in long term facilities.
- Reduce instances when sedation or other anesthesia is used on children needing treatment.
- Be extremely cost effective.

Delta Dental Smiles provides for the application of silver diamine fluoride as follows:

- Allowed up to 2 applications in one calendar year per tooth with a maximum of 4 applications for the life of the tooth.
- Covered Services are limited to treatment of 4 cavitated teeth on the same date of service.

- Once a tooth has been treated with silver diamine fluoride, a restoration is not allowed for 3 months following the date of service of the application.
- A tooth that has had a previous restoration is not eligible for silver diamine fluoride.
- Once a tooth has been treated with silver diamine fluoride, a sealant is no longer a Covered Service for that tooth.

Space Maintainers

- Fixed unilateral (D1510)
- Fixed bilateral (D1516/D1517)
- Removable bilateral (D1526/D1527)
- When submitting a claim for a space maintainer, the missing tooth/teeth should be identified for which the space is being maintained.
- Removal, or repairs of a space maintainer are not a Covered Service
- Recementations of space maintainers are a covered benefit following 12 months after insertion of the appliance and limited to once in a 24 month period.
- Space Maintainers are limited to once per maintained space.
- Space Maintainers are not covered when maintaining the space of an anterior tooth.
- Two fixed unilateral space maintainers (D1510) submitted on the same Enrollee will be covered as a single fixed bilateral space maintainer (D1516 - maxillary or D1517 – Mandibular).

Consultations

- A consultation (D9310) includes services provided by a Specialist whose opinion or advice is requested by another dentist or other appropriate source for the further evaluation and/or management of a specific problem. When the consulting dentist assumes responsibility for the continuing care of the patient, any subsequent service provided by him or her is not a consultative service.
- Consultations are limited to two per year by a Specialist. The yearly limit is based on a calendar year and allows only one per dentist or Specialist. Extensions of this Covered Service are available to Enrollees under the age of 21 when the consultation is Medically Necessary.

7.1.2 Minor Restorations

Amalgam Fillings

- Amalgam fillings are covered once per tooth, per surface in a 24 consecutive month period.
- Fillings are not allowed on a tooth having a crown placed within the first 12 months following the placement of the crown.

Composite Fillings

- Composite fillings are covered for anterior teeth only.
- If a posterior composite is performed, the Covered Service available will be made for the corresponding amalgam.
- Covered Services are limited to once per tooth surface in a 24 consecutive month period.
- Fillings are not allowed on a tooth having a crown placed within the first 12 months following the placement of the crown.
- Restoration placement must extend through the enamel into the dentin and be in compliance with operative dentistry best practices principles.

General

- Sedative fillings are not a Covered Service. If a sedative filling is performed in conjunction with a restoration, the fee should be included in the total fee of the restoration.
- The fee for the filling restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct or indirect pulp caps, local anesthesia, polishing, occlusal adjustment, and caries removal. These procedures are not separately payable.

7.1.3 Crowns – Single Restorations Only

General Information

- For Enrollees under age six (6), you are required to have clinical diagnostic information, radiographs or clinical photographs available for consultant review upon request.
- For Enrollees age six (6) and above, you are required to have clinical diagnostic radiographs available for our review upon request. If diagnostic radiographs were not taken, documentation as to clinical reasoning must be documented in the patient's clinical record. Clinical photographs should be available for consultant review when radiographs were not taken.
- It is recommended you submit radiographs and/or clinical photographs with Preauthorizations, predeterminations or date of service claims when a Preauthorization was not required. A provider narrative is required if radiographs or clinical photographs were not obtained.

Prefabricated Stainless Steel (Chrome)

- D2930 – Prefabricated Stainless Steel Crowns, primary teeth, are allowed once in a two (2) year period, per tooth, as an alternative to a multi-surface filling when a filling material will not suffice.
- D2931 – Prefabricated Stainless Steel Crown, permanent teeth, are allowed once in a two (2) year period, per posterior tooth with loss of cuspal function. The crown is given as an alternative to a multi-surface filling when the filling material will not suffice.
- D2934 - Prefabricated esthetic coated stainless steel crown, primary tooth, may be performed and submitted, but will be alternated and covered as a D2930, prefabricated stainless steel crown, primary tooth.

Major Crown Procedures

- Delta Dental Smiles does not cover cast crowns for posterior teeth.
- D2752 – Porcelain to metal crowns may be approved only in unusual cases for anterior teeth for Enrollees 14 – 20 years of age. Porcelain crowns require a preoperative periapical radiographs and/or photographs, which have been dated and labeled right and left, and show the documented tooth breakdown. For all involved teeth, the entire crown and root apex of the tooth must be visible on the radiograph(s) submitted.
    - A porcelain/ceramic crown (D2740) can be submitted and will pay as a porcelain to metal crown (D2752). The same requirements, criteria, and limitations as the D2752 apply.
- Anterior crowns may be approved as a resin-based composite crown (D2710) for Enrollees under the age of 21. Preauthorization is required.
- Crowns, when approved as a Covered Service, are allowed once per tooth, in a five year period. This includes any type crown whether stainless steel, resin based, or porcelain to metal crowns.
- When a claim for an approved crown is submitted, we will recoup any payments made to you for fillings within the six (6) month period prior to the date of service for the crown.

Post and Core in Addition to Crown – Core buildups, post and core in addition to crown, indirectly fabricated or prefabricated are not a Covered Service. An exception to this rule may be for anterior fractures due to recent trauma in cases that do not involve other extractions, missing teeth or rampant caries in the same arch. Documentation of the need along with pre-operative x-rays and other items may be requested.

Crown Recement

- Crown recementations are not covered within the first 12 months of the placement of the crown.
- After 12 months have passed from the crown seat date, a recementation is covered once in a 12 month period per tooth.

7.1.4 Endodontics

Pulpal Therapy

- Current indications require carious exposure of the pulp. **Pulp caps** are included in the cost of the restoration of that tooth and not separately payable.
- D3220 -- Pulpotomy is a Covered Service for children under the age of 21 once per tooth for primary teeth, not permanent teeth.
- Pulpal debridement (D3221) is usually done for the relief of pain when the debridement includes the entire pulp chamber and canals as gross pulpal debridement. If the treatment does not include these conditions, the treatment may be benefited as a palliative treatment (D9110).
- Pulpal debridement or pulpotomy is not separately payable on the same date as a root canal by the same dentist or dental office.
- It is recommended you submit radiographs and/or clinical photographs with Preauthorizations, predeterminations or date of service claims when a Preauthorization was not required. A provider narrative is required if radiographs or clinical photographs were not obtained.

Root Canal Therapy

- Providers are encouraged to submit a Predetermination Estimate Request for badly decayed or broken down teeth requiring root canal therapy to determine if the tooth is restorable.
- A claim for a root canal, D3310, D3320 or D3330, requires submission of a pre-treatment radiograph and a post-treatment radiograph of the anatomical root apex of the involved tooth demonstrating the final endodontic fill.
- Root canal therapy is not covered for third molars except in unusual situations that are determined to be Medically Necessary and require our review. Related first and second molars are required to be missing and a comprehensive treatment plan explaining the Medical Necessity is required for our review. Dental consultant review may be required.
- Root canal therapy is not a Covered Service for a tooth that is deemed a Non-Restorable Tooth.
- Root canal therapy is not a covered service for a tooth that requires a crown build-up for restoration. See Non-Restorable Tooth in section 1.1

- Root canal therapy is not allowed on the 2nd molars, with the exception of when the 1st molar is absent. Also, root canal therapy is not allowed on maxillary 1st molar if the 2nd molar is unerupted. When the 2nd molar is partially erupted a Preauthorization is recommended.
- Root canal therapy is not covered for non-restorable or periodontally involved teeth such as teeth with periodontitis.
- Endodontic retreatment, apexification, retrograde fillings, or root amputation are not Covered Services.

Guidelines:

Root canal treatment should attempt to achieve the following:

- Achieve and maintain access to apical anatomy during chemo-mechanical debridement.
- Obturate the canal with densely compacted material within 2 mm of the apical terminus.
- Prevent reinfection with a coronal restoration. If unable to conform in the above guidelines, the dentist must provide a narrative as to why it does not conform and the plan for monitoring the patient. Radiographic evidence (preoperative and postoperative) must demonstrate completion of treatment and be maintained in the patient file. The following procedures may not be billed when performed on the same tooth and same day as root canal therapy: pulpotomy, pulpectomy, temporary restorations, palliative treatment or sedative fillings.

7.1.5 Periodontics

Periodontal Treatment

Scaling and Root Planing

- When periodontal treatment is requested, a brief narrative of the patient's diagnosis, photograph(s) and radiographs are required if selected for Consultant Review.
- Each quadrant to be treated must be indicated on separate lines when requesting Preauthorization or payment.
- If selected for Dental Consultant review, Delta Dental will request clinical note documentation, a periodontal chart, and bitewing X-rays of the affected area or areas which show evidence of bone loss, numerous 4-5 mm pockets and obvious calculus. The periodontal diagnosis should be notated in the clinical notes.
- If more than two quadrants of scaling and root planning are performed on the same date of service, claim submission for payment must include:

    - Clinical notes, including treatment time, to justify extenuating circumstances for completing in one appointment,
    - Patient treatment record including type and amount of anesthesia,
    - Current periodontal charting (including clinical attachment levels), and
    - Diagnostically acceptable preoperative periapical and bitewing radiographs to document bone loss, dated and marked right and left.
- Scaling and root planing is a Covered Service once per quadrant in any 24 consecutive month period.

Periodontal Maintenance

- Periodontal Maintenance is a Covered Service for patients with documented or prior history claims of active periodontal therapy for periodontal disease. This is a Covered Service once in a calendar year.
- Qualifying Periodontal Maintenance can be performed at least 30 days following periodontal therapy.
- One additional periodontal maintenance is allowed during the calendar year as a Value Added Service for individuals with documented diagnosis of periodontal disease with history of periodontal therapy.

7.1.6 Removable Prosthetic Services

Removable Complete and Partial Dentures

- Billing date for removable prosthetic appliances is the delivery date to the Enrollee.
- Only permanent teeth are eligible for partial denture replacement.
- Covered Services for removable full and partial dentures are allowed 1 per arch, per lifetime, regardless of whether delivered as conventional or immediate dentures.
- Immediate partial dentures (D5221 and D5222) are not subject to mandatory Preauthorization
- The fee for a diagnostic cast in preparation of a removable full or partial denture, is included in the cost of the prosthesis, and not separately payable.
- One removable complete conventional denture, or removable complete immediate denture, is a Covered Service once per arch in a lifetime.
- One removable partial conventional denture, or removable partial immediate denture is a Covered Service once per arch in a lifetime.
- An Enrollee must be missing two or more posterior teeth on at least one side of the mouth for a partial denture to be a Covered Service. This does not include a second and third molar in that quadrant.

- A partial denture may be a Covered Service if the Enrollee is missing an anterior tooth.
- You are responsible for any necessary adjustments and exams for the first six months in this process. These are not a separate Covered Service.

Immediate Complete and Partial Dentures

- Immediate complete and partial dentures are delivered on the date of service for the last anterior tooth extraction.
- One removable complete conventional denture, or removable complete immediate denture, is a Covered Service once per arch in a lifetime.
- One removable partial conventional denture, or removable partial immediate denture, is a Covered Service once per arch in a lifetime.
- Immediate complete dentures require Preauthorization and a signed consent form prior to delivery. Immediate partial dentures do not require preauthorization prior to deliver. See the Immediate Dentures Preauthorization Requirements and Submission section below for a full list of Preauthorization requirements for immediate complete dentures.
- In order for an immediate complete denture to be Preauthorized, all posterior teeth distal to the canines must be extracted a minimum of 6 weeks prior to the Preauthorization for the immediate denture. Immediate dentures delivered without the mandatory Preauthorization will be denied and not billable to the Patient.
- You agree to make every reasonable effort to provide follow-up care to ensure that any immediate denture is serviceable to the enrollee since it is a once in a lifetime benefit.
- By providing immediate dentures, you agree and recognize that you are subject to chart audits to validate compliance with post-delivery follow-up and care. Failure to demonstrate reasonable effort to do so, will result in a refund request.
- If you receive excessive complaints regarding immediate dentures, you may be subject to restriction from providing immediate dentures to future Medicaid enrollees and possible termination of your provider agreement.
- You must advise the enrollee of the increased need for and importance of making and keeping appointments after delivery of the denture(s).
- The Enrollee must sign the Immediate Denture consent form available on the Delta Dental Smiles website, www.deltadentalsmiles.com, and acknowledge that they understand the importance of and need for aftercare. They also acknowledge they have the ability and commitment to make and keep needed appointments after the delivery of the dentures.

- CDT Code D0140 or any other exam fees cannot be charged in conjunction with any procedures related to the immediate dentures within the first 6 months of delivery.
- All adjustments, tissue conditioners and relines needed to result in a comfortable, properly functioning denture will be included in the fee for the first 6 months following delivery.

Immediate Complete Denture Preauthorization Requirements and Submission

- In order for an immediate complete denture to be Preauthorized, all posterior teeth distal to the canines must be extracted a minimum of 6 weeks prior to the Preauthorization for the immediate denture. Immediate dentures delivered without the mandatory Preauthorization will be denied and not billable to the Patient.
- Submission and approval of a Preauthorization request is required for payment of an immediate complete denture. This Preauthorization request must contain the following:

    i. Documentation of all posterior teeth distal to the canines extracted a minimum of 6 weeks prior to the date of the Preauthorization request.
    ii. Acceptable documentation can include prior claim(s) of extracted posterior teeth detailing date of 6 weeks prior and/or panoramic film documenting the absence of the required missing teeth.
    iii. Signed consent form (*see consent form available on the Delta Dental Smiles website, www.deltadentalsmiles.com)
- Preauthorization should be submitted as any other claim. See Section 8.0. Claims and Preauthorization.
- Following receipt of an approved Preauthorization request from Delta Dental Smiles, you must verify the Enrollee's eligibility again prior to delivery of the immediate denture. Even though a service is preauthorized, the enrollee MUST be eligible on the final delivery date of the immediate denture.
- After the request for preauthorization is approved, the immediate denture can be delivered. If the immediate denture is delivered before preauthorization approval, the claim will be denied and the enrollee must not be billed for the service.
- The consent form can be located in the Delta Dental Smiles website under Forms and Resources. This is accessible from DOT through a link in the Announcement section.

Lab Services

- You may choose the lab from which a denture or partial is fabricated for an Enrollee.
- You are responsible for the quality of materials used in the complete or partial denture as described in Section 3.11. This information must be retained as part of the Enrollee's record and made available to us upon request.
- As described in Section 3.11, we will recoup reimbursement made from you if the quality standards are found not to have been met.
- Lab fees are not separately reimbursed. The fee for a complete or partial denture is included in the fee reimbursed for the appropriate code.

Billing

- Billing date for removable prosthetic appliances is the delivery date to the Enrollee.
- You will use the following applicable CDT codes when submitting a claim for a complete denture or partial denture:
    - D5110: Complete denture – maxillary
    - D5120: Complete denture – mandibular
    - D5130: Immediate denture – maxillary
    - D5140: Immediate denture - mandibular
    - D5211: Maxillary partial denture – resin base
    - D5212: Mandibular partial denture – resin base
    - D5221: Immediate maxillary partial denture – resin base
    - D5222: Immediate mandibular partial denture – resin base

Diagnostic Casts and Limited Oral Evaluation for Pediatric Denture Program

- Limited oral evaluations, D0140, are not a Covered Service for complete denture or partial denture fabrication.
- Diagnostic casts, D0470, are not a Covered Service for complete denture or partial denture fabrication.

Adjustments of Removable Full and Partial Dentures

- Adjustments are not a Covered Service for children and the fee is included in the total fee of the removable prosthetic.

Repair

- Repairs are limited to once in a three (3) year period.
- Codes D5511 and D5512 for the repair of dentures are Covered Services.

- Code D5520 for replacing a missing or broken tooth on a complete denture is a Covered Service.
- Adding a tooth to a partial (D5650) is benefited when additional extractions are performed with the addition to the partial for replacing the missing tooth/teeth.

Rebases

- Rebases are not a Covered Service.

Relines

- Reline coverage for children is the reline of a complete maxillary (upper) denture (D5750) and is a Covered Service once in a 3 year period.

Dental Consultant Review May be Required

- A claim for a repair or adding a tooth to an existing partial denture may require Dental Consultant review for which you may be required to submit documentation along with the requested radiographs. Documentation should include a treatment plan and, if a partial denture, tooth numbers to be replaced.
- If you are requested to provide documentation and X-rays for a claim on repairs or adding a tooth to an existing partial, please include the date of the initial placement of the partial and include the treatment plan and/or narrative as to the reason for repair.

Fixed Partial Denture and/or Fixed Partial Denture Repair

- Fixed partial dentures and fixed partial denture repairs are not Covered Services.

Fixed Partial Denture Recementation

- Fixed partial denture recementation is a Covered Service once in a 12 month period after 12 months have passed since the insertion of the prosthesis. Please include the date of insertion of the fixed partial denture being repaired along with the teeth numbers included in the fixed partial denture unit.

7.1.7 Oral Surgery

Routine (Non-surgical) Extractions

- D7111 and D7140 extractions may be performed in most cases without our review.

- When requesting a Predetermination or submitting a Preauthorization, it is required you submit radiographs and/or clinical photographs. In those limited situations where you are unable to submit these items, a provider narrative explaining the proposed treatment plan as well as the circumstances preventing you from providing radiographs and/or clinical photographs is required. Those situations will be evaluated on a case by case basis.

Surgical Extractions

- When a D7140 extraction evolves into a surgical extraction, you may be requested to provide a brief explanation of the circumstances along with a preoperative x-ray.
- Surgical extractions may require Dental Consultant review and/or Preauthorization. See section 7.2 for a full list.
- Surgical extractions performed on an Emergency Dental Care basis for the relief of pain may be reimbursed subject to the approval of a Dental Consultant. In these cases, the claim with radiograph and a brief explanation should be submitted to Delta Dental. The fee for surgical extraction includes local anesthesia and routine postoperative care.

Other Oral Surgery Procedures

- Incision and drainage of an abscess (D7510) is a Covered Service as long as no other definitive work is being done on that day.
- D7250, removal of residual tooth roots (roots left after extraction attempt, cutting procedure) refers to roots left after an extraction visit. D7250 does not refer to a difficult extraction of an erupted tooth or the removal of the exposed root. If removing bone or section of an erupted tooth is required use D7210.
- If other definitive work is done on the same date of service as the incision and drainage (D7510) by you or in your office, including root canals, periodontal therapy, and/or oral surgery, the fee of the D7510 is Not Billable to The Patient and must be included in the total fee of the definitive service.
- Incisional biopsy of hard (D7285) or soft oral tissue (D7286) requires a copy of the pathology report attached to the submitted claim. Pretreatment and posttreatment photographs must be available to us upon request.
- D7280 and D7283 are Covered Services if the Enrollee is having approved orthodontic treatment done. Preauthorization is required.
- Tooth reimplantation (D7270), is a Covered Service upon approval by Dental Consultant review. A narrative is required giving explanation of the trauma event and attached with the submitted claim. Additional information may be requested by the Dental Consultant for further review.

- Frenulectomy – frenectomy or frenotomy (D7961 & D7962) is a Covered Service.
    - Medical Necessity will be evaluated for a Maxillary labial frenectomy when all of the following conditions are met:
        i. Patient approved for, or in active Medicaid approved orthodontic treatment
        ii. Maxillary cuspids erupted
        iii. Age 11 through 20
    - Mandibular labial frenectomy requires a photograph displaying probable damage to the free gingival margin with resulting periodontal problems
    - Mandibular lingual frenectomy require Preauthorization and will be approved on:
        i. Neonates who have documented feeding problems
        ii. Children who have partial ankyloglossia, defined as the inability to protrude their tongue past the mandibular incisors
        iii. Children who have documented speech problems (referral from speech pathologist)

- Consultant Review May be Required
    - A claim may require professional review at any time for which you may be required to submit documentation along with the requested pre-operative x-rays. Documentation should include treatment plan, tooth number(s), clinical notes, and/or narrative as requested.

Non-intravenous Conscious Sedation

- Non-intravenous (conscious) sedation, D9248, requires the below information and can be entered in the remarks section of the claim form:
    i. Proposed treatment medications
    ii. Name of Provider administering medication and Arkansas State Board of Dental Examiners certificate number
    iii. Documented Medical Necessity for conscious sedation.
    iv. Verification of signed parental consent for conscious sedation to be maintained in the patient's treatment chart.

- Nitrous oxide/analgesia, N2O, is covered when used with a procedure other than diagnostic and preventive services.
- Intravenous moderate (conscious) sedation, D9239 and D9243, are not Covered Services.

Deep Sedation/General Anesthesia

- Providers administering general anesthesia/deep sedation must possess the appropriate permit as required by Arkansas State Law. Services performed in the dental office must be documented in the patient's record to include specific information on intubation, pharmacologic agents and amounts used, monitoring of vital signs and total anesthesia time.
- Preauthorization is not required for deep sedation and general anesthesia procedures. Claims received with more than two (2) D9223 will be subject to consultant review to determine if more than one (1) was Medically Necessary. No more than one (1) D9222 will be a Covered Service.
- Non-intravenous conscious sedation and nitrous oxide are not a Covered Service on the same date as the Deep Sedation/General Anesthesia.

7.1.8 Orthodontics

- Orthodontic treatment is a Covered Service only when Medically Necessary. Medical Necessity is determined based on the Handicapping Labio-Lingual Deviation (HLD) Index described below.
- For a majority of the Enrollees, Orthodontic Treatment is a once-in-a-lifetime benefit with a lifetime maximum benefit not to exceed the fee of D8090 (adult comprehensive orthodontics) for all orthodontic services.
- In severe cases in which two phases of treatment are indicated, both phases must be documented in the preauthorization of the first phase of treatment. The second phase of treatment will require a separate preauthorization prior to banding.
- If a case was authorized and treated with a first phase of treatment, the case may not qualify on the HLD index necessary for approval of the second phase. Documentation of the first phase of approved treatment will be required for approval of the second phase of treatment.
- When treatment is rendered for more than one phase, including any limited treatment, the combined payment will not exceed the total lifetime maximum benefit equal to D8090.
- All orthodontic treatment requires Preauthorization before treatment is initiated.

For purposes of billing the following definitions will apply:

- Transitional Dentition (D8020, D8070): The final phase of the transition from primary to adult teeth, in which the deciduous molars

and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition (D8030, D8080): The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- Adult Dentition (D8040, D8090): The dentition that is present after the cessation of growth that would affect orthodontics treatment. Third molars, if present, are usually erupted unless there is a lack of space for eruption or the teeth are malposed.

Preauthorization Documents

- All orthodontic records must be of diagnostic quality and properly identified with the patient's name and date taken on the image to be considered.
- All orthodontic records submitted to us must be no older than 6 months from the date of submission.
- Items that must be included are:
    - Completed Handicapping Labio-Lingual Deviation (HLD) Index form;
    - A completed Claim Form, with a treatment plan documented on the Claim Form for limited cases;
    - Cephalometric film with a calibration ruler to scale incorporated in image;
    - Panoramic film (or intraoral complete series);
    - Quality diagnostic casts when requested by us, properly occluded and trimmed (the diagnostic casts should simulate centric occlusion of the Enrollee when the diagnostic casts are placed on their heels); the casts must contain your name as the treating dentist and the Enrollee's full name clearly inscribed on the maxillary and mandibular casts with date impressions were taken.
    - At least three extraoral photographs (frontal, profile, smile frontal);
    - And five intraoral photographs (right side occluded, left side occluded, anterior occluded, upper and lower arch occlusal views).
    - Delta Dental Smiles Orthodontic Treatment Clearance Form completed by orthodontic provider or the Enrollee's Primary Care Dentist.

If the submitted diagnostic casts, photographs and/or radiographs are of such a quality that they cannot be read or interpreted by us, new records will be requested and must be submitted by you prior to further consideration for treatment. These records will be provided at no expense to DHS, us, or the Enrollee.

- The orthodontic examination and orthodontic records are only separately reimbursable when a Preauthorization request is not approved. Records may be reimbursed when a case submitted for comprehensive orthodontic treatment is denied if the HLD score determined by our consultants is 20 or higher, or in the cases of limited orthodontic treatment the HLD score is 16 or higher.
- If the orthodontic Preauthorization was approved, and the Enrollee did not start treatment for any reason, the examination and orthodontic records may be requested for reimbursement. Claim will be considered for payment upon review.

NOTE: Diagnostic casts, hard physical models, should be submitted ONLY WHEN requested by us. Diagnostic casts will be destroyed by us after the models are digitized.

Request for Preauthorization/Claim Submission

- Preauthorizations should be submitted as any other claim. See Section 8.0, Claims and Preauthorizations.
- Following receipt of an approved Preauthorization request from us, you must verify the Enrollee's eligibility again prior to beginning orthodontic treatment. It is important for you to verify eligibility each time a treatment/service is performed. Even though a service is Preauthorized, the Enrollee MUST be eligible on the date the banding occurs. If the Enrollee is eligible, you should proceed to treat the orthodontic condition as soon as possible, in accordance with the preauthorized treatment plan. For instructions on checking eligibility, see Section 5.0, of this manual or contact your Delta Dental Professional Relations Representative.
- When treatment is approved, we will remit reimbursement for comprehensive orthodontia after the corrective appliances are placed in the Enrollee's mouth and after we receive a frontal full face photograph showing the orthodontic appliance in place submitted with the date of service claim. Delta Dental will pay you 33% of the total reimbursement at the time the Enrollee is banded. The remaining 66% will be paid in quarterly installments over the course of the treatment plan. This arrangement is one of the tools we use to aid in ensuring treatment is completed and the Enrollee is receiving the needed care in a timely manner.

Transfer Cases

- An Enrollee transferring to Delta Dental Smiles for Kids from another state that has started orthodontic treatment may be allowed to complete orthodontic treatment in unusual and hardship cases. Preauthorization of an orthodontic continuation of care cases is required. To ensure proper evaluation of the continuation of care we require the following from the provider who is assuming continuation of treatment:
    - All information and records previously described for an comprehensive orthodontic case;
    - An American Association of Orthodontists (or similar) transfer form from the transferring provider to you;
    - CDT code identified on the claim form representing the treatment planned for the Enrollee;
    - And length of time the Enrollee has been in active orthodontic treatment and approximate time required to complete active treatment.
- If deband and retention only use code D8999.
- A request for transfer from the initial orthodontic provider documenting the need for transfer; a transfer between orthodontic providers requires coordination between the providers to ensure continuity and appropriateness of care.
- The amount of reimbursement for the remaining treatment will be based on the Delta Dental Smiles for Kids Fee Schedule and prorated based on the time left in treatment as evaluated by our dental consultant. Removal of fixed appliances with or without retention may be approved if any of these requirements are not met.
- The Orthodontic Discontinue Treatment Form (see the Delta Dental Smiles for Kids website under Provider Forms and under Delta Dental Smiles Resources in the Dental Office Toolkit) for premature removal of an orthodontic appliance must be signed by the parent or legal guardian of a Enrollee, or by the Enrollee if they are 18 years of age or older or an emancipated minor. A copy of the signed release form must be kept in the Enrollee's chart. The following are reasons for premature termination from treatment:
    - The Enrollee is uncooperative or is non-compliant.
    - The Enrollee requested the removal of orthodontic appliance(s).
    - The Enrollee has requested the removal due to extenuating circumstances, including, but not limited to:
        - Relocation
        - Incarceration

- Mental health complications, with a recommendation from the treating physician
- Foster Care placement
- Induction in the Armed Forces

Limited Orthodontic Covered Services

- Limited orthodontic codes D8020, D8030, and D8040 are Covered Services with Preauthorization.

Limited orthodontics may be a Covered Service to Enrollees under 21 years of age that meet one or more of the following criteria:

- Single or multiple teeth (tooth) anterior crossbite. If the anterior crossbite is slight and does not require correction because it is not Medically Necessary the case may be Denied.
- Unilateral crossbite with functional shift. Documentation of the shift must be provided, i.e., frontal photo showing midlines off and facial photo showing chin off, etc., and must be essentially all teeth on one side.
- Bilateral posterior crossbite. There must be two or more teeth on each side to be considered and one must be a permanent molar tooth.
- Anterior impacted teeth. In order to be considered, the impacted teeth either have not come in ("erupted") when expected or must be erupting in an abnormal path and overlapping a significant portion of an adjacent tooth. If the tooth in question is erupting vertically and the issue could likely be resolved by extraction of bicuspid(s) or primary teeth, it is not considered a qualifying impaction. Delayed eruption by itself is not considered an impaction. The tooth (teeth) must be unerupted and making no progress in eruption as reflected in a serial radiographic images taken six (6) months apart.

Cases not qualifying under these guidelines may be considered and would require a written narrative indicating why the problem is Medically Necessary to correct.

The orthodontic examination and orthodontic records are only separately reimbursable when a case has been denied. Records will not be reimbursed if the consultant determines the HLD score is 20 or less when comprehensive treatment has been requested, or 16 or less when limited treatment is requested.

Guidelines for Client Self-Pay and Managed Care Orthodontic Services

In the event services are approved by Medicaid or Delta Dental of Arkansas for limited orthodontic treatment (D8020, D8030, or D8040) and the client or client's guardian requests additional covered or non-covered services for which the client does not meet the clinical requirements, the provider and client may enter into a self-pay agreement. The following guidelines apply when concurrent services are rendered:

1. The treatment plan and/or medical records must differentiate Delta Dental of Arkansas's approved covered services from the self-pay services and clearly document the completion of the covered services according to the approval.
2. A narrative must be included in the client's treatment plan describing the additional orthodontic services.
3. The client's record must include a financial responsibility form documenting the client/client's guardian's responsibility to pay for all additional orthodontic services.
4. The provider cannot delay or deny a regularly scheduled treatment prior to completion of the approved orthodontic services as a result of the responsible party's failure to make required payments for the additional orthodontic services.
5. If the provider fails to complete treatment for any approved services or a second provider has to redo some of the work of the first provider due to the failure to continue medical care, that provider may have monies recouped for the remaining treatment.

Minor Treatment to Control Harmful Habits

D8210 (removable appliance therapy) and D8220 (fixed appliance therapy) may be a Covered Service on a case-by-case basis for tongue thrusting and thumb sucking. Aggressive habit validation must be documented by you along with appropriate photographs illustrating the effects of the harmful habit (i.e. anterior open bite or excessive overjet, etc.), models (upon request), and a narrative.

Comprehensive Orthodontics

- Comprehensive orthodontics is only approved for the **most severe and handicapping** malocclusions. Assessment of the most severe malocclusion is determined by the magnitude of the following variables: degree of malalignment, craniofacial deformities of the head, skull, face, neck, jaws and associated structures, missing/impacted

teeth, overjet, overbite, open bite and cross bite. Because a case must be severe to be accepted for orthodontic treatment, Enrollees whose molars and bicuspids are in good occlusion seldom qualify. Crowding or spacing alone does not qualify. Orthodontic services primarily for cosmetic purposes are not a Covered Service.

- The Handicapping Labio-Lingual Deviation (HLD) Index is used to determine when comprehensive orthodontic services are Medically Necessary.
- The following requirements must be met to obtain comprehensive orthodontic treatment. The Enrollee must:
    - Be under 21 years of age with severe malocclusion.
    - Be under the care of a dentist for Routine Care and all necessary care (i.e., prophylaxis, restorations, etc.) must be completed prior to submission of a Preauthorization.
    - Exhibit good oral hygiene; you must submit the Orthodontic Treatment Clearance Form with the Preauthorization request and it must not be dated more than six (6) months from the date of the submission of the Preauthorization request. The Enrollee must not be under 13 years of age or have any deciduous teeth remaining (unless the primary teeth are retained due to ectopic position of the underlying permanent tooth or a missing permanent tooth in this area) or the remaining deciduous teeth have no root structure remaining; permanent dentitions are not required for Enrollees with cleft palate or craniofacial cases.
    - Meet one or more of the following criteria (as defined on HLD Index and noted with “X”)
        a. Cleft Palate Deformity
        b. Deep Destructive Overbite
        c. Anterior impaction
        d. Severe Traumatic Deviations
        e. Overjet greater than 9mm
        f. Reverse Overjet greater than 3.5 mm
        g. Severe Maxillary Anterior Crowding, greater than 8mm
    - Comprehensive Orthodontics is also approved when at least one of the automatic qualifying conditions is present, regardless of the HLD index score. Automatic qualifying conditions are identified on the HLD index with an “X.” This value will be scored by our Dental Consultant based on the diagnostic records provided with the Preauthorization request. This is not to imply

that cases scoring less than 28 points do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage. It is important to note that when scoring the HLD Index, you are not diagnosing malocclusion, but simply measuring and/or noting the presence or absence of certain key indicators. We will only cover Medically Necessary orthodontic services.

    - Make the necessary arrangements for ancillary services, such as extractions. Extractions are not included in the fee for the orthodontic treatment but are separately covered under the dental program.

- Reimbursement for comprehensive orthodontic treatment includes all services and supplies, including, but is not limited to:
    - Clinical examination.
    - Diagnostic casts.
    - Photos and 2D cephalometric and panoramic radiographic images.
    - Complete diagnostic records and a written treatment plan.
    - Placement of all necessary appliances to properly treat the Enrollee (both removable and fixed appliances).
    - All necessary adjustments.
    - Removal of appliances at the completion of the active phase of treatment.
    - Placement of retainers or necessary retention techniques.
    - Adjustment of the retainers and observation of the Enrollee for a proper period of time (approximately 18 to 24 months).

7.1.9 Smoking Cessation

Tobacco counseling and behavior management for the control and prevention of oral disease are a Covered Service subject to the following:

- D1320 – Tobacco counseling for an existing tobacco user is a Covered Service when you counsel the Enrollee using the Public Health Service (PHS) Guideline Based Check List (available on the Delta Dental Smiles Website). You must review the PHS Guideline Based Checklist with the Enrollee and indicate the Enrollee's current tobacco use. In order to be reimbursed for the services, a completed PHS Guideline Based Check

List for the Enrollee is required to be submitted with the claim form. You must retain the counseling checklist in the Enrollee's records.

- D9920 – Behavior management is a Covered Service when tobacco counseling to an existing tobacco user is provided to an Enrollee in need of intensive tobacco counseling. In order for the services to be covered you must make a referral to the Arkansas Tobacco Quit Line using the referral form available on the Delta Dental Smiles website. You will receive fax-back confirmation of the referral to the Arkansas Tobacco Quit Line. You must submit a copy of the fax-back confirmation with the claim form for reimbursement.

- Counseling services are limited to no more than two D1320 and two D9920 appointments for a maximum allowable of four (4) per year.

For reimbursement for services provided to an Enrollee under 16 years old, you must submit a "nicotine dependency" letter from the Enrollee's Primary Care Provider (PCP).

7.2 Delta Dental Smiles for Kids Covered Services Code List with Fees and Limitations

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D0120	$26.60	periodic oral evaluation-established patient	Yes	Yes	No	No
D0140	$34.20	periodic oral evaluation-problem focused	Yes	Yes	$10.00 per office visit	No
D0190	$7.98	screening of a patient	Yes	Yes	No	No
D0210	$86.45	intraoral radiographic images - complete series	Yes	Yes	$10.00 per office visit	No
D0220	$18.05	intraoral radiographic images - periapical first	Yes	Yes	$10.00 per office visit	No
D0230	$14.25	intraoral radiographic images - periapical additional	Yes	Yes	$10.00 per office visit	No
D0240	$24.70	intraoral radiographic image - occlusal	Yes	Yes	$10.00 per office visit	No
D0250	$53.20	extraoral radiographic image	Yes	Yes	$10.00 per office visit	No
D0270	$12.35	bitewing – single radiographic image	Yes	Yes	$10.00 per office visit	No
D0272	$24.70	bitewings - two radiographic images	Yes	Yes	$10.00 per office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D0330	$62.70	panographic radiographic image	Yes	Yes	$10.00 per office visit	Yes / required for children under age 6
D0340	$67.45	cephalometric radiographic image	Yes	Yes	$10.00 per office visit	Yes
D0350	$33.25	2D oral/facial photographic image	Yes	Yes	$10.00 per office visit	Yes
D0470	$47.50	diagnostic casts	Yes	Yes	$10.00 per office visit	Yes
D0601 (VAS)	$5.00	caries risk assessment and documentation with finding of low risk	Yes	Yes	No	No
D0602 (VAS)	$5.00	caries risk assessment and documentation with finding of moderate risk	Yes	Yes	No	No
D0603 (VAS)	$5.00	caries risk assessment and documentation with finding of high risk	Yes	Yes	No	No
D1110	$48.45	prophylaxis - child 10 and above including adult	Yes	Yes	$10.00 per office visit	No
D1120	$36.10	prophylaxis - child 0 thru 13	Yes	Yes	$10.00 per office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D1206	$19.95	topical application of fluoride varnish	Yes	Yes	$10.00 per office visit	No
D1208	$19.95	topical application of fluoride - excluding varnish	Yes	Yes	$10.00 per office visit	No
D1320	$25.00	tobacco counseling for the control of oral disease	Yes	Yes	$10.00 per office visit	No
D1351	$28.50	sealant - per tooth	Yes	Yes	$10.00 per office visit	No
D1354 (VAS)	$15.00	application of caries arresting medicament	Yes	Yes	$10.00 per office visit	No
D1510	$171.95	space maintainer - fixed - unilateral	Yes	Yes	$10.00 per office visit	No
D1516	$256.50	space maintainer - fixed – bilateral - maxillary	Yes	Yes	$10.00 per office visit	No
D1517	$256.50	Space maintainer – fixed – bilateral – mandibular	Yes	Yes	$10.00 per office visit	No
D1526	$266.00	space maintainer - removable – bilateral - maxillary	Yes	Yes	$10.00 per office visit	No
D1527	$266.00	Space maintainer – removable – bilateral – mandibular	Yes	Yes	$10.00 per office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D1551	$37.05	Re – cement or re – bond bilateral space maintainer - maxillary	Yes	Yes	$10.00 per office visit	No
D1552	$37.05	Re – cement or re – bond bilateral space maintainer - mandibular	Yes	Yes	$10.00 per office visit	No
D1553	$37.05	Re – cement or re – bond unilateral space maintainer – per quadrant	Yes	Yes	$10.00 per office visit	No
D2140	$65.55	amalgam restoration one surface, primary or permanent	Yes	Yes	$10.00 per office visit	No
D2150	$80.75	amalgam restoration two surfaces, primary or permanent	Yes	Yes	$10.00 per office visit	No
D2160	$94.05	amalgam restoration three surfaces, primary or permanent	Yes	Yes	$10.00 per office visit	No
D2161	$114.95	amalgam restoration four or more surfaces, primary or permanent	Yes	Yes	$10.00 per office visit	No
D2330	$76.95	resin based composite - one surface anterior	Yes	Yes	$10.00 per office visit	No
D2331	$95.95	resin based composite - two surfaces anterior	Yes	Yes	$10.00 per office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D2332	$114.95	resin based composite - three surfaces anterior	Yes	Yes	$10.00 per office visit	No
D2335	$144.40	resin based composite - four or more surfaces anterior or involving incisal angle	Yes	Yes	$10.00 per office visit	No
D2710	$371.45	crown - resin based composite (indirect)	Yes	Yes	$10.00 per office visit	Yes
D2752	$610.85	crown-- porcelain fused to noble metal	Yes	Yes	$10.00 per office visit	Yes
D2920	$43.70	recement or rebond crown	Yes	Yes	$10.00 per office visit	No
D2930	$140.60	prefabricated stainless steel crown - primary tooth	Yes	Yes	$10.00 per office visit	No
D2931	$158.65	prefabricated stainless steel crown - permanent tooth	Yes	Yes	$10.00 per office visit	No
D3220	$86.45	therapeutic pulpotomy- removal of pulp coronal to the dentinocemental junction and application of medicament	Yes	Yes	$10.00 per office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D3221	$92.15	pulpal debridement, primary and permanent teeth	Yes	Yes	$10.00 per office visit	No
D3310	$404.70	endodontic therapy, anterior tooth (excluding final restoration)	Yes	Yes	$10.00 per office visit	No
D3320	$474.05	endodontic therapy, bicuspid tooth (excluding final restoration)	Yes	Yes	$10.00 per office visit	No
D3330	$599.45	endodontic therapy, molar (excluding final restoration)	Yes	Yes	$10.00 per office visit	No
D3410	$380.00	apicoectomy - anterior	Yes	Yes	$10.00 per office visit	No
D4341	$142.50	periodontal scaling and root planning - four or more teeth per quadrant	Yes	Yes	$10.00 per office visit	No
D4910	$66.50	periodontal maintenance	Yes	Yes	$10.00 per office visit	No
D5110	$807.50	complete denture - maxillary	Yes	Yes	$10.00 per office visit	No
D5120	$807.50	complete denture - mandibular	Yes	Yes	$10.00 per office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D5130	$864.50	Immediate denture – maxillary	Yes	Yes	$10.00 per office visit	Yes
D5140	$864.50	Immediate denture – mandibular	Yes	Yes	$10.00 per office visit	Yes
D5211	$570.00	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	Yes	Yes	$10.00 per office visit	No
D5212	$570.00	mandibular partial denture resin base (including any conventional clasps, rests and teeth)	Yes	Yes	$10.00 per office visit	No
D5221	$609.00	Immediate maxillary partial denture – resin base	Yes	Yes	$10.00 per office visit	No
D5222	$609.00	Immediate mandibular partial denture – resin base	Yes	Yes	$10.00 per office visit	No
D5511	$76.95	repair broken complete denture base, mandibular	Yes	Yes	$10.00 per office visit	No
D5512	$76.95	repair broken complete denture base, maxillary	Yes	Yes	$10.00 per office visit	No
D5520	$75.05	replace missing or broken tooth, complete denture (each tooth)	Yes	Yes	$10.00 per office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D5611	$76.95	repair resin partial denture base, mandibular	Yes	Yes	$10.00 per office visit	No
D5612	$76.95	repair resin partial denture base, maxillary	Yes	Yes	$10.00 per office visit	No
D5621	$127.30	repair cast partial framework, mandibular	Yes	Yes	$10.00 per office visit	No
D5622	$127.30	repair cast partial framework, maxillary	Yes	Yes	$10.00 per office visit	No
D5640	$75.05	replace broken teeth - per tooth - partial denture	Yes	Yes	$10.00 per office visit	No
D5650	$97.85	add tooth to existing partial denture	Yes	Yes	$10.00 per office visit	No
D5750	$259.35	reline complete maxillary denture (laboratory)	Yes	Yes	$10.00 per office visit	Yes
D6930	$64.60	recement or rebond fixed partial denture	Yes	Yes	$10.00 per office visit	No
D7111	$47.50	extraction, coronal remnants - decidious teeth	Yes	Yes	$10.00 per office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D7140	$72.20	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Yes	Yes	$10.00 per office visit	No
D7210	$138.70	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Yes	Yes	$10.00 per office visit	No
D7220	$180.50	removal of impacted tooth - soft tissue	Yes	Yes	$10.00 per office visit	No
D7230	$234.65	removal of impacted tooth - partially bony	Yes	Yes	$10.00 per office visit	No
D7240	$268.85	removal of impacted tooth completely bony	Yes	Yes	$10.00 per office visit	No
D7241	$306.85	removal of impacted tooth completely bony w/complication	Yes	Yes	$10.00 per office visit	Yes

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D7250	$158.65	surgical removal of residual tooth roots (cutting procedure)	Yes	Yes	$10.00 per office visit	No
D7270	$211.85	tooth reimplantation or stabilization of accidentally evulsed or displaced tooth	Yes	Yes	$10.00 per office visit	No
D7280	$149.15	exposure of an unerupted tooth	Yes	Yes	$10.00 per office visit	Yes
D7283	$215.05	Placement of device to facilitate eruption of impacted tooth	Yes	Yes	$10.00 per office visit	Yes
D7285	$119.70	incisional biopsy of oral tissue - hard	Yes	Yes	$10.00 per office visit	No
D7286	$110.20	incisional biopsy of oral tissue - soft	Yes	Yes	$10.00 per office visit	No
D7510	$87.40	incision and drainage of abscess - intraoral soft tissue	Yes	Yes	$10.00 per office visit	No
D7630	$680.00	mandible-open reduction (teeth immobilized, if present)	Yes	Yes	$10.00 per office visit	Yes - exclude Oral Surgeons from Mandatory Pre-auth
D7640	$488.00	mandible-closed reduction (teeth immobilized, if present)	Yes	Yes	$10.00 per office visit	Yes - exclude Oral Surgeons from Mandatory Pre-auth

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D7740	$720.00	mandible-closed reduction	Yes	Yes	$10.00 per office visit	Yes - exclude Oral Surgeons from Mandatory Pre-auth
D7961	$189.05	Buccal/labial frenulectomy - frenectomy or frenotomy - separate procedure not incidental to another procedure; buccal / labial frenectomy	Yes	Yes	$10.00 per office visit	Yes
D7962	$189.05	Lingual frenulectomy - frenectomy or frenotomy - separate procedure not incidental to another procedure; lingual frenectomy (frenulectomy)	Yes	Yes	$10.00 per office visit	Yes
D8020	Manually Priced	limited orthodontic treatment-transitional dentition	Yes	Yes	$10.00 per office visit	Yes
D8030	Manually Priced	limited orthodontic treatment-adolescent dentition	Yes	Yes	$10.00 per office visit	Yes

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D8040	Manually Priced	limited orthodontic treatment-adult dentition	Yes	Yes	$10.00 per office visit	Yes
D8070	$3,838.00	comprehensive orthodontic treatment of the transitional dentition	Yes	Yes	$10.00 per office visit	Yes
D8080	$3,924.45	comprehensive orthodontic treatment of the adolescent dentition	Yes	Yes	$10.00 per office visit	Yes
D8090	$4,174.30	comprehensive orthodontic treatment of the adult dentition	Yes	Yes	$10.00 per office visit	Yes
D8210	$624.15	removable appliance therapy	Yes	Yes	$10.00 per office visit	Yes
D8220	$825.55	fixed appliance therapy	Yes	Yes	$10.00 per office visit	Yes
D8670	Part of total fee – monthly payment	periodic orthodontic treatment visit	Yes	Yes	$10.00 per office visit	No
D8999	Manually Priced	unspecified orthodontic procedure, by report	Yes	Yes	No	Yes
D9110	$43.70	palliative (emergency) treatment of dental pain - minor procedure	Yes	Yes	$10.00 per office visit	No
D9222	$95.95	deep sedation/general anesthesia - First 15 minute unit	Yes	Yes	$10.00 office visit	No

Code	Fee	CDT Description	Medicaid/ ARKids-A Covered Service	CHIP/ ARKids-B Covered Service	CHIP/ ARKids-B co-pay (Subject to payment cap)	*Mandatory* Preauthorization Required
D9223	$95.95	deep sedation/general anesthesia - each 15 minute increment	Yes	Yes	$10.00 per office visit	No
D9230	$26.60	inhalation of nitrous oxide/analgesia anxiolysis	Yes	Yes	$10.00 per office visit	No
D9248	$96.74	non-intravenous conscious sedation	Yes	Yes	$10.00 per office visit	No
D9310	$40.13	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes	Yes	$10.00 per office visit	No
D9920	$20.00	behavior management (smoking cessation referral only) by report	Yes	Yes	$10.00 per office visit	No
D9999	Manually Priced	unspecified adjunctive procedure, by report	Yes	Yes	$10.00 per office visit	Yes

7.3 Delta Dental Smiles Coverage

The following describes Covered Services for individuals who DHS determines are eligible for adult Medicaid dental coverage.

At the end of this section we provide you with a summary chart of:

- Covered Services, including applicable billing code and service description
- Current fee
- Whether Preauthorization is required

Some Covered Services are only covered one time in an Enrollee's life, for example, removable full and partial dentures. If Medicaid has already paid for an Enrollee to have one of these services, the Enrollee may not be able to have the service under our plan. You can call us with your questions about these services.

Under Delta Dental Smiles, our adult Medicaid program, Enrollees have a $500 annual maximum benefit. Covered Services to which the $500 annual maximum benefit does not apply are (i) extractions and (ii) removable full and partial dentures. Refer to section 7.4 for a detailed list of procedure codes.

Some services described in this section as not being a Covered Service may be a Covered Service as an EPSDT benefit for someone age 19 or 20. You can contact us for information about these benefits.

7.3.1 Diagnostic and Preventive Services

Evaluations (Exams)

- A periodic evaluation (D0120) is a Covered Service once in a calendar year.
- If a comprehensive exam (D0150, D0160) is submitted, the allowance of a periodic evaluation will be given which is subject to the time limitation.

Periapical X-rays

- Limited to 6 in a calendar year with a limitation of two per office visit.
- Images included in the combination of six per calendar year include all intraoral and extraoral films. (D0220, D0230)

Bitewing X-rays

- Limited to 1 set of 2 films (D0272) per calendar year.

- D0273 and D0274 can be submitted if performed on the same day and will pay as D0272.
- A single film bitewing (D0270) is a Covered Service limited to 1 per office visit with a maximum of 2 per year. This limit applies to the limits set out above for D0272.

Full Mouth Complete Series and Panoramic Radiographic Images

- Covered Services are limited to only one of a complete full mouth series (D0210) or panoramic image (D0330) in a five consecutive year period.
- If a complete full mouth series (D0210) is performed, no additional images will be benefited and the fee is considered to be included in the total fee of the full mouth procedure.
- A panoramic radiographic image (D0330) with additional images such as periapicals, bitewings, or occlusal films, performed on the same dates of service, by the same dentist or dental office, is considered a complete full mouth series (D0210) and benefited as such.
- If multiple images (x-rays) are submitted on the same date of service, they will be combined and given the allowance of a complete full mouth series (D0210) if the total fee is equal or greater than the fee for a full mouth series (D0210). The fee for multiple images (x-rays) should never exceed the allowed fee for a complete full mouth series, D0210.
- Delta Dental utilizes the American Dental Association's Dental Radiographic Examination Guidelines.

Emergency Dental Care

- Limited oral evaluation, problem focused (D0140) is limited to 12 per calendar year.
    - If submitted in conjunction with the seating of a full or partial denture, the fee is not separately billable but is part of the fee of the denture.
- Palliative (emergency) treatment of dental pain (D9110) as needed.
    - Palliative treatment is not a Covered Service when definitive work has been performed on the same date by the same dentist or dental office except for exams and X-rays to diagnose the problem.
    - If a definitive Covered Service is performed on the same date, by you, the more inclusive procedure will be benefited. The remaining services are Not Billable to The Patient
    - and considered as a part of the fee for the more inclusive procedure.
- Delta Dental may request documentation and/or patient's records for Dental Consultant review for multiple submissions of limited, problem focus evaluations and/or Palliative treatment over a period of 6 to 12 months.

Prophylaxis (cleanings)

- Cleanings (D1110) are allowed once in a calendar year.
- One additional cleaning is allowed as a Value Added Service for expectant mothers. The time of eligibility for the additional cleaning is from the beginning of pregnancy through the end of 3 months following the delivery of the child.
- Scaling in the presence of generalized moderate or severe gingival inflammation (D4346) will be payable as a routine cleaning according to the Enrollee's age. The maximum plan allowable fee and time limitations of a routine cleaning will apply.

Fluoride

- D1206 – Topical application of fluoride varnish.
- D1208 – Topical application of fluoride – excluding varnish.
- Topical application of fluoride is covered one time per calendar year.

Sealants

- Sealants are not a Covered Service for adults age 21 and over.

Interim Caries Arresting Medicament Application (Silver Diamine Fluoride)

Silver diamine fluoride (D1354) is a Value Added Service. It is a topical desensitizing and cariostatic agent. It is used by placing a small amount of the solution directly on the affected tooth. Silver diamine fluoride is a minimally invasive treatment that is shown to effectively treat and prevent caries and relieve sensitivity of the teeth.

Since its introduction in the U.S., it has been demonstrated to:

- Effectively arrest or reduce the rate of caries progression.
- Prevent further caries.
- Be a non-invasive procedure that makes it particularly helpful in treating patients with special needs and patients in long term care facilities.
- Be extremely cost effective.

Delta Dental Smiles provides for the application of silver diamine fluoride as follows:

- Allowed up to 2 applications in one calendar year per tooth with a maximum of 4 applications for the life of the tooth.

- Covered Services are limited to treatment of 4 cavitated teeth on the same date of service.
- Once a tooth has been treated with silver diamine fluoride, a restoration is not allowed for 3 months following the date of service of the application.
- A tooth that has had a previous restoration is not eligible for the silver diamine fluoride.
- Once a tooth has been treated with the silver diamine fluoride, a sealant is no longer a Covered Service for that tooth.

Space Maintainers

- Space Maintainers are not a Covered Service for adults ages 21 and over.

Consultations

- Consultations are not a Covered Service for adults ages 21 and over.

7.3.2 Minor Restorations

Amalgam Fillings

- Amalgam fillings are covered once per tooth, per surface in a 24 consecutive month period.
- Fillings are not allowed on a tooth having a crown placed within the first 12 months following the placement of the crown.

Composite Fillings

- Composite fillings are covered for anterior teeth only.
- If a posterior composite is performed, the Covered Service available will be made for the corresponding amalgam.
- Covered Services are limited to once per tooth surface in a 24 consecutive month period.
- Fillings are not allowed on a tooth having a crown placed within the first 12 months following the placement of the crown.

General

- Sedative fillings are not a Covered Service. If a sedative filling is performed in conjunction with a restoration, the fee should be included in the total fee of the restoration.
- The fee for the filling restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct or indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal. These procedures are not separately payable.

7.3.3 Crowns – Single Restorations Only

Prefabricated Stainless Steel (Chrome)

- D2931 – Prefabricated Stainless Steel Crown, permanent teeth, are allowed once per tooth in a five year period and only for posterior teeth with loss of cuspal function. The crown is given as an alternative to a multi-surface filling when the filling material will not suffice.

Major Crown Procedures

- Crowns are not a Covered Service.

Crown Recement

- Crown recementations are not covered within the first 12 months of the placement of the crown.
- After 12 months have passed from the crown placement date, a recement is covered once in a 12 month period per tooth.

Endodontics

- Endodontic Therapy is not a Covered Service.

7.3.4 Periodontics

Periodontal Treatment

Scaling and Root Planing

- When periodontal treatment is requested, a brief narrative of the patient's condition, photograph(s) and radiographs are required.
- Each quadrant to be treated must be indicated on separate lines when requesting Preauthorization or payment.
- If selected for Dental Consultant review, Delta Dental will request a report, a perio chart, and bitewing X-rays of the affected area or areas which show evidence of bone loss, numerous 4-5 mm pockets and obvious calculus.
- If more than two quadrants of scaling and root planing are performed on the same date of service, claim submission for payment shall include:
    - A narrative, including treatment time, to justify extenuating circumstances for completing in one appointment,
    - Patient treatment record including type and amount of anesthesia
    - Current periodontal charting (including clinical attachment levels), and

    - Diagnostically acceptable preoperative periapical and bitewing radiographs to document bone loss, dated and marked right and left.
- Scaling and root planing is a Covered Service once per quadrant in any 24 consecutive month period.

Periodontal Maintenance

- Periodontal Maintenance is a Covered Service for patients with documented or prior history claims of active periodontal therapy for periodontal disease. This is a Covered Service once in a calendar year.
- Qualifying Periodontal Maintenance can be performed 30 days following periodontal therapy.
- One additional periodontal maintenance is allowed during the calendar year as a Value Added Service for individuals with documented diagnosis of periodontal disease with history of periodontal therapy.

Full Mouth Debridement

- Full mouth debridement is performed to enable comprehensive evaluation and diagnosis.
- It is limited to once per lifetime.

7.3.5 Removable Prosthetic Services

Removable Complete and Partial Dentures

- Billing date for removable prosthetic appliances is the delivery date to the Enrollee.
- Only permanent teeth are eligible for partial denture replacement.
- Covered Services for removable full and partial dentures are allowed 1 per arch, per lifetime, regardless of whether delivered as conventional or immediate dentures.
- Immediate partial dentures (D5221 and D5222) are not subject to mandatory Preauthorization
- The fee for a diagnostic cast in preparation of a removable full or partial denture is included in the cost of the prosthesis, and not separately payable.
- One removable complete conventional denture, or removable complete immediate denture, is a Covered Service once per arch in a lifetime.
- One removable partial conventional denture or removable partial immediate denture is a Covered Service once per arch in a lifetime.
- An Enrollee must be missing two or more posterior teeth on at least one side of the mouth for a partial denture to be a Covered Service. This does not include a second and third molar in that quadrant.

- A partial denture may be a Covered Service if the Enrollee is missing an anterior tooth.
  You are responsible for any necessary adjustments and exams for the first six months in this process. These are not a separate Covered Service.

Immediate Complete and Partial Dentures

- Immediate complete and partial dentures are delivered on the date of service for the last anterior tooth extraction.
- In order for an immediate complete denture to be Preauthorized, all posterior teeth distal to the canines must be extracted a minimum of 6 weeks prior to the Preauthorization for the immediate denture. Immediate dentures delivered without the mandatory Preauthorization will be denied and not billable to the Enrollee.
- One removable complete conventional denture, or removable complete immediate denture, is a Covered Service once per arch in a lifetime.
- One removable partial conventional denture, or removable partial immediate denture, is a Covered Service once per arch in a lifetime.
- Immediate complete dentures require Preauthorization and a signed consent form prior to delivery. Immediate partial dentures do not require preauthorization prior to deliver. See the Immediate Dentures Preauthorization Requirements and Submission section below for a full list of Preauthorization requirements for immediate complete dentures.
- You agree to make every reasonable effort to provide follow-up care to ensure that any immediate denture is serviceable to the enrollee since it is a once in a lifetime benefit.
- By providing immediate dentures, you agree and recognize that you are subject to chart audits to validate compliance with post-delivery follow-up and care. Failure to demonstrate reasonable effort to do so will result in a refund request.
- If you receive excessive complaints regarding immediate dentures, you may be subject to restriction from providing immediate dentures to future Medicaid enrollees and possible termination of your provider agreement.
- You must advise the enrollee of the increased need for and importance of making and keeping appointments after delivery of the denture(s).
- The Enrollee must sign the Immediate Denture consent form available on the Delta Dental Smiles website, www.deltadentalsmiles.com, and acknowledge that they understand the importance of and need for aftercare. They also acknowledge they have the ability and commitment to make and keep needed appointments after the delivery of the dentures.

- CDT Code D0140 or any other exam fees cannot be charged in conjunction with any procedures related to the immediate dentures within the first 6 months of delivery.
- All adjustments, tissue conditioners and relines needed to result in a comfortable, properly functioning denture will be included in the fee for the first 6 months following delivery.

Immediate Complete Denture Preauthorization Requirements and Submission Documents

- In order for an immediate complete denture to be Preauthorized, all posterior teeth distal to the canines must be extracted a minimum of 6 weeks prior to the Preauthorization for the immediate denture. Immediate dentures delivered without the mandatory Preauthorization will be denied and not billable to the Patient.

- Submission and approval of a Preauthorization request is required for payment of an immediate complete denture. This Preauthorization request must contain the following:

    i. Documentation of all posterior teeth distal to the canines extracted a minimum of 6 weeks prior to the date of the Preauthorization request.
    ii. Acceptable documentation can include prior claim(s) of extracted posterior teeth detailing date of 6 weeks prior and/or panoramic film documenting the absence of the required missing teeth.
    iii. Signed consent form (*see consent form available on the Delta Dental Smiles website, www.deltadentalsmiles.com)
- Preauthorization should be submitted as any other claim. See Section 8.0. Claims and Preauthorization.
- Following receipt of an approved Preauthorization request from Delta Dental Smiles, you must verify the Enrollee's eligibility again prior to delivery of the immediate denture. Even though a service is preauthorized, the enrollee MUST be eligible on the final delivery date of the immediate denture. .
- After the request for preauthorization is approved, the immediate denture can be delivered. If the immediate denture is delivered before preauthorization approval, the claim will be denied and the enrollee must not be billed for the service.
- The consent form can be located in the Delta Dental Smiles website under Forms and Resources. This is accessible from DOT through a link in the Announcement section.

Lab Services

- You may choose the lab from which a denture or partial is fabricated for an Enrollee.
- You are responsible for the quality of materials used in the complete or partial denture as described in Section 3.11. This information must be retained as part of the Enrollee's record and made available to us upon request.
- As described in Section 3.11, we will recoup reimbursement made from you if the quality standards are found not to have been met.
- Lab fees are not separately reimbursed. The fee for a complete or partial denture is included in the fee reimbursed for the appropriate code.

Billing

- Billing date for removable prosthetic appliances is the delivery date to the Enrollee.
- You will use the following applicable CDT codes when submitting a claim for a complete denture or partial denture:
    - D5110: Complete denture – maxillary
    - D5120: Complete denture – mandibular
    - D5130: Immediate denture – maxillary
    - D5140: Immediate denture - mandibular
    - D5211: Maxillary partial denture – resin base
    - D5212: Mandibular partial denture – resin base
    - D5221: Immediate maxillary partial denture – resin base
    - D5222: Immediate mandibular partial denture – resin base

Lab fees are included in the billing of a D5110, D5120, D5130, D5140, D5211, D5212, D5221 and D5222. The denture fees do not apply to the Enrollee's $500.00 annual maximum benefit.

Diagnostic Casts and Limited Oral Evaluation for Adult Denture Program

- Limited oral evaluations, D0140, are not a Covered Service for complete denture or partial denture fabrication.
- Diagnostic casts, D0470, are not a Covered Service for complete denture or partial denture fabrication.

Adjustments of Full Dentures

- D5410 – Adjust Complete Denture – Maxillary
- D5411 – Adjust Complete Denture - Mandibular

- D5421 – Adjust Partial Denture – Maxillary
- D5422 – Adjust Partial Denture – Mandibular
- Adjustments for the first six (6) months following delivery are included in the appropriate complete/partial denture CDT code. After the first six (6) months, an Enrollee is entitled to one adjustment per arch in any twelve (12) consecutive month period.

Repairs

- Repairs are limited to once in a three (3) year period.
- Codes D5511 and D5512 for the repair of dentures are Covered Services.
- Code D5520 for replacing a missing or broken tooth on a complete denture is a Covered Service.
- Codes D5611, D5612 and D5640 for the repair of a removable partial denture are Covered Services.
- Adding a tooth to a partial (D5650) is a Covered Service when additional extractions are performed with the addition to the partial for replacing the missing tooth/teeth.

Rebases

- Rebases are not a Covered Service.

Relines

- Relines are a Covered Service for a complete maxillary (upper) denture reline (D5730) and a complete mandibular (lower) denture reline (D5731).
- Denture relines are limited to once in a 3 year period following one (1) year after delivery.

Dental Consultant Review May Be Required

- A claim for a repair or adding a tooth to an existing partial denture may require Dental Consultant review for which you may be required to submit documentation along with the requested radiographs. Documentation should include a treatment plan and, if a partial denture, tooth numbers to be replaced.
- If you are requested to provide documentation and radiographs for a claim on repairs or adding a tooth to an existing partial, you must include the date of the initial placement of the partial and the treatment plan and/or narrative as to the reason for repair.

Fixed Partial Dentures and/or Fixed Partial Denture Repair

- Fixed partial dentures and fixed partial denture repairs are not a Covered Service.

Fixed Partial Denture Recementation

- Fixed partial denture recementation is a Covered Service once in a 12 month period after 12 months have passed since the insertion of the prosthesis. Please include the date of insertion of the fixed partial denture being repaired along with the teeth numbers included in the fixed partial denture unit.

7.3.6 Oral Surgery

Dental Consultant Review May Be Required

- A claim may require our review at any time for which you may be required to submit documentation along with the requested preoperative x-rays. Documentation should include treatment plan, tooth number(s), clinical notes, and/or narrative as requested. If you have any questions we encourage you to consider doing a Predetermination review.

Routine (non-surgical) Extractions

- D7140 extractions may be performed without Preauthorization but are subject to Dental Consultant review.

Surgical Extractions

- When a simple extraction evolves into a surgical extraction, you may be requested to write a brief explanation of the circumstances along with a preoperative X-ray.
- Surgical extractions may require Dental Consultant review and/or Preauthorization. See list provided.
- Surgical extractions performed on an Emergency Dental Care basis for the relief of pain may be reimbursed subject to the approval of a Dental Consultant. In these cases, the claim with radiograph and a brief explanation should be submitted to Delta Dental. The fee for surgical extraction includes local anesthesia and routine postoperative care.

Other Oral Surgery Procedures

- Removal of incisional biopsy of soft (D7285) or hard oral tissue (D7286) requires a copy of the pathology report attached to the submitted claim.
- Alveoloplasty (D7310) is covered for adults ages 21 and over. This is performed in conjunction with extractions of four or more teeth per quadrant and is payable up to 90 days following the date of extractions.

- Alveoloplasty (D7311) is covered for adults ages 21 and over. This is performed in conjunction with extractions of three or less teeth per quadrant and is payable up to 90 days following the date of extractions.
- Incision and drainage of an abscess (D7510) is a Covered Service as long as no other definitive work is being done on that day.
    - If other definitive work is done on the same date of service as the incision and drainage (D7510) by you or your office, including root canals, periodontal therapy, and/or oral surgery, the fee of D7510 would be considered Not Billable to The Patient and must be included in the total fee of the definitive service.

7.3.7 Deep Sedation/General Anesthesia

- Deep Sedation/General Anesthesia is not a Covered Service for adults ages 21 and over.
- Deep Sedation/General Anesthesia may be a Covered Service for someone age 19 or 20 as an EPSDT benefit if Medically Necessary; the requirements and limits described in Section 7.1.7 apply.
    - D9248 or D9230 are not allowed on the same date as the deep sedation codes D9222 and D9223.

7.3.8 Orthodontics

- Orthodontic treatment is not a Covered Service for adults ages 21 and over.
- Orthodontics may be a Covered Service for someone age 19 or 20 as an EPSDT benefit if Medically Necessary.

7.3.9 Smoking Cessation

Tobacco counseling and behavior management for the control and prevention of oral disease are a Covered Service on a current tobacco user subject to the following:

- D1320 – Tobacco counseling for an existing tobacco user is a Covered Service when you counsel the Enrollee using the Public Health Service (PHS) Guideline Based Check List (available on the Delta Dental Smiles Website). You must review the PHS Guideline Based Checklist with the Enrollee and indicate the Enrollee's current tobacco use. In order to be reimbursed for the services, a completed PHS Guideline Based Check List for the Enrollee is required to be submitted with the claim form. You must retain the counseling checklist in the Enrollee's records.

- D9920 – Behavior management is a Covered Service when tobacco counseling to an existing tobacco user is provided to an Enrollee in need of intensive tobacco counseling. In order for the services to be covered you must make a referral to the Arkansas Tobacco Quit Line using the referral form available on the Delta Dental Smiles website. You will receive fax-back confirmation of the referral to the Arkansas Tobacco Quit Line. You must submit a copy of the fax-back confirmation with the claim form for reimbursement.

- Counseling services are limited to no more than two D1320 and two D9920 appointments for a maximum allowable of four (4) per year.

- For Enrollees age 21 and over, the cost for tobacco counseling and behavior management apply towards the Enrollee's $500.00 annual maximum benefit.

7.4 Delta Dental Smiles COVERED SERVICES CODE LIST WITH FEES

Code	Fee	CDT Description	Medicaid Adult Covered Service	*Mandatory* Preauthorization Required
D0120	$26.60	periodic oral evaluation-established patient	Yes	No
D0140	$34.20	periodic oral evaluation-problem focused	Yes	No
D0210	$86.45	intraoral radiographic images - complete series	Yes	No
D0220	$18.05	intraoral radiographic images - periapical first	Yes	No
D0230	$14.25	intraoral radiographic images - periapical additional	Yes	No
D0270	$12.35	bitewing – single radiographic image	Yes	No
D0272	$24.70	bitewings - two radiographic images	Yes	No
D0330	$62.70	panoramic radiographic image	Yes	No
D0470	$47.50	diagnostic casts	Yes	Yes
D1110	$48.45	prophylaxis	Yes	No
D1206	$19.95	Topical application of fluoride varnish	Yes	No
D1208	$19.95	topical application of fluoride - excluding varnish	Yes	No

Code	Fee	CDT Description	Medicaid Adult Covered Service	*Mandatory* Preauthorization Required
D1320	$25.00	tobacco counseling for the control of oral disease	Yes	No
D1354 (VAS)	$15.00	interim caries arresting medicament application	Yes	No
D2140	$65.55	amalgam restoration one surface, primary or permanent	Yes	No
D2150	$80.75	amalgam restoration two surfaces, primary or permanent	Yes	No
D2160	$94.05	amalgam restoration three surfaces, primary or permanent	Yes	No
D2161	$114.95	amalgam restoration four or more surfaces, primary or permanent	Yes	No
D2330	$76.95	resin based composite - one surface anterior	Yes	No
D2331	$95.95	resin based composite - two surfaces anterior	Yes	No
D2332	$114.95	resin based composite - three surfaces anterior	Yes	No
D2335	$144.40	resin based composite - four or more surfaces anterior or involving incisal angle	Yes	No
D2920	$43.70	Recement or rebond crown	Yes	No

Code	Fee	CDT Description	Medicaid Adult Covered Service	*Mandatory* Preauthorization Required
D2931	$158.65	prefabricated stainless steel crown - permanent tooth	Yes	No
D4341	$142.50	periodontal scaling and root planning - four or more teeth per quadrant	Yes	No
D4355	$93.10	full mouth debridement to enable comprehensive evaluation and diagnosis	Yes	No
D4910	$66.50	periodontal maintenance	Yes	No
D5110	$474.00	complete denture - maxillary	**Yes –** Not Subject to $500.00 Cap per Calendar Year	No
D5120	$474.00	complete denture - mandibular	**Yes –** Not Subject to $500.00 Cap per Calendar Year	No
D5130	$531.00	Immediate denture – maxillary	**Yes –** Not Subject to $500.00 Cap per Calendar Year	Yes
D5140	$531.00	Immediate denture – mandibular	**Yes –** Not Subject to $500.00 Cap per Calendar Year	Yes

Code	Fee	CDT Description	Medicaid Adult Covered Service	*Mandatory* Preauthorization Required
D5211	$395.00	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	Yes – Not Subject to $500.00 Cap per Calendar Year	No
D5212	$395.00	mandibular partial denture resin base (including any conventional clasps, rests and teeth)	Yes– Not Subject to $500.00 Cap per Calendar Year	No
D5221	$434.00	Immediate maxillary partial denture – resin base	Yes– Not Subject to $500.00 Cap per Calendar Year	No
D5222	$434.00	Immediate mandibular partial denture – resin base	Yes– Not Subject to $500.00 Cap per Calendar Year	No
D5410	$41.80	adjust complete denture maxillary	Yes	No
D5411	$41.80	adjust complete denture mandibular	Yes	No
D5421	$41.80	adjust partial denture maxillary	Yes	No
D5422	$41.80	adjust partial denture mandibular	Yes	No
D5511	$76.95	repair broken complete denture base, mandibular	Yes	No
D5512	$76.95	repair broken complete denture base, maxillary	Yes	No

Code	Fee	CDT Description	Medicaid Adult Covered Service	*Mandatory* Preauthorization Required
D5520	$75.05	replace missing or broken tooth, complete denture (each tooth)	Yes	No
D5611	$76.95	repair resin partial denture base, mandibular	Yes	No
D5612	$76.95	repair resin partial denture base, maxillary	Yes	No
D5640	$75.05	replace broken teeth - per tooth - partial denture	Yes	No
D5650	$97.85	add tooth to existing partial denture	Yes	No
D5730	$163.40	reline complete maxillary denture (chairside)	Yes	No
D5731	$163.40	reline complete mandibular denture (chairside)	Yes	No
D6930	$64.60	recement or rebond fixed partial denture	Yes	No
D7140	$72.20	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Yes – Not Subject to $500.00 Cap per Calendar Year	No
D7210	$138.70	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Yes – Not Subject to $500.00 Cap per Calendar Year	No

Code	Fee	CDT Description	Medicaid Adult Covered Service	*Mandatory* Preauthorization Required
D7220	$180.50	removal of impacted tooth - soft tissue	**Yes** – Not Subject to $500.00 Cap per Calendar Year	No
D7230	$234.65	removal of impacted tooth - partially bony	**Yes** – Not Subject to $500.00 Cap per Calendar Year	No
D7240	$268.85	removal of impacted tooth completely bony	**Yes** – Not Subject to $500.00 Cap per Calendar Year	No
D7241	$306.85	removal of impacted tooth completely bony w/complications	**Yes** – Not Subject to $500.00 Cap per Calendar Year	Yes
D7250	$158.65	surgical removal of residual tooth roots (cutting procedure)	**Yes** - Not Subject to $500.00 Cap per Calendar Year	No
D7285	$119.70	incisional biopsy of oral tissue - hard	Yes	No
D7286	$110.20	incisional biopsy of oral tissue - soft	Yes	No
D7310	$135.85	alveoloplasty in conjunction with extractions--four or more teeth or tooth spaces, per quadrant	Yes	No
D7311	$104.50	Alveoloplasty in conjunction with extractions—one to three teeth, per quadrant	Yes	No

Code	Fee	CDT Description	Medicaid Adult Covered Service	*Mandatory* Preauthorization Required
D7472	$249.85	removal of torus palatinus	Yes	No
D7473	$249.85	removal of torus mandibularis	Yes	No
D7510	$87.40	incision and drainage of abscess - intraoral soft tissue	Yes	No
D9110	$43.70	palliative (emergency) treatment of dental pain - minor procedure	Yes	No
D9920	$20.00	behavior management (smoking cessation referral only) by report	Yes	No

7.5 Billing and Collecting for Services Not Paid By Delta Dental

After a claim is processed we issue you an Explanation of Payment (EOP)/Remittance Advice (RA). If some procedures or services on your claim are Denied or are determined to be Not Billable to The Patient, the EOP/RA will state whether you can bill and collect payment from the Enrollee.

If the EOP/RA does not expressly state you can bill and collect payment from the Enrollee, then you are not allowed to seek payment from them.

However, if the EOP/RA states you can bill and collect payment from the Enrollee, you may do so only if the Enrollee has agreed in writing to pay for that procedure or service before the service is provided. The Enrollee's signed agreement must include a statement that:

1. Describes the service(s) to be provided;
2. Explains the Enrollee is responsible for paying you for the service(s); and
3. Reflects Delta Dental of Arkansas will not pay for the service(s).

You should keep the Enrollee's signed agreement in your files in case there is ever a concern raised by the Enrollee about a billing statement they receive from you. You should be ready to share a copy of the signed agreement with us if we request it.

For Covered Services, the fee you charge the Enrollee plus any amount paid by us cannot exceed the Maximum Allowed Amount. Even if you believe that a Covered Service is Not Billable to The Patient in whole or in part because of a frequency limitation, or because the Enrollee has exceeded their Contract Year Maximum, you must still submit the claim to Delta Dental of Arkansas so that the Maximum Allowed Amount can be calculated.

For services that were Denied because they were not reimbursable, the fee you charge the Enrollee cannot exceed your normal Billed Charge for the service. We may ask you for supporting documents that confirm your normal Billed Charge if we have questions.

If you do not have a signed agreement from the Enrollee, then you cannot seek payment from them.

8.0 CLAIMS AND PREAUTHORIZATIONS

8.1 Claim Filing

You must use an American Dental Association (ADA) claim form (or another form as prescribed and as may be modified by Delta Dental from time to time, see Appendix A) for all Covered Services rendered to Enrollees for which a charge is made. Each claim form may contain charges for only one Enrollee.

Additionally, your Participation Agreement requires you to follow Delta Dental's claims and payment requirements, which cover billing instructions and claim filing timelines. See a list of ADA procedure codes covered by Delta Dental Smiles in section 7.4 and Delta Dental Smiles for Kids in section 7.2.

You must complete and submit to us the ADA claim form when:

- Billing for services using ADA procedure codes
- Requesting Preauthorization or a Predetermination Estimate Request

Once Preauthorized services are provided, you should submit to us the Preauthorization request dated and signed for payment instead of submitting a new claim. For additional information about Preauthorization requests, see section 8.12.

Claims should be submitted electronically whenever possible. Submitting claims electronically generally reduces processing time and makes the billing and tracking of documents easier. Claims can be submitted electronically using a claims clearing house or via our online portal, the Dental Office Toolkit (DOT). To access DOT go to www.deltadentalsmiles.com and click Login at the top right of the page. For more information on DOT see section 9.1.

If you are unable to submit claims electronically, you may mail paper claims to the address below:

Delta Dental of Arkansas
Attn: Claims
PO Box 6247
Sherwood, AR 72124

You should carefully read and follow the instructions outlined in this manual so that your claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Handwritten claims must be completed neatly and accurately.

8.2 Electronic Claims

Electronic claims can be submitted through DOT. To see a full explanation of how to use DOT or setting up a DOT account see section 9.1.

To submit an electronic claim via DOT:

- Log in to the toolkit at www.deltadentalsmiles.com
- Locate the “Patient Info/Enter Claims” link on the Navigation Bar
- Look up the Patient
- Click the “Add Claim” icon
- Enter the applicable information for the claim in the fields

All types of requests can be submitted via DOT, including but not limited to:

- Claims submitted for payment
- Predetermination Estimate Requests
- Preauthorization requests

Claims with radiographs and/or other attachments can be submitted electronically through NEA or RSS. Or you can submit the claim via DOT and wait for an Information Request requesting the additional information required for claim processing. For more information, see section 8.2 regarding Electronic Attachments.

With direct deposit, you can check DOT daily to access the information necessary to reconcile your accounts. For more information on Direct Deposit see section 8.10.

8.3 Paper Claims

Paper claims must be submitted on an ADA approved claim form. The patient’s name, identification number and date of birth must be listed on all claims filed. If this information is missing, the patient cannot be identified which could result in the claim being returned and cause a delay in payment.

Paper claims you submit must have your signature along with your valid tax identification number, license number, and a treating address. The date of service must be provided on the claim form for each service line submitted, and each line must have an approved ADA dental code used to identify all services. (Dates of service are not required for Preauthorization requests or Predetermination Estimate Requests.)

8.4 Claim Attachments

Delta Dental accepts electronic attachments through National Electronic Attachments (NEA) and Tesia Clearinghouse. The attachment must be sent with an electronic claim filed either through the Dental Office Toolkit (DOT) or an electronic clearinghouse. If you receive a "Request for Additional Information" (Information Request) from us, you may submit an electronic attachment without a claim if you submit the claim number within the NEA/Tesia attachment. For best results, submitting the Information Request will speed up the processing.

For more information about NEA visit www.welcometonea.com. For more information about Tesia Clearinghouse visit www.tesia.com.

Delta Dental will not return radiographs unless submitted with a self-addressed, stamped envelope. When radiographs are needed, please send duplicates only; do not send us the originals. Be sure to properly identify and date the copy of the image.

8.5 Reconsideration of Claims

Before you decide to file a Grievance or Appeal with us if you do not agree with a decision we made in processing a claim or with respect to a Preauthorization or Predetermination Estimate Request, you may consider asking us to reconsider our initial decision. To request a reconsideration you should:

- Send an inquiry requesting the reconsideration. The most convenient way to submit your request is through the Inquiry feature in our Dental Office Toolkit (DOT).
- Document the reasons why we should reconsider the original decision and outline what new information, if any, is being submitted.
- Provide all appropriate review documentation (e.g., narrative, patient treatment record, radiographs, etc.).
- Include your name, patient's name and the patient identification number on all documents.

You can also send the reconsideration request and supporting documents via the following:

- Fax Number: 1-833-866-4650
- Call Customer Service: 1-866-864-2499

If you request to have a claim reconsidered, it will be reviewed by a licensed Arkansas dentist located in the State. If after we have considered your request for a reconsideration you still do not agree with our decision, you can still initiate an Appeal using the process described in Grievances & Appeals as long as the time to initiate the Appeal has not expired.

Asking for a reconsideration does not change the deadline you have for initiating an Appeal.

Within one business day of a request by the Participating Dentist, a Dental Consultant (clinical peer reviewer) making the initial determination will discuss the non-certification decision with the Participating Dentist, if available. If unavailable, a different clinical peer (Dental Consultant) will review the system notes and have the conversation with the Participating Dentist.

8.6 Payment of Claims

We pay for all Medically Necessary Covered Services provided to Enrollees, up to the maximum Benefit amounts, including Medically Necessary Covered Services that are Denied by Delta Dental's Utilization Management process but are later overturned by DHS, an administrative law judge, or upon judicial or appellate review.

An Enrollee who receives Medically Necessary Covered Services is not responsible for paying the costs of such services, other than applicable coinsurance, unless the Enrollee has exhausted their annual maximum and you have obtained a written agreement from the Enrollee prior to the performance of the service in accordance with Section 7.5 of this Manual.

If you recommend treatment that is not reimbursable under the applicable Delta Dental Smiles Enrollee's plan or policy, you are prohibited from collecting any amount from the Enrollee for such a service unless you have complied with Section 7.5 of this Manual.

8.7 Third Party Liability

If an Enrollee has other dental insurance, that insurance will pay before we pay unless there is an exception under the law. We do not pay co-payments for other insurance. As the Enrollee's dentist, you should be alert to the possibility of there being other sources of payment and you must bill the other dental carrier before you bill us.

We pay the difference between the amounts paid by the Enrollee's other dental carrier and our maximum allowed amount. We will not make any

payment if the amount you receive from the Enrollee's other dental carrier is equal to or greater than our maximum allowed amount.

We may not pay anything after the Enrollee's other dental carrier pays. You may not bill or collect from the Enrollee.

If both the Enrollee's other dental carrier and we pay for the same service, you must reimburse us the amount we paid.

8.8 Provider Preventable Conditions

Under the Patient Protection and Affordable Care Act (the ACA) and federal regulations at 42 CFR 447.26, as a Medicaid provider you must report Provider Preventable Conditions to us. We are prohibited from paying you for Provider Preventable Conditions.

Under existing law, examples of a Provider Preventable Condition are the wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

8.9 Payment to Federally Qualified Health Care Centers (FQHCs)

Under our contract with DHS, we are not responsible for cost settlements with Federally Qualified Healthcare Centers (FQHCs). Instead, DHS has retained responsibility for ensuring that FQHCs receive the rate required under the prospective payment system.

8.10 Direct Deposit

You have the option of receiving payment from us via paper check or electronic funds transfer (EFT). Our EFT process offers many benefits such as faster payment, lower overhead for your office because payment goes right into your designated account, with no risk of lost, stolen, counterfeit, or altered checks.

If you elect payment by direct deposit, after a claim is paid you can access electronic copies of the Explanation of Payment (EOP)/ Remittance Advice (RA) via DOT. You can check DOT daily to access the information necessary to reconcile your accounts. For more information on the DOT see section 9.1.

You also have the option of receiving the EOP/RA in the form of an electronic remittance advice (ERA 835 ANSI X12N 5010A1 format). Contact us for more information on the availability of receiving these files.

8.11 Record of Services

You must keep accurate and complete dental and financial records that support the type and extent of services you provide to Enrollees and you bill to us. These records must be retained for at least ten (10) years following termination of your Participation Agreement.

Delta Dental uses the Universal Tooth numbering system to identify tooth numbers, mouth quadrants and tooth surfaces for both children and adults.

The numbering system identifies permanent and supernumerary teeth and an alpha arrangement to identify both regular and deciduous supernumerary teeth. Specifically:

- Valid values for regular permanent teeth include the numbers 1 through 32.
- Numbers 51 through 82 indicates supernumerary permanent teeth.
- Alpha letters A through T indicate regular deciduous teeth.
- AS through TS indicate supernumerary deciduous teeth.

The mouth is divided into four quadrants: upper right (UR), upper left (UL), lower right (LR) and lower left (LL). When filing a claim, use the following codes to identify the quadrants of the mouth:

Quadrant	Code
Upper right	10
Upper left	20
Lower left	30
Lower right	40

In addition to identifying the tooth number, some Dental Services require identification of the tooth surface. The following single letter codes are used to identify surfaces:

Surface	Code
Buccal	B
Distal	D
Facial	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

When completing a claim form, list all tooth numbers, quadrants and surfaces for dental codes that necessitate identification. Otherwise, there may be a

delay in or denial of claim payment. Refer to the Current Dental Terminology (CDT) Manual for a tooth chart.

8.12 Preauthorization Requests

Certain Covered Services require Preauthorization for all Participating Dentists. We may make exceptions at our discretion to this requirement for some Specialists depending on the service intended to be provided.

The determination of Medical Necessity is necessary for Preauthorization, and procedures requiring Preauthorization must be approved by Delta Dental before the treatment is provided. Refer to the section 7.0 for a complete list of Covered Services and Provider types that require Preauthorization.

Delta Dental does not require Preauthorization for:

- Medically Necessary pediatric preventive services.
- Diagnostic dental services.
- Services provided to patients with a specific symptomatic problem, such as dental pain.
- Dental emergencies, such as trauma or acute infection.

We will not pay for a Covered Service that requires Preauthorization if the treatment is not approved by us prior to being provided. When this happens the service(s) are Not Billable to The Patient and the Billed Charges will be your responsibility. You will not be able to bill and collect from the Enrollee.

Preauthorization requests that have been approved by us will be valid for 12 months from the date of our approval, as long as the Enrollee has not lost eligibility for coverage by the time the services are provided. After 12 months, you will be required to submit a new Preauthorization request. If the Enrollee loses eligibility and regains eligibility during this 12 month period, the Preauthorization may still be valid as long as the 12 months have not lapsed. In this event, you should confirm the Preauthorization is still valid prior to providing services by calling us or resubmitting a Preauthorization.

To submit a Preauthorization request, file a claim with us using any of the same methods available under Claim Filing previously described in this section. The only difference for Preauthorization is that you will leave the date of service on the claim blank. To submit a Preauthorization request, you follow the same requirements for submitting a claim for payment. Be sure to include all required documentation with your Preauthorization requests.

Preauthorization requests will be reviewed by us similar to the way we review a claim with a date of service. We check frequency limitations, age limitations, benefit limits, and other information deemed necessary to make a decision.

Once we make a decision with respect to a Preauthorization request, whether approved or not, we will send you a Pretreatment Estimate voucher to let you know our decision.

Once you provide the approved Dental Services, you should return the Pretreatment Estimate voucher dated and signed by you for payment instead of submitting a new claim.

8.13 Predetermination Estimate Requests

A Predetermination Estimate Request is different than a Preauthorization request.

A Preauthorization request is required in order to have some Covered Services paid for by us.

In contrast, there is no requirement for a Predetermination Estimate Request to be done. Instead, if you would like, you can have an estimate done by us prior to your providing treatment to an Enrollee by filing a claim with us and leaving the date of service blank.

We process Predetermination Estimate Requests like a claim submitted for payment. We then advise you of the expected results via a Pretreatment Estimate voucher. Once the treatment is performed, simply date, sign and return the voucher to us for processing.

A Predetermination Estimate is not a guarantee of payment but rather an estimate of what will pay if the claim is approved based on medical necessity, clinical guidelines and plan policies.

9.0 ADDITIONAL RESOURCES

9.1 Provider Web Portal (Dental Office Toolkit)

The Dental Office Toolkit (DOT) is a free internet site that allows you as a Participating Dentist and your staff to have the ability to sign on to our secure, HIPAA compliant, online system. DOT offers the following functionality:

- View patient information
- Check eligibility and Covered Services
- Submit, review and manage claims with real-time adjudication
- Submit Preauthorization's and Predetermination Estimate Requests
- View claims history
- Access education-focused materials
- View Explanation of Payments (EOPs)
- Send electronic attachments to us
- Manage user accounts
- Change your email address
- Enroll in direct deposit

DOT enrollment allows you to send Predetermination Estimate Requests and Preauthorization requests and claims directly from your office to Delta Dental. DOT gives you the option of receiving claims-related information, Explanation of Benefits (EOB's), and EFT data electronically from us.

DOT is available 24 hours a day, 7 days a week, except during updates and maintenance, from any location where you have internet access.

To access DOT:

- Visit www.deltadentalsmiles.com
- Click Log In/Register in the top right corner

If you do not have a DOT account, click register to create an account. To register for DOT, you must have a valid dental license number, tax ID number (TIN), and service office location. You can only have one TIN per DOT account, but you can have more than one DOT account per TIN.

9.2 Translation Services

Delta Dental provides a language translation service to all Delta Dental Smiles and Delta Dental Smiles for Kids Participating Dentists at no cost. Costs for the services are billed directly to Delta Dental. If you have a language barrier with an Enrollee, Voiance will provide translation services for you. You can either conference Voiance into a call between you and the Enrollee or use a speaker phone if the non-English speaking patient is in your office. Voice and video calls are available.

How to Access These Services:

1. Dial Voiance at 1-844-648-5669
2. Enter your 4 digit Arkansas license number
3. Say the language you need
4. Select if you would like to add an additional person to the call
5. When the interpreter comes on the line:
    - Give the interpreter a brief explanation of the call
    - Speak in the first person
    - Avoid slang, jargon or metaphors
    - Allow clarification in linguistic or cultural issues

Need assistance using these services? Say "Client Services" or press 0 at the language request prompt.

Voiance Mobile App

Voiance also offers a mobile app to assist you with translations with your Enrollees. To use the app following these steps:

1. Download the app from the app store
2. Set up an account using the following information:
   User email: Voiance@deltadentalar.com
   Password: Delta Dental2017
3. Activate the app
4. Select language (including sign language)
5. Voice or Video calls are available

9.3 Transportation

Medicaid and ARKids First A Enrollees will continue to have non-emergent transportation (NET) provided through the Division of Medical Services (DMS). Enrollees access this service by calling their regional broker or by calling our Customer Service Representatives at 1-866-864-2499 and they will help arrange transportation for Enrollees. Transportation needs to be arranged 48 hours prior to the Enrollee's appointment.

10.0 ENROLLEE RIGHTS

Enrollees have rights through Delta Dental Smiles and Delta Dental Smiles for Kids. The Enrollee can locate these in the Enrollee Handbook. These rights are:

- To be treated with respect, dignity and privacy.
- To receive care -- race, color, nationality, disability, sex, religion or age do not matter.
- To get correct, easy to understand information to help them make good choices.
- To file a complaint or Grievance about us, a dentist or the care received.
- To file an Appeal about an action or decision we made.
- To know:
    - How Delta Dental decides whether a service is covered and/or Medically Necessary.
    - Who in Delta Dental's office decides these things.
- To know the names of Participating Dentists.
- To pick from a list of enough dentists so that they can get the right kind of care when needed.
- To take part in all decisions about their dental care. This may include refusing treatment.
- To get a second opinion from another dentist about what kind of treatment is needed.
- To be treated fairly by us, Participating Dentists and other dentists.
- Enrollees have a right to:
    - Talk to a dentist in private
    - Have dental records kept private
    - Request a copy of dental records
    - Ask for changes to those records
- To know dentists who can advise them about:
    - Health status
    - Dental care
    - Treatment
- To know they are not responsible for paying for Covered Services. As a Participating Dentist you cannot require them to pay for Medically Necessary Covered Services.
- To receive all information, including, but not limited to, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood.
- To receive a spoken translation at no cost for all non-English languages, not only those identified as prevalent.
- To recommend changes in policies and services under Delta Dental Smiles.

- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
    - What constitutes an emergency medical condition, Emergency Dental Care, and post-Stabilization Services.
    - Emergency Dental Care does not require prior approval.
    - The process and procedures for obtaining Emergency Dental Care.
    - The locations of any emergency settings and other locations at which Providers and hospitals provide Emergency Dental Care and post-Stabilization Services covered under the contract.
    - To use any hospital or other setting for Emergency Dental Services and post-Stabilization Services.
- To be able to request and receive a copy of their medical records and to request that they be amended or corrected.
- To have their privacy protected in accordance with the privacy requirements in federal law to the extent that they are applicable.
- To exercise these rights without adversely affecting the way Delta Dental, Providers or DHS treats them.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in the federal regulations on the use of restraints and seclusion.
- To make recommendations about these rights and responsibilities.

11.0 ENROLLEE RESPONSIBILITIES

Enrollees have Responsibilities while in Delta Dental Smiles and Delta Dental Smiles for Kids. The Enrollee can locate these in the Enrollee Handbook. These are:

- Try to follow healthy habits.
- Work together with their dentist to pick a treatment agreed upon.
- If they have a disagreement with Delta Dental, they should try first to resolve it using Delta Dental's Grievance Process.
- They should learn what Delta Dental Smiles does and does not cover.
- They should read the Enrollee Handbook to understand how the rules work.
- If they make an appointment, they should try to get to the dentist's office on time. If they cannot keep the appointment, they should be sure to call and cancel it.
- Be active in decisions about their health care.
- Present their Delta Dental Smiles ID card when receiving dental care.
- Report any fraud or wrongdoing to Delta Dental or the proper authorities. This may be about Delta Dental, or other dental or medical plans.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals.
- Inform Delta Dental of any change of address or any changes to enrollment that could affect eligibility.

12.0 GRIEVANCE AND APPEAL SYSTEM

Enrollees and Participating Dentists have access to Delta Dental's Grievance and Appeal System. This system includes a Grievance and Appeals Process and access to the Arkansas Department of Human Service's Administrative Hearing process.

12.1 Grievance Process

A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The Grievance can be about Delta Dental, the Delta Dental Smiles or Delta Dental Smiles for Kids programs, a Dental Service Provider, or services received, including the quality of those services. Grievances can also be in regards to the failure to respect an Enrollee's rights.

To file a Grievance you must:

- Submit to us a written or verbal explanation of the Grievance
- Provide all appropriate documentation requested by us

On our receipt of your Grievance and any requested documentation, we will provide you with written acknowledgement of receipt of the Grievance.

Resolution of your Grievance will be provided by us in writing within the timeframes outlined in the **Grievance and Appeal Times for Resolution** section.

Your request may be sent to us using the following options:

- Fax Number: 1-833-866-4650
- Mailing Address:
  Delta Dental Smiles
  Attn: **Grievance and Appeals**
  PO Box 6247
  Sherwood, AR 72124
- Toll Free Number: 1-866-864-2499

Consolidated Grievances

Claims of the same or similar payment or coverage issues may be submitted together. This can include multiple patients or claims. Consolidated Grievances must include all applicable patients, claims, and note that it is a consolidated Grievance.

12.2 Appeal Process

An Appeal is a request for review of an Adverse Benefit Determination. An Adverse Benefit Determination can be appealed by an Enrollee or by you.

To request an Appeal, you must:

- Submit a written request to review. You may also request an Appeal by calling our Customer Service Department, but you must confirm your Appeal in writing. Your request for an Appeal must be received within 60 days of the Notice of Adverse Benefit Determination.
- Provide all appropriate documentation (narrative, patient treatment record, radiograph, photo, etc.).

Upon receipt of this information, we will:

- Provide written acknowledgement of our receipt of your Appeal.
- Respond in writing with the final resolution of the Appeal within the timeframes outlined in the **Grievance and Appeal Times for Resolution** section.
- Include information in our response about how to request an Administrative Hearing in the event the original decision is upheld.

Your request may be sent via the following options:

- Fax Number: 1-833-866-4650
- Mailing Address:
  Delta Dental Smiles
  Attn: **Grievance and Appeals**
  PO Box 6247
  Sherwood, AR 72124
- Toll Free Number: 1-866-864-2499

DDAR will send written notice of significant changes to the Appeal process to all Enrolled Members and Network Providers at least thirty (30) calendar days prior to implementation."

12.3 Expedited Appeal

A dentist may request an Expedited Appeal on behalf of an Enrollee. An Expedited Appeal can be written or verbal. An Expedited Appeal can be requested if taking the time for the standard Appeal could seriously jeopardize the Enrollee's life, health or ability to maintain or regain maximum function. Delta Dental will provide a decision within the timeframes outlined in the **Grievance and Appeal Times for Resolution** section.

12.4 Continuation of Benefits

When an Enrollee or a dentist initiates an Appeal, the Enrollee may request a Continuation of Benefits. A Continuation of Benefits may be requested if all of the following are true:

- The request for Appeal is filed timely.
- The Enrollee timely files for Continuation of Benefits, meaning on or before the later of the following:
    - Within 10 days of the Notice of Adverse Benefit Determination (Remittance Advice)
    - The intended effective date of the applicable Adverse Benefit Determination
- The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized Dental Service Provider
- The authorization period has not expired, if applicable
- If the above criteria are met, DDAR will continue or reinstate the benefits while the Appeal is pending, the benefits must be reinstated promptly and continue during the Appeal, until one of the following occurs:
    - The Appellant withdraws the Appeal
    - The Enrolled Member, or the Enrolled Member's parent/legal guardian in the event that the Enrolled Member is a minor or not legally competent, withdraws the request for continuation of benefits.
    - The appeal resolution is unfavorable to the Enrolled Member and the Appellant fails to request a Fair Hearing and continuation of benefits within ten (10) calendar days after the resolution of notice is sent."
- The Enrollee may be liable for the cost of any continued benefits while the Appeal or state Fair Hearing is pending if the final decision is adverse to the Enrollee.

12.5 Administrative Hearing

If the dentist or Enrollee is not satisfied with our Appeal decision, they may have the right to an Administrative Hearing. The hearing must be requested within 120 days of the notice of Adverse Benefit Determination (remittance advice).

To request an Administrative Hearing, send the request to:

Provider:
Arkansas Department of Health

Office of Medicaid Provider Appeals
4815 West Markham Street, Slot 31
Little Rock, AR 72205
Phone 501-683-6626
Fax: 501-661-2357

Enrollee:

Department of Human Services
Office of Appeals and Hearings
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437
Phone 501-682-8622
Fax 501-404-4628

(Note: Enrollees Administrative Hearings are heard through the Department of Human Services and Provider Administrative Hearings are heard through the Department of Health.)

12.6 Grievance and Appeal Times for Resolution

DDAR will resolve each Grievance or Appeal as expeditiously as the Enrolled Member's health condition requires, not to exceed the outlined calendar days below from the date that we receive the Grievance or Appeal, whether orally or in writing:

We will issue a written decision on Grievances within the following timeframe:

- All Grievances: Within 90 calendar days of receiving your Grievance

We will issue a written decision on Appeals within the following timeframes:

- Standard Non-Emergency Appeals: Within 30 calendar days of receiving your Appeal
- Expedited Appeals related to ongoing issues involving Emergency Dental Care: Within 24 hours of receiving your Appeal or by the close of the next business day, but no later than 72 hours

12.7 Extensions

We may extend the timeframes in the **Grievance and Appeal Times for Resolution** by up to 14 calendar days if:

- You or the Enrollee requests an extension; or
- We think there is a need for more information and a delay may be in your or the Enrollee's best interest.

DDAR will give the Enrolled Member written notice of the delay within two (2) calendar days of the decision. The written notice will include the reason for the extension and describe the Enrolled Member's right to file a Grievance if they disagree.

13.0 PROGRAM INTEGRITY

13.1 Fraud, Waste and Abuse

Delta Dental is dedicated to conducting business in an ethical and legal manner. We maintain a Program Integrity Plan for continuous monitoring of potential fraud, waste, and abuse activity. We are committed to preventing, detecting and reporting fraud, waste, and abuse and overpayments.

Definitions:

- Fraud is a knowing misrepresentation of a fact to obtain benefits whether or not successful
- Abuse refers to overused or unneeded services, which include dentist or Enrollee actions that result in unneeded costs to the Delta Dental Smiles program
- Waste is the misuse of services
- Over-payments refer to any amount paid by Delta Dental that may be a result of improper claims, unacceptable practices, errors, mistakes, fraud, waste and/or abuse

Delta Dental monitors and audits the activities of its dentists, Enrollees, employees, and vendors. The dentist activities monitored and audited may include, but are not limited to, both contract and regulatory compliance requirements. Delta Dental may periodically request the completion of a questionnaire, submission of documentation, and/or attestation to applicable policy, procedure, and compliance requirements.

Delta Dental may also perform in office or desk audits, which may include the inspection of the facilities, systems, books, procedures, and/or records related to services provided.

Disciplinary actions could result from these monitoring activities including, but not limited to, payment recoupment, education, Corrective Action Plans, and/or contract termination. A Corrective Action Plan is the written plan agreed on between us and a Participating Dentist to correct any identified problem or meet acceptable levels of performance measures.

Final resolution reached by Delta Dental of Arkansas regarding a suspected case of waste, abuse, or fraud in no way binds the State of Arkansas from taking further action for the circumstances that brought rise to the matter.

If you suspect fraud or an overpayment was made, report it immediately to Delta Dental at 1-866-864-2499.

Some common types of fraud and abuse include:

- Billing for a service not performed
- Keeping over-payments
- Billing for a non-Covered Service as a Covered Service
- Misrepresenting dates of service, diagnosis, or procedures performed
- Misrepresenting location of a service
- Misrepresenting the Dental Service Provider of a service
- Billing twice for the same service
- Billing for inappropriate or unnecessary services
- Reporting a higher level of dental service than was actually performed
- Falsifying a patient name or their personally identifiable information to obtain payment for services
- Deliberately failing to report the existence of additional dental benefits coverage and billing two or more carriers for the full amount
- Kickbacks or bribes
- Lying about education degrees and licenses
- A patient who misrepresent themselves as another person to obtain dental benefits

Anti-Fraud Laws

In accordance with the federal Deficit Reduction Act (DRA), entities like Delta Dental that receive or make payments totaling at least $5 Million annually must comply with the "Employee Education about False Claims Recovery" requirements of the DRA. This means that as a contractor doing business with us you and your staff have the same obligation to report any actual or suspected violations of Medicaid funds either by fraud, waste or abuse. You must have written policies that inform and educate your staff, contractors, and agents about the following:

- The Federal False Claims Act and State laws related to submitting false claims
- How you will detect and prevent fraud, waste and abuse
- Employee protection rights as a whistleblower, that is, someone who reports instances of fraud, waste or abuse to the government

Pursuant to the Federal False Claims Act (31 U.S.C. §§ 3729-3733), civil penalties and damages may be brought against anyone who knowingly submits, or causes another to submit, a false or fraudulent claim for payment, or knowingly makes, or causes to be made, a false statement or record in connection with a claim for payment; or knowingly retains an overpayment.

The False Claims Act defines "knowingly" to mean that a person has actual knowledge of information, acts in a deliberate ignorance of the truth or falsity of the information, or acts in a reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The Federal Fraud Civil Remedies Act (31 U.S.C. §§ 3802-3811) provides administrative remedies for false claims and false statements in connection with claims designated to federal agencies, including the U.S. Department of Health and Human Services.

Furthermore, the Arkansas Medicaid Fraud False Claims Act (Ark. Code Ann. §§ 20-77-901 *et seq.*) is a civil statute that helps the State combat fraud and recover losses resulting from fraud in the Arkansas Medicaid program. The Arkansas Medicaid Fraud Act (Ark. Code Ann. §§ 5-55-101 *et seq.*) provides criminal sanctions in cases of Medicaid Fraud.

Additional details about these laws and Delta Dental's policies and procedures for complying with these laws can be found in our Anti-Fraud Laws Policy, which is available upon request or at www.deltadentalsmiles.com.

Compliance with Policies and Procedures

We require you as a Participating Provider to comply with all State and federal laws relating to Medicaid Providers as well as all of our policies and procedures distributed and made available to you. These policies and procedures include, but are not limited to, the following:

- Anti-Fraud Laws Policy
- Delta Dental's Code of Conduct
- Delta Dental's Program Integrity Plan
- Other relevant Delta Dental policies and procedures

These policies are available upon request or at any time on www.deltadentalsmiles.com.

You agree to provide upon request immediate access to records, books, and other documents as necessary for audits to us, the U.S. Department of Health and Human Services, the Arkansas Department of Human Services, and other State and federal governmental agencies with appropriate jurisdiction in connection with any activity involving the prevention, detection, or reporting of fraud, waste, abuse and/or overpayments.

Focused review is a component of our quality management process and is aligned with appropriateness of care. Providers are identified for focus review

13.2 Focused Review

by random selection, statistical difference compared to peers, or from patient complaint.

13.3 Required Disclosures

Providers selected for focus review will receive a letter informing them of their focus review status and the requirements associated with focus review.

Delta Dental, as well as Dental Service Providers, whether contracted or non-contracted, must comply with all federal requirements (42 CFR Part 455) on disclosure reporting, including but not limited to business transaction disclosure reporting (42 CFR § 455.104) and certain criminal convictions (42 CFR § 455.106), and must further provide any additional information necessary for DHS to perform its own exclusion status checks pursuant to 42 CFR § 455.436, if requested.

Because you will bill and/or receive Arkansas Medicaid funds as the result of your Participation Agreement, you must submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and the terms of your Participation Agreement, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at any time upon request.

These disclosures must be made on the State's Enrollment Disclosure form (available upon request).

If you do not make these required disclosures or otherwise do not meet any of the requirement of 42 CFR Part 455, you will not be able to continue to participate in the Network.

See section 3.0.

13.4 Screening for Excluded and/or Disbarred Entities

Delta Dental, as well as Dental Service Providers, whether contracted or non-contracted, must comply with all federal requirements (42 CFR § 1002) on exclusion and debarment screening.

All tax-reporting Dental Service Provider entities that bill and/or receive Arkansas Medicaid funds as the result of the Participation Agreement must screen their owners and employees against the federal exclusion databases (such as LEIE and SAM) as well as the Arkansas database of excluded entities enacted under DHS Policy 1088.

Any services provided by excluded individuals must be refunded to and/or obtained by the State and/or Delta Dental. Where the excluded individual is the provider of services or an owner of a business entity providing the services, all amounts paid to that Dental Service Provider must be refunded to the State.

Any Dental Service Provider listed in any of these excluded or disbarred entity databases must not be included in the Network.

For information about Network participation, including removal from the Network and reinstatement, see section 3.0, “Participation and Provider Roles.”

Appendices

Appendix A – Examples

Below is an example of the Delta Dental of Arkansas claim form. Visit the Delta Dental of Arkansas Dental Office Toolkit to download an electronic version of this form at www.deltadentalsmiles.com.

Appendix B – Revision History

Section	Revision Summary	Effective Date
1.1	Clarification of Terms and Definitions • Covered Service(s) • Denied • Disallow/Disallowed	7/15/18
3.8	Primary Care Dentist • Updated list request	Immediately
7.1.1	Diagnostic and Preventive Services • Updated Prophylaxis ages • Space Maintainers clarification	Retroactive 1/1/18
7.1.3	Crowns – Single Restorations Only • Clarification of Major Crown Procedures ages	Immediately
7.1.4	Endodontics • Updated Pulpal Therapy • Updated Root Canal Therapy	7/15/18
7.1.6	Removable Prosthetic Services • Added codes to Repair	7/15/18
7.1.7	Oral Surgery • Updated Routine and Surgical Extractions with codes • Updated other Oral Surgery Procedures • Non-intravenous Conscious Sedation • Non-intravenous Conscious Sedation removal of Preauthorization	7/15/18 7/15/18 Retroactive 1/1/18 7/15/18
7.1.8	Orthodontics • Clarification of Comprehensive Orthodontics • Request for Preauthorization/ Claim Submission update on transfer of cases • Updated to Limited Orthodontic Covered Services	7/15/18
7.1.9	Smoking Cessation clarification	Retroactive 1/1/18
7.2	Delta Dental Smiles for Kids Fee Schedule • Added D5511, D5512, and D5520	7/15/18
7.3.5	Removable Prosthetic Services • Updated Repairs • Fees for lab and denture fabrication do not apply to annual max	7/15/18 7/15/18
7.3.6	Oral Surgery • Updated Routine (non-surgical) Extractions	7/15/18
7.3.7	Deep Sedation • Clarification of Same Day Sedation	Immediately
7.3.9	Smoking Cessation clarification	Retroactive 1/1/18
7.4	Delta Dental Smiles Fee Schedule Added D5511, D5512, and D5520	7/15/18

7.5	Clarification of Billing and Collecting for Services Not Paid by Delta Dental	7/15/18
8.6	Payment of Claims clarification	7/15/18
8.10	Direct Deposit • Explanation of Payment/ Remittance Clarification	Immediately
9.2	Translation Services phone number correction	Immediately
Appendix A	Updated Delta Dental Claim Form	Immediately

Revision History - Version 3:

Section	Revision Summary	Effective Date
3.10	Access to Care • Added more on Cultural Competence	10/1/18
5.1	Enrollee Eligibility Verification • Clarification on when to check – "on the day of"	10/1/18
7.1.1	Bitewing X-Rays • D0273 and D0274 clarification • Added D0270 single film bitewing Full Mouth Complete Series and Panoramic Images • Clarification on submittal of multiple images	10/1/18 10/1/18
7.1.3	Prefabricated Stainless Steel Crowns • Updated to allow once in a 2 year period Major Crown Procedures • Clarification on D2740	8/20/18 10/1/18
7.1.6	Removable Full and Partial Dentures • Clarification on adjustments and exams for first 6 months	10/1/18
7.1.8	Orthodontics • Added billing definitions • Clarification on Preauthorization Documents Request for Preauthorization/Claim Submission • Clarification on reimbursement on comprehensive orthodontia Transfer Cases • Pulled out as own section • Added the Orthodontic Discontinue Treatment Form Limited/interceptive Orthodontic Covered Services • Added D8020, D8030, D8040 and D8060 • Clarification to anterior crossbite, bilateral posterior crossbite, and anterior impacted teeth • Added the Orthodontic Treatment Clearance Form and deleted need for letter	10/1/18 10/1/18 10/1/18 10/1/18
7.2	Delta Dental Smiles for Kids Code List • Added D0270 • Added D8020, D8030, D8040, and D8060	10/1/18

7.3.1	Bitewing X-Rays • D0273 and D0274 clarification • Added D0270 single film bitewing Full Mouth Complete Series and Panoramic Images • Clarification on submittal of multiple images	10/1/18 10/1/18
7.3.5	Removable Full and Partial Dentures • Clarification on adjustments and exams for first 6 months Billing • Clarification on timing of billing	10/1/18
7.4	Delta Dental Smiles Code List • Added D0270 • Noted D5110, D5120, D5211, and D5212 not subject to $500 annual maximum	10/1/18 7/15/18
12.1	Grievance Process • Added consolidated Grievance process	10/1/18

Revision History - Version 4:

Section	Revision Summary	Effective Date
7.1.1	Diagnostic Casts • Record approval clarification Space Maintainers • Updated codes: D1516/D1517/D1526/D1527	1/1/19
7.1.6	Removable Full and Partial Dentures • Clarification of billing date	1/1/19
7.1.7	Routine (Non-surgical) Extractions • Predetermination/Preauthorization clarification Other Oral Surgery • D7280/D7283 explanation expanded	1/1/19 1/1/19
7.1.8	Preauthorization Documents • NOTE on diagnostic casts and models updated	1/1/19
7.3.5	Billing • Clarification of billing date	11/1/19

Revision History - Version 5:

Section	Revision Summary	Effective Date
1.1	Modify definitions • Added non-restorable tooth • Changed disallow to not billable to the patient • Added Utilization Management	1/1/20
6.2	Clarify decision making criteria	1/1/20

6.5	Added Access to Utilization Management Services	1/1/20
7.1	ARKIDS B co-pay clarification	1/1/20
7.1.1	Diagnostic and Preventive Services • Evaluations D0190 clarification • Prophylaxis D4346 clarification	1/1/20
7.1.2	Minor Restoration • New statement	1/1/20
7.1.4	Root Canal Therapy • Added Predetermination information	Immediately
7.1.6	Removable Prosthetic Services • Permanent teeth clarification	1/1/20
7.1.7	Other Oral Surgery Procedures • D7250 addition • Frenulectomy clarification Non-intravenous Conscious Sedation • Verification clarification	1/1/20
7.1.8	Orthodontics • Lifetime and sever case clarification • Treatment not started after Preauthorization clarification • Limited orthodontics criteria clarification	1/1/20
7.3.1	Diagnostic and Preventive Services • Emergency dental care clarification • Prohylaxis D4346 clarification	1/1/20
7.3.5	Removable Prosthetic Services • Added codes D5421, D5422, and adjustments clarification	1/1/20
7.4	Delta Dental Smiles Covered Services Code List • Added D5421 and D5422 • D7250 not subject to $500 cap • Added D7311	1/1/20
8.5	Reconsideration of claims • Peer-to-peer clarification	
13.2	Added Focused Review	1/1/20

Revision History - Version 6:

Section	Revision Summary	Effective Date
1.1	Clarification of Definition of	9/1/20
7.1.8	Limited ortho criteria clarification & records clarification	9/1/20
7.2	Delta Dental Smiles for Kids Covered Services Code List • Added D5120 and D5140 • Added D5221 and D5222 • Codes are not subject to $500 cap	9/1/20
7.3.5	Removable Prosthetic Services	9/1/20

	• Definition and Pre-Authorization requirements	
7.4	Delta Dental Smiles Covered Services Code List • Added D5120 and D5140 • Added D5221 and D5222	9/1/20

Revision History - Version 7:

Section	Revision Summary	Effective Date
2.5	Provider Data Accuracy and Validation	Immediately
3.2	Credentialing • Added instruction surrounding Group Enrollment • Explained methods for payment	Immediately
7.1.1	Addition of Space Maintainer Recementation Benefit	1/1/21
7.2	ADA CDT Code Changes • Deletion of D7960 • Addition of D7961 & D7962	1/1/21
7.1.7	Updated Frenulectomy Codes • Deletion of D7960 • Addition of D7961 & D7962	1/1/21
7.1.7	Addition of Space Maintainer Recementation Codes • Addition of D1551 • Addition of D1552 • Addition of D1553 • Clarification on conditions of coverage	1/1/21
12.5	Update to Administrative Hearing Contact Information	1/1/21

Revision History - Version 8:

Section	Revision Summary	Effective Date
1.1	Addition of Definitions: • Provider Preventable Condition	5/1/21
3.6	Provider Rights Additions	5/1/21
5.4	Update to ID Cards	5/1/21
12.2	Update to explain how significant changes to the Appeal process will be communications	5/1/21
12.4	Additional information on continuation of benefits during an appeal process	5/1/21
12.6	Update to Grievances & Appeals Resolution Timelines	5/1/21
12.7	Clarification on delay notices	5/1/21

Revision History - Version 9:

Section	Revision Summary	Effective Date
1.1	Updated Non-Restorable Tooth definition	1/1/22
3.12	Added "Missed Appointments"	1/1/22
3.5	Added "Termination of a Provider for Administrative Reasons"	1/1/22
7.1.1	Evaluations (Exams) • Added "General Policy" • Removed D0150, 0160 & 0180 from "Evaluation (Exams)"	1/1/22
7.1.8	Removed policy D8060 Removed "Interceptive"	1/1/22
7.2	Added D0190 Removed "interim" from D1354 description	1/1/22
12.4	Added final sentence of paragraph	1/1/22

Revision History - Version 10:

Section	Revision Summary	Effective Date
All	Updated Delta Dental Smiles for Kids website address (www.deltadentalsmiles.com)	9/26/22
3.2	Updated network participation backdate/adjustment verbiage	9/26/22
7.1.1	Added 2nd bulletin under Diagnostic Casts	9/26/22
7.1.8	Preauthorization Documents – Updated statement on records not being reimbursed	9/26/22