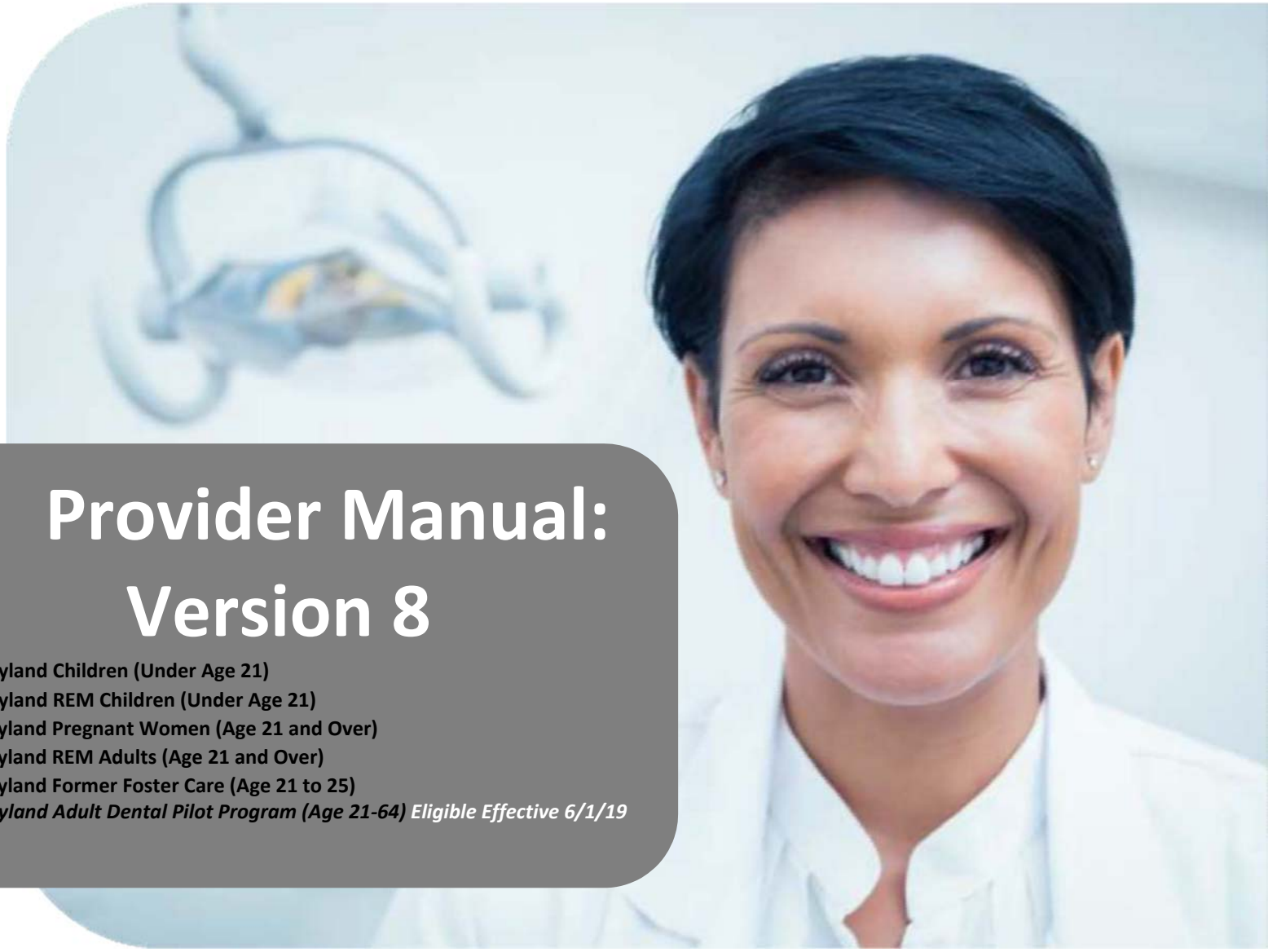
MARYLAND
Healthy Smiles
DENTAL PROGRAM



Provider Manual: Version 8

Maryland Children (Under Age 21)
Maryland REM Children (Under Age 21)
Maryland Pregnant Women (Age 21 and Over)
Maryland REM Adults (Age 21 and Over)
Maryland Former Foster Care (Age 21 to 25)
Maryland Adult Dental Pilot Program (Age 21-64)* *Eligible Effective 6/1/19

Program Effective: January 1, 2016

Maryland Healthy Smiles Dental Program

Revision Effective: January 1, 2020

POWERING HEALTHCARE FOR THE DIGITAL AGE

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Quick Reference Guide

Provider Web Portal: Online, All the Time

Getting paid for the high-quality care you've provided to patients should be quick, easy, and convenient. SKYGEN USA's user-friendly Provider Web Portal offers a full set of self-service tools that help you get more done, faster.

Everything You Need - When You Need It - 24/7/365

Use the Provider Web Portal to:

- Check real-time eligibility for multiple patients—***at the same time***.
- Submit electronic authorization requests—***with attachments***.
- View a decision tree that shows you the same clinical guidelines our consultants use to evaluate your authorization requests.
- Use our claim estimator to find out in advance whether your claim will be paid or denied, and why—***before you render services***.
- Attach supporting documentation, such as EOBs and x-rays—***online, for no charge***.
- Submit ***pre-filled*** claim forms and review claim history—***with just a few clicks***.
- Check the real-time status of claims and authorizations—***no need to wait for paper letters to arrive by postal mail***.
- View and print provider manuals, remittance reports, and more.

www.provider.MDhealthysmiles.com

When You Need Us – We'll Be There!

SKYGEN USA is committed to delivering world-class service to you and your patients. Our Maryland-based customer service teams will provide local service with the support of national resources. A dedicated provider relations representative will be available to answer your questions and arrange in-person visits. ***When you need us, we'll be there!***

Contact us any time for assistance, training, or to arrange an onsite visit:

Call Provider Services: 844-275-8753

Email: providerservices@skygenusa.com

Quick Contacts	
Authorizations mailing address	Maryland Healthy Smiles: Authorizations PO Box 422 Milwaukee WI 53201
Claims mailing address	Maryland Healthy Smiles: Claims PO Box 2186 Milwaukee WI 53201
Corrected Claims mailing address	Maryland Healthy Smiles: Corrected Claims PO Box 541 Milwaukee WI 53201
Grievances and Appeals mailing address	Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee WI 53201
Electronic Funds Transfer	Fax: 262-721-0722 Email: providerservices@skygenusa.com
Web Portal Team	855-434-9239 Email: providerportal@skygenusa.com
Fraud & Abuse Hotline	877-378-5292
Provider Web Portal	www.provider.MDhealthysmiles.com

Quick Reference to Common Questions

Member Eligibility	To verify member eligibility, you can either: • Log on to Provider Web Portal: www.provider.MDhealthysmiles.com • Call Interactive Voice Response (IVR) eligibility hotline: **844-275-8753**
Authorization Submission	Submit authorizations in one of the following formats: • Provider Web Portal: www.provider.MDhealthysmiles.com • Electronic submission via clearinghouse, Payer ID: **SCION** • Paper 2019 ADA Dental Claim Form, sent via postal mail: Maryland Healthy Smiles: Authorizations PO Box 422 Milwaukee WI 53201 Providers are responsible for asking women if they are pregnant, and then submitting authorizations accordingly. See (Submitting Authorizations for Pregnant Women) in the Provider Manual. For help submitting authorizations via Provider Web Portal, call the SKYGEN USA Web Portal Team: **855-434-9239**.
Claims Submission	The timely filing requirement is 12 months. Submit claims through the following formats: • Provider Web Portal: www.provider.MDhealthysmiles.com. For help submitting claims, call the SKYGEN USA Web Portal Team: **855-434-9239**. • Electronic submission via clearinghouse, Payer ID: **SCION** • Paper 2019 ADA Dental Claim Form, sent via postal mail: Maryland Healthy Smiles: Claims PO Box 2186 Milwaukee WI 53201 • Note: The 2012 ADA Dental Claim Form will be accepted through April 30, 2020. Effective May 1, 2020 all claims must be submitted on the 2019 version of the claim form or the claim will be denied. • Providers are responsible for asking women if they are pregnant, and then submitting claims accordingly. See (Submitting Claims for Pregnant Women) in the Provider Manual.
Grievances and Appeals	To make a grievance or file an appeal, either: • Write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee WI 53201 • Call Provider Services: **844-275-8753**

Provider Appeals – Authorizations	Authorization Appeals must be filed within 30 days following the date the denial letter was mailed. SKYGEN USA issues a decision within 30 days of receiving an appeal request, unless an extension is granted. Expedited resolution is within 3 business days. To request reconsideration of a denied authorization, write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee WI 53201
Provider Appeals – Claims	Claim Appeals must be filed within 30 days following the date the denial letter was mailed. SKYGEN USA issues a decision within 30 days of receiving an appeal request, unless an extension is granted. To request reconsideration of a claims denial, write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee WI 53201
Member Appeals	To submit a written appeal on behalf of a member, write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee WI 53201
EFT (Direct Deposit) Enrollment	Send a completed EFT Authorization Agreement form and voided check by either fax or email: • Fax: 262-721-0722 • Email: providerservices@skygenusa.com The EFT Authorization Agreement form is included in the Provider Manual and posted on the Provider Web Portal: www.provider.MDhealthysmiles.com.
Provider Web Portal	For training or help registering for or using the Provider Web Portal, contact the SKYGEN USA Web Portal Team: • Email: providerportal@skygenusa.com • Call: 855-434-9239
Additional Provider Resources	For information about additional provider resources: • Log on to Provider Web Portal:www.provider.MDhealthysmiles.com • Send email to Provider Services: providerservices@skygenusa.com • Call Provider Services: **844-275-8753** • Send email to Web Portal Team: providerportal@skygenusa.com • Call Web Portal Team: **855-434-9239**

Quick Contacts for Credentialing	
Credentialing	*Effective 8/27/18 SKYGEN USA is no longer responsible for provider enrollment and credentialing.* Please contact 1-844-463-7768 or visit ePREP.health.maryland.gov, for Provider enrollment and credentialing related activities.
Electronic Provider Revalidation and Enrollment Portal (ePREP)	Phone: 1-844-463-7768 or ePREP.health.maryland.gov
Provider Services	844-275-8753 Email: providerservices@skygenusa.com

Welcome

Welcome to the Maryland Healthy Smiles Dental Program provider network! We are committed to providing our members the best possible care – it's our reason for being here. We are pleased to welcome you to our team.

We are SKYGEN USA, a nationwide leader in managed benefits administration. The State of Maryland has chosen us to administer dental benefits for members enrolled in the Maryland Healthy Smiles Dental Program.

Throughout your ongoing relationship with SKYGEN USA, refer to this provider manual for quick answers and useful information, including how to contact us, how to submit claims and authorizations, and details regarding the benefit plans.

When you need answers, log on to www.provider.MDhealthysmiles.com, send an email message to providerservices@skygenusa.com, or call Provider Services: **844-275-8753**.

SKYGEN USA retains the right to add to, delete from, and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by SKYGEN USA as proprietary and confidential.

To see an overview of the changes made in *Provider Manual: Version 8*, please see the history revision section.

*This manual describes SKYGEN USA policies and procedures that govern our administration of dental benefits for the Maryland Department of Health (MDH). SKYGEN USA makes every effort to maintain accurate information in this manual; however, we will not be held liable for any damages due to unintentional errors. If you discover an error, please report it to us by calling **844-275-8753**. If information in this manual differs from your Participating Agreement, the Participating Agreement takes precedence and shall control.*

Maryland Healthy Smiles Adult Dental Pilot Program

The Maryland Healthy Smiles Adult Dental Pilot Program (the Pilot) provides dental services to adults ages 21 through 64 who are eligible for both Medicaid and Medicare and who are not enrolled in an MCO. The Pilot will cover dental services up to $800 each calendar year. No preauthorization is required for reimbursement of services covered under the Pilot's benefit plan. Some of the covered dental services include oral evaluations, teeth cleanings, X-rays, full-mouth debridement, restorations, extractions, and nitrous.

Program Details

The Maryland Healthy Smiles Adult Dental Pilot Program started on June 1, 2019. Members in this plan have an annual maximum benefit allowance of $800 per calendar year (January 1 - December 31). The benefit allowance will reset on January 1st.

- Before each visit, the provider must check the member's eligibility and the remaining amount in the member's benefit allowance by contacting Provider Services at 844-275-8753 and selecting option 5 to speak with a representative (Monday through Friday, 7:30 am to 6 pm EST).
- If a member has an appointment scheduled on the weekend, the provider can call on Friday to obtain the amount remaining in the member's benefit allowance. If there is an emergency on the weekend, it is at the provider's discretion whether the member will be treated.
- The member's clinical history is viewable via the Provider Web Portal; however, this information may not accurately reflect the amount the member has remaining in their benefit allowance. The Pilot has a limited benefit package which includes 28 services.
- Claims will be applied to the member's annual benefit allowance as they are received. Reimbursement rates for the program are consistent with the current Maryland Medicaid Dental Fee Schedule and other benefit plans offered through the Maryland Healthy Smiles Dental Program. The rates for services are listed on the Adult Dental Pilot Program Fee Schedule and the Global Treatment Plan listed on page 9 of this manual.
- At each visit, the provider and member must sign a global treatment plan before any services are provided.

The Global Treatment Plan

A global treatment plan is a document that details the dental services recommended by the provider and the costs for those services. The provider and member must review the recommended course of treatment and both parties must sign this form prior to services being rendered at each visit. Urgent issues should be prioritized.

Prior to having the member sign the global treatment plan, the provider should ensure that the member understands that:

- Services covered under the Pilot are limited to $800 annually;
- The annual benefit allowance will be reset at the beginning of the next calendar year, if the member remains eligible for the Pilot;
- Once the member's annual maximum benefit allowance has been reached, the member can choose to pay out-of-pocket for additional services by signing the Non-Covered Services Agreement, detailing the cost of the services to be rendered.
- The provider may only ask members to pay up to the Medicaid rate of reimbursement for the services covered under the Adult Dental Pilot Program.

You may also find The Global Treatment Plan (Spanish version) on the Provider Web Portal, under documents.

Maryland Adult Dental Global Treatment Plan

Instructions: At each visit, the provider and member must sign this agreement prior to services being rendered. If rendering any services that are not covered by the Adult Dental Pilot, or that exceed the patient's maximum benefit allowance, a signed Non-Covered Services Agreement will also be required.

CDT Code	Description Diagnostic Procedure	Medicaid Fee	Visit 1	Visit 2	Visit 3	Member Initial
Oral Evaluations						
D0120	Periodic oral evaluation - established patient	$29.08				
D0140	Limited oral evaluation	$43.20				
D0150	Comprehensive oral evaluation - new or established patient	$51.50				
Diagnostic Imaging (X-rays)						
D0270	Bitewing- Single Radiographic Image	$9.00				
D0272	Bitewings- Two Radiographic Images	$15.00				
D0273	Bitewings- Three Radiographic Images	$18.00				
D0274	Bitewings- Four Radiographic Images	$22.00				
D0210	Intraoral - Complete Series of Radiographic Images	$57.00				
D0220	Intraoral – Periapical First Radiographic Image	$9.00				
D0230	Intraoral – Periapical Each Additional Radiographic Image	$6.00				
D0330	Panoramic Radiographic Image	$42.00				
Preventive Care (Cleanings)						
D1110	Prophylaxis – Adult (Permanent Dentition)	$58.15				
Restorative Care (Cavity Fillings)						
D2140	Amalgam – One Surface, Permanent	$70.00				
D2150	Amalgam – Two Surfaces, Permanent	$88.00				
D2160	Amalgam – Three Surfaces, Permanent	$104.00				
D2161	Amalgam – Four or More Surfaces, Permanent	$104.00				
D2330	Resin-Based Composite - One Surface, Anterior	$84.00				
D2331	Resin-Based Composite – Two Surfaces, Anterior	$102.00				
D2332	Resin-Based Composite – Three Surfaces, Anterior	$125.00				
D2335	Resin-Based Composite – Four or More Surfaces or Involving Incisal Angle (Anterior)	$151.00				
D2391	Resin-Based Composite – One Surface, Posterior	$93.00				
D2392	Resin-Based Composite – Two Surfaces, Posterior	$120.00				
D2393	Resin-Based Composite – Three Surfaces, Posterior	$150.00				
D2394	Resin-Based Composite – Four Or More Surfaces, Posterior	$150.00				
Non-Surgical Periodontal Service						
D4355	Full Mouth Debridement to Enable a Comprehensive Evaluation and Diagnosis On a Subsequent Visit	$100.00				
Oral Surgery						
D7140	Extraction, Erupted Tooth Or Exposed Root	$103.01				
D7210	Surgical Removal – Erupted Tooth, Removal of Bone/Sectioning of Tooth	$103.01				
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	$18.00				
	Total Funds Needed for Visit (All-Inclusive Rate for FQHCs)					

I,_____(*member name*), understand that Maryland Adult Dental Pilot Program has an annual $800.00 maximum benefit allowance for covered dental services. I also understand that my maximum benefit allowance for dental services will be reset at the beginning of the next calendar year, if I am still eligible for this benefit plan. If I need dental services that exceed the maximum benefit allowance during this calendar year, I understand that I will be responsible for signing a Non-Covered Service Agreement that will detail my out-of-pocket expenses. I also understand that I can only be required to pay up to the Medicaid rate of reimbursement for the services listed above.

Member Signature_____Date_____

Provider/Office Representative Signature_____Date_____

Revised 6/19/19

Verifying eligibility and funds available:

Providers must verify member eligibility when scheduling an appointment, as well as on the date of service.

- Member eligibility can be verified by logging onto the Provider Web Portal: www.provider.MDhealthysmiles.com or by calling the Interactive Voice Response (IVR) eligibility hotline: 844-275-8753.
- Eligible members will be identified as eligible for the Pilot with the following message: "Maryland Medicaid Medicare – Limited Dental $800 Maximum."

Providers must also verify the amount of funds available in the member's $800 annual benefit allowance.

- To verify the amount of funds available, call Provider Services 844-275-8753 and select option 5 to speak with a representative.
- This should be done when scheduling the appointment, as well as on the date of service prior to the member being treated.

Claims reimbursement:

Claims will be reimbursed in the order they are submitted to SKYGEN USA. It is very important to submit claims as soon as possible.

- Valid claims will be paid up to the $800 maximum benefit allowance for each member annually.

For example, if there is only $25 remaining and the claim equals $50, then $25 will be reimbursed by the MHSDP and the provider is able to charge the member for the remaining balance at the Medicaid rate, as long as the member signs a Non-Covered Services Agreement agreeing to pay for the service out-of-pocket.

- The Maryland Healthy Smiles Adult Dental Pilot Program will not be responsible for any amounts not paid, beyond the annual maximum.
- Providers should not give the member the option to sign the Non-Covered Services Agreement until they have exhausted their annual benefit allowance or confirmed that services will exceed the maximum benefit allowance.

Dental Home Assignments

Providers can view a roster of members assigned to them at any time by going to SKYGEN USA's Provider Web Portal and following these steps:

1. Click on Report at the top of the toolbar
2. Click Primary Care Assignments
3. Keep default at "All" for location and provider
4. Click Print Report to export to PDF or Excel

Federally Qualified Health Center (FQHC) Billing

FQHC's should continue to bill for dental services using D0999 and their cost-based rate. At least one CDT code on the claim must be part of the Pilot's benefit package. As long as $1 is remaining in the member's annual benefit allowance, the FQHC will receive reimbursement of their full cost-based rate.

What if a Member needs services that are not covered?

Members who are covered under the Pilot are eligible to receive dental services listed in the benefit package.

- If a member wants or needs to receive a service not covered under the Pilot, the member must sign a Non-Covered Services Agreement.
- The Non-Covered Service Agreement must be written in the member's native language and should be easily understood. It must include the specific dental codes and costs for any services that the member agrees to pay for out-of-pocket.
- If the service is part of the Pilot's benefit package, the provider may only charge the member the Medicaid rate for that service.
- If the service is not one of the 28 covered services under the Pilot's benefit package, the member can be charged the office's usual and customary fee.

What if Member who is eligible for the Pilot becomes pregnant?

If a member who is eligible for the Adult Dental Pilot Program becomes pregnant, her coverage in the Pilot will end and she will become eligible under the benefit plan for pregnant women, which covers additional dental services. Once she delivers the baby, her coverage under the pregnant woman plan will end and she will be reinstated the Adult Dental Pilot Program, as long as she remains eligible.

Member Rights & Responsibilities

Members of the Maryland Healthy Smiles Dental Program have the following rights and responsibilities.

Member Rights

The Maryland Healthy Smiles Dental Program/SKYGEN USA is committed to the following core concepts in our approach to member care:

- **Access** to providers and services.
- **Wellness** programs include member education and disease management initiatives.
- **Outreach** programs that educate members and give them the tools they need to make informed decisions about their dental care.
- **Feedback** that measures provider and member satisfaction.

We believe all members have the right to:

- **Privacy**, respectful treatment, and recognition of their dignity when receiving dental care.
- **Participate** fully with caregivers in making decisions about their health care.
- **Be fully informed** about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
- **Voice a grievance** against the Maryland Healthy Smiles Dental Program/SKYGEN USA, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the member's expectations.
- **Appeal** any decisions related to patient care and treatment.
- **Make recommendations** regarding our member rights and responsibilities policies.
- **Receive relevant, updated information** about Maryland Healthy Smiles Dental Program, the services provided, the participating dentists and dental offices.

Member Responsibilities

Along with rights, members have important responsibilities, including:

- Becoming familiar with benefit plan coverage and rules.
- Giving dental providers complete and accurate information they need to provide care.
- Following treatment plans and instructions received from dental providers.
- Supporting the care given to other patients and behaving in a way that helps the clinic, dental office, and other dental locations run smoothly.
- Notifying Customer Service of any questions, concerns, problems, or suggestions.

Provider Rights & Responsibilities

The Maryland Healthy Smiles Dental Program/SKYGEN USA has established the following core concepts in our approach to a positive provider experience:

- **Access** to flexible participation options in provider networks.
- **Outreach** programs that lower provider participation costs.
- **Technology** tools that increase efficiency and lower administrative costs.
- **Feedback** that measures provider and member satisfaction.

Provider Rights

Enrolled participating providers have the right to:

- **Communicate with patients** about dental treatment options.
- **Recommend a course of treatment** to a member, even if the treatment is not a covered benefit or approved by the Maryland Healthy Smiles Dental Program/SKYGEN USA.
- **File an appeal or grievance** about the procedures of the Maryland Healthy Smiles Dental Program/SKYGEN USA.
- **Supply accurate, relevant, and factual information** to a member in conjunction with an appeal or grievance filed by the member.
- **Object to policies, procedures, or decisions** made by the Maryland Healthy Smiles Dental Program/SKYGEN USA.
- **Discuss concerns and issues with members** by contacting their SKYGEN USA provider representative or the SKYGEN USA Call Center.

Provider Responsibilities

Participating providers have the following responsibilities:

- Providers may not bill members for covered CDT codes and procedures covered under the Maryland Healthy Smiles Dental Program under any circumstance. **Except in the MD Adult Dental Pilot when the members' $800 benefit maximum is reached* (*See MD Adult Dental Pilot Program – Page 8)*.
- If a recommended treatment plan is not covered (not approved by the Maryland Healthy Smiles Dental Program/SKYGEN USA), the participating dentist, if intending to charge the member for the non-covered services, must notify and obtain agreement from the member in advance. (See Payment for Non-Covered Services section – page 27).
- A provider wishing to terminate participation with the Maryland Healthy Smiles Dental Program provider network must follow the termination guidelines stipulated in the Medicaid provider agreement.
- A provider may not bill both medical codes and dental codes for the same procedure.
- The provider is responsible for making their patient records available for a chart review.
- Providers may not "balance bill" a member for any CDT code or procedure that is covered under the Maryland Healthy Smiles Dental Program.
- Any Medicaid providers that practice balance billing are in violation of their agreement with the State's Medicaid Program and are subject to sanctions, including termination from the Program.

Positive Provider Experience

Committed dentists are essential to the success of every government-sponsored dental program. Our Maryland Healthy Smiles Dental Program provider network is structured to give dentists the flexibility they need to participate in dental programs on their own terms. At SKYGEN USA, we are not only the benefits management partner for the State of Maryland, we also consider ourselves to be ***your partner*** in patient care.

At SKYGEN USA, we consider ourselves allies of dental associations while maintaining flexibility within the changing political climate surrounding government-sponsored dental programs. We recognize the significant link between good dental care and overall patient health, and we advocate increasing provider funding while improving member education and outreach. We partner with thousands of providers across the country to deliver high-quality care to all members of government-sponsored dental programs.

Flexible Participation Options

The Maryland Healthy Smiles Dental Program invites all licensed dentists to participate in our provider network. Providers can choose their own level of participation for each of their practice locations.

Providers can choose to:

- Be listed in a directory and accept appointments for all new patients.
- Be excluded from directories and accept appointments for only new patients directed to their office from the Maryland Healthy Smiles Dental Program/SKYGEN USA.
- Treat only emergencies or special needs cases on an individual basis.

Consistent, Transparent Authorization Decisions

Trained paraprofessionals and dental consultants use predefined clinical guidelines to ensure a consistent approach for determining authorizations submitted for review.

When you submit an online authorization through the SKYGEN USA Provider Web Portal, you have the option of stepping through the guideline yourself, for a quick indication of whether your authorization request is likely to be approved. Authorization requirements are also outlined in this provider manual. (See **Benefit Plan Details & Authorization Requirements**).

In addition, when you submit an authorization through the Provider Web Portal, you can see at a glance whether documentation, such as x-rays or medical necessity narratives, are required. You can attach and send electronic documents as part of your online authorization request—saving you both time and money.

Provider Web Portal

Our Provider Web Portal offers quick access to easy-to-use self-service tools for managing daily administration tasks. The Provider Web Portal offers you many benefits including:

- Lower administrative and participation costs, faster payment through streamlined claim and authorization submissions and real-time member eligibility verification.
- Immediate access to member information, claim and authorization history, and payment records at any time, 24 hours a day, 7 days a week.

A web browser, Internet connection, and a valid User ID and password are required for online access. From the Provider Web Portal, providers and authorized office staff can log in for secure access anytime from anywhere and handle a variety of day-to-day tasks, including:

- Verify eligibility for multiple members simultaneously, and review individualpatient treatment history.
- Set up office appointment rosters that automatically verify eligibility and fill in claim forms for online submission.
- Submit claims and authorizations with pre-filled forms and data entry shortcuts.
- Step through clinical guidelines as part of submitting authorizations for a quick indication of whether a service request is likely to be approved.
- Attach and securely send supporting documents, such as digital X-rays, EOBs, and treatment plans, for no extra charge.
- Generate a pricing estimate before submitting a claim for a quick indication of whether a service may be denied, and if so, the reason why.
- Check real-time status of claims and authorizations, review historical payment records.
- Review provider clinical profiling data relative to your peers.

Online help is available, offering quick answers, animated videos, and step-by-step instructions.

Provider Web Portal Registration

The Provider Web Portal was designed to keep administrative costs low, give immediate access to real-time information, and make it fast and easy to submit claims and authorizations. To register for our Provider Web Portal, visit www.provider.MDhealthysmiles.com and click the provider login link. On the login page, click Register Now and register as a Payee so you have the option to view remittances and be paid electronically. Call the Web Portal Team at 855- 434-9239 to obtain your Payee ID. As soon as you register, you can log in and start using the portal. If you don't find answers to your questions, or if you want personalized training for your office staff, call the SKYGEN USA Web Portal Team for assistance: 855-434-9239.

Electronic Payments

Electronic Funds Transfer (EFT)

SKYGEN USA offers all providers the option of Electronic Funds Transfer (EFT) for claims payments. With EFT, we can pay claims more efficiently—and you can receive payments faster—because funds are deposited directly into payee bank accounts, eliminating the steps of printing and mailing paper checks. To receive claims payments through the EFT program:

1. Complete and sign the **EFT Authorization Agreement**. The form is included in this manual and is also available from the Provider Web Portal: www.provider.MDhealthysmiles.com.
2. Include a voided check with the EFT Authorization Agreement. The transaction cannot be processed without a voided check.
3. Send the EFT Authorization Agreement form and voided check to SKYGEN USA by Fax: 262-721-0722 or Email: providerservices@skygenusa.com.

Allow up to six weeks for the EFT program to be implemented after we receive your completed paperwork. Once you are enrolled in the EFT program, you will no longer receive paper remittance statements through postal mail. Instead, your Remittance Reports will be posted online and made available from the Provider Web Portal as soon as your claims are paid: www.provider.MDhealthysmiles.com.

Once you are enrolled in the EFT program, notify SKYGEN USA of any changes to bank accounts, including changes in Routing Number or Account Number, or if you switch to a different bank. Use the EFT Authorization Agreement form to submit your changes. Allow up to three weeks for changes to be implemented after we receive your change request. SKYGEN USA is not responsible for delays in payment if we are not properly notified, in writing, of banking changes.

Electronic Remittance Reports

If you enroll in the SKYGEN USA EFT program, your Remittance Reports will be made available automatically from the Provider Web Portal. For help registering for the portal or accessing your Remittance Reports, call the SKYGEN USA Web Portal Team: 855-434-9239. If you prefer to receive paper checks rather than EFT's, you can still eliminate paper Remittance Reports and access your payment reports online. To have quick, easy access to Remittance Reports, send an email message to Provider Services to request electronic remittances: providerservices@skygenusa.com. As soon as the Provider Services team processes your request, paper Remittance Reports will no longer be mailed to you. Your Remittance Reports will be available online through the Provider Web Portal. For more information about electronic Remittance Reports, call the SKYGEN USA Web Portal Team: 855-434-9239.

EFT Authorization Agreement

A copy of the SKYGEN USA EFT Authorization Agreement form is included on the following page. The form is also available for download from the Provider Web Portal: www.provider.MDhealthysmiles.com.

I agree to receive all vendor payments from SKYGEN USA by electronic funds transfer according to the terms of the EFT program. I agree to return to SKYGEN USA any EFT payment incorrectly disbursed by SKYGEN USA. I agree to hold harmless SKYGEN USA and its agencies and departments for any delays or errors caused by inaccurate or outdated registration information or by the financial institution listed above.

Be sure to include a voided check with the EFT Authorization Agreement. The transaction cannot be processed without a voided check.

Send the EFT Authorization Agreement form and voided check to SKYGEN USA by fax or email:

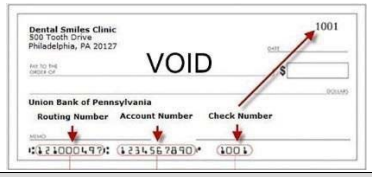
- Fax: 262-721-0722
- Email: providerservices@skygenusa.com

Electronic Funds Transfer (EFT) Authorization Agreement

Get your reimbursement faster and easier with EFT! To receive your payments by EFT, please complete this form and return it with a scanned or faxed copy of a voided check. *(This Authorization Agreement will not be valid without a* voided check.*)*

Submission Options	
Send this completed form and voided check to SKYGEN USA via:	**Fax:** 262-721-0722 *or* **Email:** providerservices@skygenusa.com
Submission Reason	
Select one checkbox.	❑ New EFT Authorization | ❑ Account or bank change to existing EFT Authorization

Provider Information		
Provider Name *(Include d/b/a, if any.)*	Taxpayer Identification Number	*Select one checkbox.* ❑ SSN | ❑ EIN
Street Address		
City	State	Zip Code
Phone Number Email Address		

Financial Institution Information	
Financial Institution Name	Financial Institution Routing Number *(Include 9 digits with any leading zeros.)*
Account Number *(Include up to 10 digits with any leading zeros.)*	*To indicate account type, select one checkbox.* ❑ Checking Account | ❑ Savings Account
Note: The Authorization Agreement will not be valid if a voided check is not submitted with this form.	

Authorization	
I agree to receive all vendor payments from SKYGEN USA LLC by electronic funds transfer according to the terms of the EFT program. I agree to return to SKYGEN USA any EFT payment incorrectly disbursed by SKYGEN USA I agree to hold harmless SKYGEN USA LLC and its agencies and departments for any delays or errors caused by inaccurate or outdated registration information or by the financial institution listed above.	
Printed Name	Title
Authorized Signature	Date

Eligibility & Member Services

The Maryland Healthy Smiles Dental Program offers dental coverage for Maryland Medicaid participants including children under the age of 21, children enrolled in the Rare and Expensive Case Management (REM) Program, pregnant women, adults enrolled in the Rare and Expensive Case Management (REM) Program, former foster care members ages 21 through 25, and adults ages 21 through 64 with Medicaid and Medicare. The Maryland Department of Health (MDH) determines member eligibility.

The Maryland Healthy Smiles Dental Program coverage groups include:

- Maryland Children (Under Age 21)
- Maryland REM Children (Under Age 21)
- Maryland REM Adults (Age 21 and Older)
- Maryland Pregnant Women (Age 21 and Older)
- Maryland Former Foster Care (Age 21 to 25) *Eligible Effective: 1/1/17*
- Maryland Adult Dental (Age 21 to 64)

If your patients have questions about enrolling in the Maryland Healthy Smiles Dental Program, or questions about loss of eligibility, refer them to their local health department, the Maryland Health Exchange, or ask them to call Member Services: **855-934- 9812**.

***Please note that members whose eligibility indicates "Maryland NO DENTAL Adult Medicaid" have NO dental benefits or dental coverage. ***

Dental Home PCD Assignments

Members can be treated by any dentist even if they have been assigned to a specific Primary Care Dentist (PCD) as part of the Dental Home Program. If scheduling problems arise, please advise the member to contact the SKYGEN USA Member Services team at **855-934-9812** to update their PCD assignment. For more information on tactics you can take to help prevent missed appointments, see Preventing Missed Appointments.

Providers can view a roster of members assigned to them at any time by going to SKYGEN USA's Provider Web Portal and following these steps:

1. Click on Report at the top of the toolbar
2. Click Primary Care Assignments
3. Keep default at "All" for location and provider
4. Click Print Report to export to PDF or Excel

Dental Services for Pregnant Women

Women eligible for Maryland Medicaid benefits qualify for dental services while they are pregnant—until their delivery date. Dental benefits do not extend past the delivery date, even if the member's Medicaid eligibility continues past this date. For information about covered services, see the **Maryland Healthy Smiles Dental Program: Pregnant Women & REM Adults** Age 21 and over section.

Providers are responsible for asking women if they are pregnant, and then submitting claims or authorizations accordingly. Women who are eligible for benefits may or may not have a Maryland Healthy Smiles Dental Program Member ID card and may or may not be identified in SKYGEN USA's benefits management software system. See the sections on **Submitting Authorizations for Pregnant Women** and **Submitting Claims for Pregnant Women**.

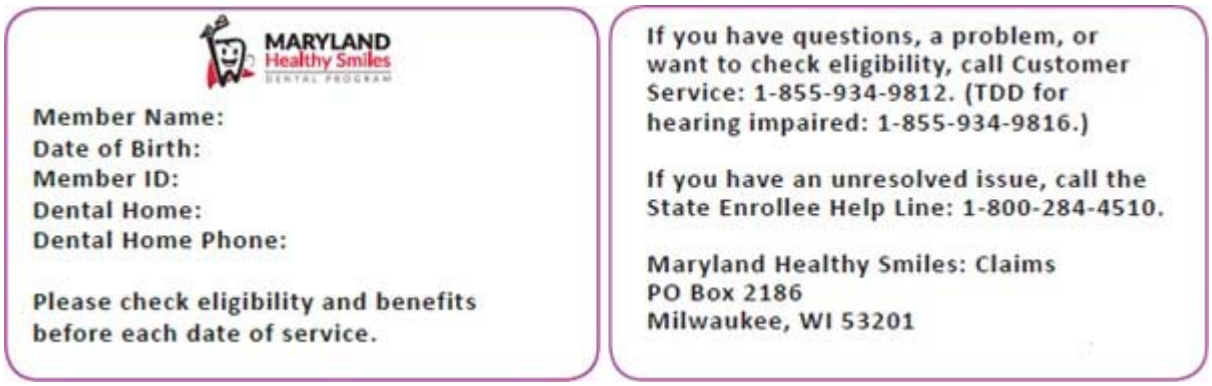
Member ID Card

Members receive Maryland Healthy Smiles Dental Program Member ID cards from SKYGEN USA. Participating providers are responsible for verifying that members are eligible when services are rendered and for determining whether recipients have other health insurance. Because it is possible for a member's eligibility status to change at any time without notice, presenting a Member ID card does not guarantee a member's eligibility, nor does it guarantee provider payment.

SKYGEN USA recommends each dental office make a photocopy of the member's identification card each time treatment is provided. Please be aware the identification card is not dated and does not need to be returned to SKYGEN USA should a member lose eligibility.

> Presenting a Member ID card **does not guarantee** that a person is currently eligible for benefits in the Maryland Healthy Smiles Dental Program.

Sample Member ID Card



Verifying Member Eligibility

To verify member eligibility, you can:

- Log on to Provider Web Portal: www.provider.MDhealthysmiles.com.
- Call Interactive Voice Response (IVR) eligibility line: **844-275-8753**.
- Check member eligibility and benefits on the **date of service**.

The Provider Web Portal and IVR system are both available 24 hours a day, 7 days a week — giving you quick access to information without requiring you to wait for an available Customer Service Representative during business hours.

Because a member's eligibility can change at any time without prior notice, **verifying eligibility does not guarantee payment**.

Verifying Eligibility via Provider Web Portal

Our Provider Web Portal allows quick, accurate verification of a member's eligibility for covered benefits, as of the date of service. Log in using your User ID and password at www.provider.MDhealthysmiles.com. First-time users need to self-register by entering their Payee ID, office name, and office address.

For help registering or using the Provider Web Portal, call the SKYGEN USA Web Portal Team: **855-434-9239**.

Once logged-in, you can quickly verify eligibility for an individual patient or for a group of patients, and you can print an online eligibility summary report for your records.

Verifying Eligibility via IVR

Use our Interactive Voice Response (IVR) system to verify eligibility for an unlimited number of patients. Call **844-275-8753**. Follow the prompts to identify yourself and the patient whose eligibility you are verifying.

Our system analyzes the information entered and verifies the patient's eligibility. If the system cannot verify the member information, you will be transferred to a Customer Service Representative. You also have the option of transferring to a Customer Service Representative after completing eligibility checks, if you have other inquiries.

Specialist Referrals

A patient who requires a referral to a dental specialist can be referred directly to any specialist contracted with the Maryland Healthy Smiles Dental Program provider network without authorization from SKYGEN USA. The dental specialist is responsible for obtaining prior authorization for services, as defined in the **Benefit Plan Details & Authorization Requirements** section of this provider manual.

If you are unfamiliar with the contracted specialty network for the Maryland Healthy Smiles Dental Program or need help locating a specialist provider, call Provider Services: **844-275-8753**.

Appointment Availability Standards

The Maryland Healthy Smiles Dental Program has established appointment time requirements to ensure patients receive dental services within a time period appropriate to their health condition. We expect dental providers to meet these appointment standards for a number of important reasons, including:

- Ensure patients receive the care they need to protect their health.
- Maintain member satisfaction.
- Reduce unnecessary use of alternative services such as emergency room visits.

Dentists are expected to meet the following minimum standards for appointment availability:

- Comprehensive assessment - An initial, comprehensive assessment must be scheduled within 90 days of a patient's enrollment.
- Routine appointments - Routine preventive care and follow-up appointments must be scheduled within 60 days.
- Specialist referrals - Specialty care appointments must be scheduled within 60 days of initial authorization from the patient's Primary Care Dentist (PCD)—or more quickly, if deemed necessary by the PCD.
- Emergency services. Emergency services must be available within 48 hours.

SKYGEN USA will educate providers about appointment standards, monitor the adequacy of the process, and take corrective action if required.

Summary: Appointment Availability Standards

Appointment Type	Appointment Required…
Emergency services	Within 48 hours
Specialist referral	Within 60 days, or sooner, per PCD request
Routine preventive, follow-up visits	Within 60 days
Comprehensive assessment	Within 90 days of patient enrollment

Missed Appointment Standards

Providers who participate in the Maryland Healthy Smiles Dental Program are not allowed to charge members for missed appointments. The Centers for Medicare & Medicaid Services (CMS) interpret federal law to prohibit a provider from billing any Medicaid Plan member for a missed appointment. In addition, your missed appointment policy for members enrolled in the Maryland Healthy Smiles Dental Program cannot be stricter than your policy for private or commercial patients.

If a Maryland Healthy Smiles Dental Program member exceeds your office policy for missed appointments and you choose to discontinue seeing the patient, ask the patient to contact Member Services for a referral to another Primary Care Dentist or Dental Home: **855-934-9812**.

Preventing Missed Appointments

At SKYGEN USA, we understand the unnecessary costs and frustration that missed appointments cause a dental office. We also understand the health risks for patients who miss scheduled appointments.

We recommend a two-pronged approach to help reduce the number of missed appointments.

- Consider implementing patient communication and scheduling tactics in your dental office that have proven to be successful in other practices.
- Our Provider Services team partners with our Member Outreach team and each dental office to track missed appointments and personally follow up with members. When a Maryland Healthy Smiles Dental Program member misses an appointment, call Provider Services: **844-275-8753**. See the **Reporting Missed Appointments section**.

Tactics for Dental Offices: Patient Communication

To help patients keep their dental appointments, consider implementing patient communication activities into your daily office workflow. These tactics have helped reduce missed appointments in other practices. Consider implementing any of the following suggestions that might work well for your office staff and your patients.

Get alternate phone numbers and email addresses. Get as much contact information as you can from your patients, so that you have alternate ways of reaching them if their living situation changes. Ask for a home phone number, home address, cell phone number, and email address.

Ask patients if they use public transportation. For patients who rely on public transportation, remind them to make their appointments according to the transportation schedule.

Repeat appointment date and time. When a patient makes an appointment with your office, state the day of the week and the date, and then repeat the date and time during the conversation. For example, *"Thanks for making an appointment for Thursday, July XX, Jane. We're looking forward to seeing you at 1:30 on July XX."*

Send patients appointment details. As soon as you make an appointment with a patient, follow up with an email message that confirms the appointment date and time, your office address and phone number, and a link to your website. If you don't have an email address for a patient, follow up with an appointment postcard, or send a letter and enclose an appointment card.

Offer patients options for appointment reminders. Ask patients whether they prefer to receive appointment reminders via telephone call, email message, or text message. Consider implementing HIPAA-compliant email and/or text messages that not only remind patients of upcoming appointments, but also let them respond to the message and confirm they received the notification. For patients who prefer to be reminded of appointments by a telephone call, ask for alternate phone numbers and ask what time of day is best to call.

Always confirm appointments. Always remind patients in advance of their upcoming appointments— either by telephone call, email message, and/or text message.

Motivate patients to keep appointments. When confirming appointments, remind patients that visiting the dentist regularly is important to their health, and that you are concerned about helping them stay healthy.

Always notify the dentist—and SKYGEN USA—of missed appointments. Missing an appointment may jeopardize a patient's health. When a patient misses an appointment, have a standard procedure in place to always notify the dentist. You should also notify SKYGEN USA when an appointment is missed, so that our Member Outreach team can follow up with members in the Maryland Healthy Smiles Dental Program. To notify us, call Provider Services: **844-275-8753**. See **Reporting Missed Appointments.**

Tactics for Dental Offices: Patient Scheduling

When setting up patient scheduling, consider implementing the following proven tactics to help reduce missed appointments.

Continuing care appointments - For patients who don't have a history of missed appointments, schedule continuing care visits with appointment dates three to six months in advance. For patients who have history of missed appointments, send a postcard or email message asking them call your office to schedule an appointment a week or two before the next continuing care visit is due.

Subsequent appointments for completing procedures - If a dental procedure requires a subsequent appointment for completion, talk with the patient personally about the importance of the next appointment. Reinforce the message by sending the patient home with written information that highlights the importance of the dental procedure, what will happen at the next appointment, and possible outcomes if the procedure isn't completed on time.

Emergency appointments - After rendering emergency services, call the patient a few days later to schedule follow-up treatment.

Flexible office hours - Daytime obligations, including work and childcare, are obstacles that can prevent patients from keeping appointments—or even making appointments in the first place. To help make it easier for patients to get the dental care they need, consider setting up an office schedule that includes extended hours on selected days of the week and/or occasional weekend hours.

Reporting Missed Appointments

Implementing patient communication and scheduling tactics should help your practice reduce the number of missed appointments. But when a patient enrolled in the Maryland Healthy Smiles Dental Program doesn't keep an appointment, our Member Outreach team wants to know about it. To keep it quick and simple, when a Maryland Healthy Smiles Dental Program member misses an appointment, just call Provider Services: **844-275-8753**.

Our Provider Services team tracks missed appointments by logging them in our Customer Service system. These records are automatically forwarded to our Member Outreach team for follow-up. They contact members personally and work with them to reschedule dental visits and provide education about the importance of keeping scheduled appointments.

The Missed Appointment log (see page 29) should be used to track your members missed appointments. This log can either be emailed to outreachcoordinator@skygenusa.com or faxed to SKYGEN USA at 410-624-5486.

If your office sends letters or postcards to members who miss appointments, the following language may be helpful to include:

- "We noticed you missed your scheduled dental appointment. Regular checkups are needed to keep your teeth healthy. Call us to schedule another appointment."
- "Call us to reschedule your missed appointment. If you cannot keep the appointment call us in advance to reschedule. Missed appointments are very costly to us. Thank you for your help."

SKYGEN USA
POWERING HEALTHCARE FOR THE DIGITAL AGE

Maryland Healthy Smiles Dental Program Missed Appointments

Providers please complete the following columns below						SKYGEN USA will complete the following columns below			
Date Missed Appointment Log Submitted	Date of Missed Appointment	Member Last Name	Member First Name	Member Medicaid Number	Provider Name	Date Member Called	Date entered in Enterprise	Call Made by (Initials)	Comments

Payment for Non-Covered Services

Enrolled participating providers shall hold members, the Maryland Healthy Smiles Dental Program and SKYGEN USA harmless for the payment of non-covered services except as provided in this paragraph. Providers may bill members for services that are not covered under the Maryland Healthy Smiles Dental Program if: (a) they inform the member that the service is not covered and (b) if the member agrees to have the service rendered and signs a **Non-Covered Services Agreement** form prior to the service being rendered.

For members who are in the MD Child or MD REM Child (ages 0-20) benefit plan, if a service or CDT code is not listed, please submit an authorization with the EPSDT box checked along with a letter of medical necessity for review. If the authorization is approved, the claim must be submitted for reimbursement with the EPSDT box selected. If the authorization for the service under EPSDT guidelines is denied, the provider must then have the member or legal guardian complete and sign a Non-Covered Services Agreement in order to provide the services.

The written Non-Covered Service Agreement must:

- Be signed prior to the service(s) being rendered;
- Be written in the member's native language;
- Specify exactly which service (CDT code) is to be performed and the cost of the service;
- Not have an open-ended explanation – it must specify the service(s) to be rendered; and
- State that that the patient will be financially liable for such services.

The Maryland Healthy Smiles Dental Program or SKYGEN USA will not pay for or be liable for these services.

Liaison Services for Members

Our liaison services for members offers:

- Three-way appointment scheduling, when requested, whereby a Customer Service Representative helps a member select an appropriate dental provider and then initiates a three-way telephone call with the dental office to schedule an office visit.
- Geo-mapping capabilities that allow a Customer Service Representative to offer turn-by- turn navigation directions to dental offices.
- Information about transportation for non-emergency dental visits.

  If your patients need help scheduling and keeping appointments, please ask them to call Member Services for assistance: **855-934-9812**.

Transportation Benefits

If your patients have questions about arranging transportation for dental appointments, refer them to their local health department or transit company. A list of location transportation contacts is available on the Provider Web Portal and is also included in this manual. Participants can also call Member Services for help: **855- 934-9812**.

Local Transportation Contacts

To set up a ride to a dental appointment for a member, call the local health department or Transit Company in the member's county. Medicaid transportation services provide transportation to members for Medicaid covered services, including dental appointments. Please note, for Adult Dental Pilot Members, once the member uses all of their benefit allowance, they will no longer be eligible to receive Medicaid transportation. As a covered entity, you are authorized to verify scheduled dental appointments with the local Medicaid transportation agencies if they contact your office.

County	Number to call (LHD unless otherwise noted)	Call Hours	After Hours Transports (Please call after close of business)
Allegany	301-759-5123	8:00 a.m. – 5:00 p.m.	County Medical Transport 301-582-6131
Anne Arundel	410-222-7152	8:00 a.m. - 2:30 p.m.	AAA Transport: 301-952-1193
Baltimore City	Enrollment & Scheduling 410-396-7633 Problem Resolution 410-396-7635 Facilities & Professional Offices 410-396-7634	7:30 a.m.-10:45 p.m. (M-F) 6:00 a.m.-8:45p.m. (Sat)	Hart to Heart 443-573-2073
Baltimore County	TransDev (Formerly Veolia) 410-783-2465 or 410-887-2828	8:00 a.m.-5:00 p.m. 8:30 a.m.-3:45 p.m.	Hart to Heart 443-573-2037
Calvert	410-414-2489	8:00 a.m.-4:30 p.m.	AAA Transport: 800-577-1050
Caroline	410-479-8014	8:00 a.m. – 4:30 p.m.	Best Care Ambulance: 410-476-3688
Carroll	410-876-4813	8:00 a.m.-4:00 p.m.	Butler Medical Transport 410-602-4007 or 1-888-602-4007
Cecil	410-996-5171	7:30 a.m.-4:00 p.m.	Ambulance 410-920-4167
Charles	301-609 6923 or 301-609-6933	8:00 a.m.-4:30 p.m.	AAA 301-952-1193 or 1-800-577-1050
Dorchester	410-901-2426	8:00 a.m.-12:00 p.m. & 1:00 p.m.-3:00p.m.	Best Care Ambulance 410-476-3688

Frederick	301-600-3124	8:00 a.m.-4:30 p.m.	Transit 301-600-2065 Para med 1-800-572-0005 Butler Medical Transport-1-888-602- 4007
Garrett	Enrollment & Scheduling 301-334-7726 Issues & Concerns 301-334-7727	8:30 a.m.-5:00 p.m.	County Medical Transport 301-582-6131
Harford	410-638-1671	8:30 a.m.-3:30 p.m.	Hart to Heart 443-573-2037 Pre-Scheduled Trips: AAA 301-952-1193
Howard	877-312-6571	8:30 a.m.-4:00 p.m.	Hart to Heart 443-573-2037
Kent	410-778-7025	8:00 a.m.-4:30 p.m.	Best Care Ambulance 410-758-1999
Montgomery	Montgomery Co Dept. of Transportation 240-777-5899	8:30 a.m.-12:00 p.m.	Freestate Transportation 410-609-2156 Butler Medical 1-888-602-4007
Prince George's	301-856-9555	8:00 a.m.-4:30 p.m.	Pro Care Ambulance 410-823-0030 or 410-661-1800 Falcon (Wheelchair Van) 240-595-0960
Queen Anne's	443-262-4462 or 410-758-0720 Ext. 4462	8:30 a.m.-11:30 p.m. 1:00 p.m. – 3:00 p.m.	Best Care Ambulance 410-476-3688 or 410-758-1999
St. Mary's	301-475-4296	8:00 a.m.-5:00 p.m.	AAA 1-800-577-1050
Somerset	443-523-1722	8:00 a.m.-4:30 p.m.	East Coast Ambulance 410-663-2012
Talbot	410-819-5609	8:00 a.m. – 3:30 p.m.	Best Care Ambulance 410-476-5907
Washington	240-313-3264	8:00 a.m.-4:15 p.m.	AAA 1-800-577-1050
Wicomico	410-548-5142 Option # 1	8:00 a.m.-4:30 p.m.	East Coast Ambulance 410-663-2012
Worchester	410-632-0092 or 0093	8:00 a.m.-4:00 p.m.	Best Care 410-476-5907 Lifestar 410-546-0809

Prior Authorization & Documentation Requirements

Prior Authorization for Treatment

The Maryland Healthy Smiles Dental Program/SKYGEN USA has specific utilization criteria, as well as a prior authorization review process, to manage the utilization of services. Whether prior authorization is required for a particular service, and whether supporting documentation is also required, is defined in this provider manual in **Benefit Plan Details & Authorization Requirements section**.

Non-emergency services requiring prior authorization should not be started until the authorization request is reviewed and approved by a SKYGEN USA consultant. Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the member, the Maryland Healthy Smiles Dental Program or SKYGEN USA LLC.

Should a procedure need to be initiated to relieve pain and suffering in an emergency situation, you are to provide treatment to alleviate the patient's condition. For more details regarding emergency services, see the **Emergency Treatment section in the manual**.

Submit requests for prior authorization online through the Provider Web Portal (www.provider.MDhealthysmiles.com), electronically in a HIPAA-compliant data file, or via postal mail on a paper 2019 ADA Dental Claim Form. (See **Authorization Submission Procedures section**). Any authorizations submitted without the required documentation will be denied and must be resubmitted to obtain prior approval before services are rendered. Any claims submitted without the required approved prior authorization will be denied for reimbursement.

Any authorization submitted without the required documents will be moved to a development status. An outreach call will be made within 48 hours in addition to a letter being sent requesting the documents needed in order to review the authorization and make a determination. If the required documents are not received within 5 days of the authorization submission date, the authorization will be denied.

SKYGEN USA will make a decision on a request for prior authorization within 2 business days from the date we receive the request, provided all information is complete. SKYGEN USA will honor prior authorizations for 180 calendar days from the date they are determined. ***An authorization does not guarantee payment***. The member must be eligible for benefits at the time services are provided. SKYGEN USA reviewers and licensed dental consultants approve or deny authorization requests based on whether:

- The item or service is medically necessary;
- A less expensive service would adequately meet the member's needs; and
- The proposed item or service conforms to commonly accepted standards in the dental community.

Dental Surgery Services

Dental services that are to be performed outside your office, either in an outpatient department of a hospital or at an ASC, must be approved by SKYGEN USA to ensure the services meet the medical necessity criteria for services rendered in an outpatient facility (hospital or ASC). See the **Dental Surgery Services** section.

Determined Authorizations: Peer to Peer Requests

If you disagree with the prior authorization decision or wish to speak to the dental reviewer, you can request a peer-to-peer review by contacting SKYGEN USA within 2 business days of the denial determination by calling Provider Services, 844-275-8753.

A peer-to-peer request is part of the State's utilization review process. In accordance with HIPAA regulations, the peer-to-peer review will only be used for payment, treatment and health care operation purposes and does not require a release of information, consent or authorization from the patient. If a request for a peer-to-peer review is not received within 2 business days, the denial determination will stand.

If SKYGEN USA denies approval for any requested service, the member will receive written notice of the reasons for each denial and will be notified of how to appeal the decision. The requesting provider will also receive notice of the decision. The provider may also appeal a denial for any requested service. To appeal an authorization decision with SKYGEN USA, submit the appeal in writing along with any necessary documentation within 30 days of the original determination date to:

Maryland Healthy Smiles:
Grievances/Appeals PO Box 393
Milwaukee, WI 53201

Summary: Prior Authorization Timelines

Authorization Request	Timeline
Decision on authorization request	SKYGEN USA approves or denies request within 2 business days.
Prior authorization expiration	SKYGEN USA honors approved prior authorizations for 180 calendar days from decision date.
Appeal acknowledgement	SKYGEN USA acknowledges receipt of appeals within 5 business days.
Authorization decision appeal: Members	Members must appeal with SKYGEN USA within 30 days of the original authorization denial date.
Authorization decision appeal: Members Fair Hearing	Members must request a fair hearing before an administrative law judge within 90 days of the original authorization denial date.
Authorization decision appeal: Providers	Providers must appeal within 30 days of the original authorization denial date. Providers must have the member's written consent to appeal a decision on the member's behalf.
Authorization appeal decision: Non-expedited	SKYGEN USA renders decision within 30 days of receiving the appeal.
Authorization appeal decision—Expedited	SKYGEN USA renders decision within 3 business days of receiving the expedited appeal.

Authorization Submission Procedures

SKYGEN USA accepts authorizations submitted in any of the following formats:

- Provider Web Portal, www.provider.MDhealthysmiles.com
- Electronic submission via clearinghouse, Payer ID: **SCION**
- Paper 2019 ADA Dental Claim Form, available from the American Dental Association

Submitting Authorizations via Provider Web Portal

Providers may submit authorizations along with any required treatment documentation directly to SKYGEN USA through our Provider Web Portal: www.provider.MDhealthysmiles.com.

Submitting authorizations via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility, pre-fill the authorization form with member information, and make data entry quick and easy.
- The online authorization process provides clinical guidelines, when applicable, giving you a quick indication of how your authorization request will be evaluated and whether it's likely to be approved. (Successfully completing a clinical guideline does not guarantee payment.)
- The online authorization process indicates whether supporting documentation is required and allows you to attach and send documents as part of the authorization request—***for no charge***.
- Dental reviewers and consultants receive your authorization requests and supporting documentation as soon as you submit them online, meaning you'll receive decisions faster.
- As soon as an authorization is determined, its status is instantly updated online and available for review. You don't have to wait for a letter to find out whether your authorization request is approved.

If you have questions about submitting authorizations online, attaching electronic documents, or accessing the Provider Web Portal, call the Web Portal Team: **855-434-9239**.

Submitting Authorizations via Clearinghouses

Providers may submit electronic claims and authorizations to SKYGEN USA directly via their preferred clearinghouse. Your clearinghouse and/or software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN USA.

The SKYGEN USA Payer ID is SCION. By using this unique Payer ID when submitting your electronic files, your clearinghouse can ensure that claims and authorizations are routed successfully to SKYGEN USA. For more information regarding clearinghouses that may already be processing claims thru SKYGEN USA please contact EDIDentalDept@skygenusa.com.

Attaching Electronic Documents

If you use the Provider Web Portal (www.provider.MDhealthysmiles.com), you can quickly and easily send electronic documents as part of submitting a claim or authorization—***for no charge***.

SKYGEN USA also accepts dental radiographs and other documents electronically via Fast Attach™ for authorization requests. For more information, visit www.nea-fast.com or call NEA (National Electronic Attachment, Inc.): **800-782-5150**.

Submitting Authorizations on Paper Forms

To ensure timely processing of submitted authorizations, the following information must be included on the paper 2019 ADA Dental Claim Form:

- Member Name
- Member Medicaid ID Number
- Member Date of Birth
- Provider Name
- Provider Location
- Billing Location
- Provider NPI
- Payee Tax Identification Number (TIN)

Use approved ADA dental codes, as published in the current CDT book or as defined in this manual, to identify all services. Include on the form: all quadrants, tooth numbers, and surfaces for dental codes that require identification (extractions, root canals, amalgams, and resin fillings).

SKYGEN USA recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Designate supernumerary teeth with codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is 1, then chart the supernumerary tooth as 51. Likewise, if the nearest tooth is A, chart the supernumerary tooth as AS.

Missing, incorrect, or illegible information could result in the authorization being returned to the submitting provider's office, causing a delay in determination. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned.

X-Ray Return Policy. To request that x-rays are returned, providers must include a self-addressed stamped envelope with x-rays. Otherwise, x-rays are shredded. Mail paper authorizations to:

Maryland Healthy Smiles:
Authorizations PO Box 422
Milwaukee, WI 53201

Submitting Authorizations for Pregnant Women

Pregnant women (age 21 or older) who are eligible for Maryland Medicaid benefits qualify for dental services while they are pregnant—until their delivery date. Dental benefits do not extend past the delivery date, even if the member's Medicaid eligibility continues past this date. For information about covered services, see the Maryland Healthy Smiles Dental Program: Pregnant Women & REM Adults Age 21 and Over section.

Providers are responsible for asking women if they are pregnant, and then submitting authorizations accordingly. Pregnant women (age 21 or older) who are eligible for dental benefits may or may not have a Maryland Healthy Smiles Dental Program Member ID card and may or may not be identified as eligible for dental benefits in SKYGEN USA's benefits management software system.

Please submit requests for authorizations and claims with the ICD-10-CM diagnostic code, ***Z3A.00***, in ***Box 29a and 34a of the 2019 ADA Dental Claim Form or the related fields in the Provider Web Portal***. Claims and authorizations submitted without the Z3A.00 diagnosis code will deny.

To verify eligibility, use either the Provider Web Portal or our IVR telephone system. If our software system indicates the individual is:

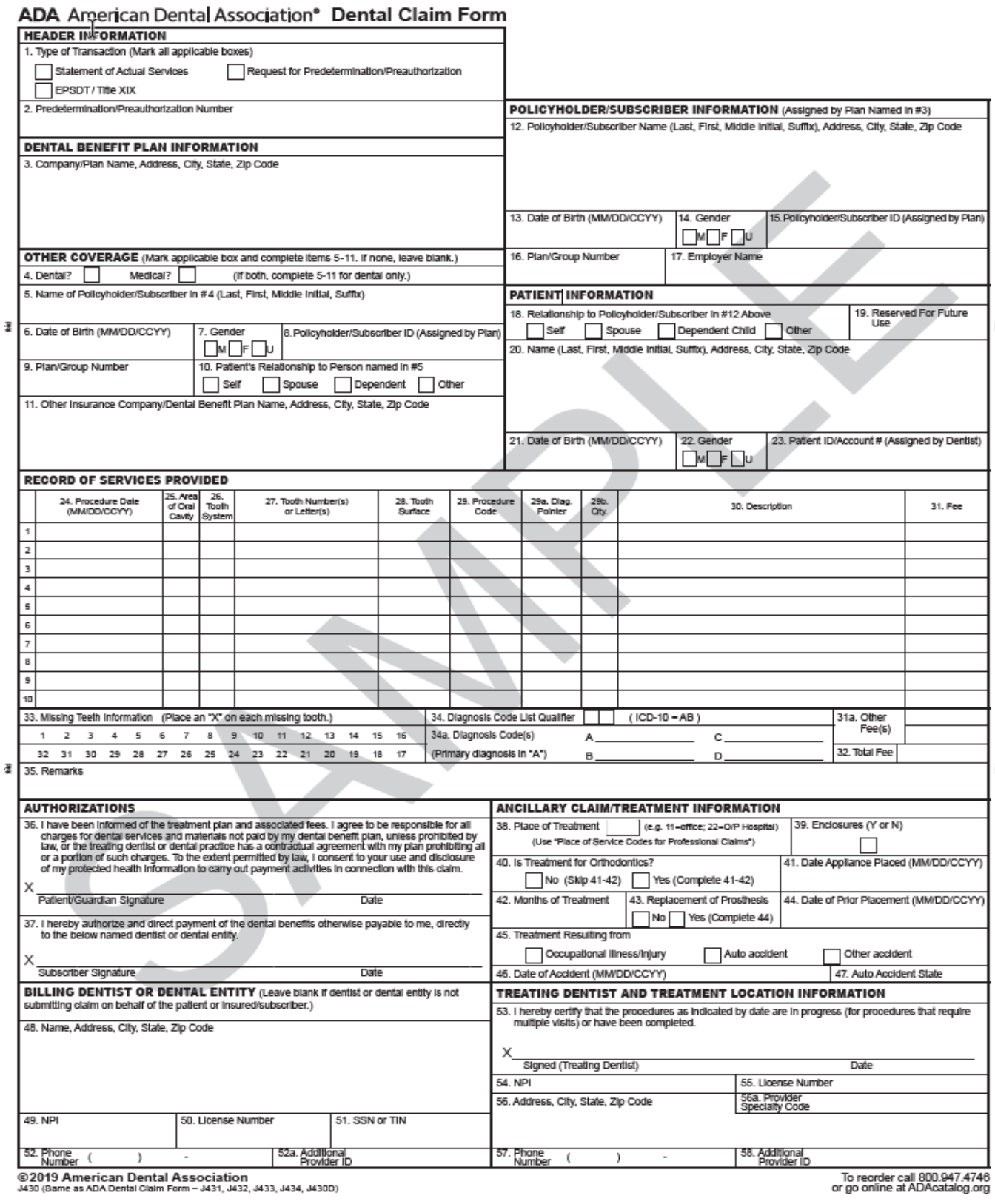
- Not found in our system, then the person is not enrolled in a Maryland Medicaid program and is not eligible for Healthy Smiles Dental Program dental benefits. Any authorizations submitted for "***member not found***" are automatically denied.
- Eligible for dental benefits in the Healthy Smiles Dental Program, you can submit either an electronic authorization or a paper authorization for services.
- An "***eligible member***" in the ***MD Dental ONLY IF Pregnant – Paper Claims Only – Note Pregnancy on Claims/Auths*** plan, then you must submit either an electronic authorization or a paper authorization.
- Providers will need to submit both claims and authorizations for members who are pregnant with the following Diagnosis Code: **Z3A.00** (Box 29a and Box 34a of ADA form).
- Providers will no longer need to write in the remarks field of the claim/authorization "member is pregnant and expected due date."
- Claims and authorizations submitted for pregnant women without Diagnosis Code: Z3A.00 will be denied.

Authorizations for patients identified in the ***MD Dental ONLY IF Pregnant – Paper Claims Only – Note Pregnancy on Claims/Auths*** plan require special handling because these members are enrolled in a Maryland Medicaid program, but they have not been previously identified as pregnant.

X-Ray Return Policy. To request that x-rays are returned, providers must include a self-addressed stamped envelope with x-rays. Otherwise, x-rays are shredded. Mail paper authorizations to:

Maryland Healthy Smiles:
Authorizations, Pregnant Women PO Box 422
Milwaukee, WI 53201

ADA Approved Dental Claim Form



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

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

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

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

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

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

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

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

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

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

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

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

ADA Approved Dental Claim Form (Cont.)

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

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

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

Claim Submission Procedures

SKYGEN USA accepts claims submitted in any of the following formats:

- Provider Web Portal, www.provider.MDhealthysmiles.com
- Electronic submission via clearinghouse, Payer ID: **SCION**
- Paper 2019 ADA Dental Claim Form, available from the American Dental Association

*** Note:** The 2012 ADA Dental Claim Form will be accepted through April 30, 2020. Effective May 1, 2020 all claims must be submitted on the 2019 version of the claim form or the claim will be denied.

Submitting Claims via Provider Web Portal

Providers may submit claims directly to SKYGEN USA through our Provider Web Portal: www.provider.MDhealthysmiles.com.

Submitting claims via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility, pre-fill the claim form with member information, and make data entry quick and easy.
- The online process allows you to attach and send electronic documents as part of submitting a claim—***for no charge***.
- Before submitting a claim—or before rendering services—you can generate an online claim estimate to find out how much you are likely to be paid or whether your claim will be denied—and the reasons why.
- Claims enter our benefits administration system faster—which means you receive payment faster.
- As soon as a claim is paid, its status is instantly updated online, and a Remittance Report is available for review.

If you have questions about submitting claims online, attaching electronic documents, or accessing the Provider Web Portal, call the Web Portal Team: **855-434-9239**.

Submitting Claims via Clearinghouses

Providers may submit electronic claims and authorizations to SKYGEN USA directly via their preferred clearinghouse. Your clearinghouse and/or software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN USA.

The SKYGEN USA Payer ID is **SCION**. By using this unique Payer ID when submitting your electronic files, your clearinghouse can ensure that claims and authorizations are routed successfully to SKYGEN USA.

For more information regarding clearinghouses that may already be processing claims through SKYGEN USA please contact EDIDentalDept@skygenusa.com.

Attaching Electronic Documents

If you use the Provider Web Portal (www.provider.MDhealthysmiles.com), you can quickly and easily send electronic documents as part of submitting a claim or authorization—***for no charge***. SKYGEN USA, in conjunction with NEA (National Electronic Attachment, Inc.), also allows enrolled providers to submit documents electronically via FastAttach™. This program allows secure transmissions of radiographs, periodontics charts, intraoral pictures, narratives and EOBs (please Coordination of Benefits for more details). FastAttach™ is compatible with most claims clearinghouses and practice management systems. For more information, visit http://www.nea-fast.com or call NEA at **800-782-5150**.

Submitting Claims on Paper Forms

To ensure timely processing of paper claims, the following information must be included on the paper 2019 ADA Dental Claim Form:

- Member Name, Member Medicaid ID Number, Member Date of Birth
- Provider Name, Provider Location
- Billing Location
- Provider NPI
- Payee Tax Identification Number (TIN)
- Date of Service, for each service line

Use approved ADA dental codes, as published in the current CDT book or as defined in this manual, to identify all services. Include on the form: all quadrants, tooth numbers, and surfaces for dental codes that require identification (extractions, root canals, amalgams and resin fillings).

SKYGEN USA recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Designate supernumerary teeth with codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is 1, then chart the supernumerary tooth as 51. Likewise, if the nearest tooth is A, chart the supernumerary tooth as AS.

As of October 1, 2015 ICD-10 diagnosis codes have replaced ICD-9 diagnosis codes. Diagnosis codes for Maryland Healthy Smiles Dental Program (MHSDP) members are ONLY required if the member has MD Dental ONLY if Pregnant coverage. The ICD-10 diagnosis code for MD Dental ONLY if Pregnant claims is Z3A.00. For all other MHSDP members, a diagnosis code is not required on the dental claim. If your dental practice submits dental claims with diagnosis codes as part of your procedural practice with a current date of service, a valid ICD-10 diagnosis code must be used. If an invalid ICD-10 or an ICD-9 diagnosis code is used, the claim will be rejected.

A new claim must then be submitted with a valid ICD-10 diagnosis code or no diagnosis code on the dental claim. Missing, incorrect, or illegible information could result in the claim being returned to the submitting provider's office, causing a delay in payment. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned. Mail paper claims to:

Maryland Healthy Smiles:
Claims PO Box 2186
Milwaukee, WI 53201

Submitting Claims for Pregnant Women

Pregnant women (age 21 or older) who are eligible for Maryland Medicaid benefits qualify for dental services while they are pregnant—until their delivery date. Dental benefits do not extend past the delivery date, even if the member's Medicaid eligibility continues past this date.

For information about covered services, see the Maryland Healthy Smiles Dental Program: Pregnant Women & REM Age 21 & Over section.

Providers are responsible for asking women if they are pregnant, and then submitting claims accordingly. Pregnant women (age 21 or older) who are eligible for dental benefits may or may not have a Maryland Healthy Smiles Dental Program Member ID card and may or may not be identified as eligible for dental benefits in SKYGEN USA's benefits management software system.

To verify eligibility, use either the Provider Web Portal or our IVR telephone system. If our software system indicates the individual is:

- Not found in our system, then the person is not enrolled in a Maryland Medicaid program and is not eligible for Maryland Healthy Smiles Dental Program dental benefits. Any claims submitted for "***member not found***" are automatically denied.
- Eligible for dental benefits in the Maryland Healthy Smiles Dental Program, you can submit either an electronic claim or a paper claim for services.
- An "***eligible member***" in the ***MD Dental ONLY IF Pregnant – Paper Claims Only – Note Pregnancy on Claims/Auths*** plan, then you must submit a paper claim for services ***for each visit***.
- Providers will need to submit both claims and authorizations for members who are pregnant with the following Diagnosis Code: **Z3A.00** (Box 29a and Box 34a of ADA form)
- Providers will no longer need to write in the remarks field of the claim/authorization "member is pregnant and expected due date."
- Claims and authorizations submitted without Diagnosis Code: **Z3A.00** will be denied.

Claims for patients identified in the ***MD Dental ONLY IF Pregnant – Paper Claims Only – Note Pregnancy on Claims/Auths*** plan require special handling because these members are enrolled in a Maryland Medicaid program, but they have not been previously identified as pregnant. Mail paper claims for each visit to:

Maryland Healthy Smiles:
Claims, Pregnant Women PO Box 2186
Milwaukee, WI 53201

Coordination of Benefits (COB)

The Maryland Healthy Smiles Dental Program/SKYGEN USA is the payer of last resort. When a participant arrives for an appointment, always ask if they have other dental insurance coverage. When the Maryland Healthy Smiles Dental Program/SKYGEN USA is the secondary insurance carrier, submit a copy of the primary carrier's Explanation of Benefits (EOB) with the claim. For paper claims the primary paper information/ EOB must be included and attached.

For electronic claim submissions via a clearing house, the primary payer information must be included on the claim submission. The electronic claim must have the primary payer information completed in the correct segments (loops) and entered by service line, according to the clearing house's "Companion Guide," in addition to the Explanation of Benefits attachment through NEA, FastAttach™, or your clearinghouse.

If the Coordination of Benefits (COB) fields are not completed, the claim will process incorrectly, and a corrected paper claim will need to be submitted with the primary insurer's EOB. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, the Maryland Healthy Smiles Dental Program/SKYGEN USA will consider the claim paid in full and no further payment will be made on the claim.

Timely Filing Limits

SKYGEN USA must receive claims requesting payment within 12 months from the date of service. Claims submitted more than 12 months from the date of service will be denied for "untimely filing." If a claim is denied for untimely filing, you may not bill the member. If the Maryland Healthy Smiles Dental Program/SKYGEN USA is not the primary carrier, the claim still must be received within 365 days from the **date of service**.

Corrected Claim Process

If a claim or a service line is denied because information was missing from the submitted claim, or if you have additional information or documentation that you believe may change the payment decision, simply resubmit the claim and include the missing information. For example, resubmit a claim with additional information if a service was denied because of a missing tooth number or surface, or if a claim was denied because documentation showing medical necessity was not originally submitted.

However, if a service line on a claim was paid that should not have been paid—or if a claim was paid to the wrong payee or on behalf of the wrong member, then submit a new "Corrected" claim to reverse the incorrect payment and reprocess the claim with the corrected information.

For example, if a claim is submitted and paid with the wrong provider NPI or clinic location, incorrect payee Tax ID, wrong member, incorrect procedure code, etc., then the paid claim must be corrected and reprocessed.

Resubmitting a Denied Claim

To resubmit a claim that has been denied with additional information, follow the standard **Claim Submission Procedures section** of this provider manual. Timely filing limitations apply when a claim is resubmitted for reprocessing.

For example, resubmit a claim with additional information if a service was denied because of a missing tooth number or surface, or if a claim was denied because documentation showing medical necessity was not originally submitted.

However, if a service line on a claim was paid that should not have been paid—or if a claim was paid to the wrong payee or on behalf of the wrong member, then submit a new "Corrected" claim to reverse the incorrect payment and reprocess the claim with the corrected information.

For example, if a claim is submitted and paid with the wrong provider NPI or clinic location, incorrect payee Tax ID, wrong member, incorrect procedure code, etc., then the paid claim must be corrected and reprocessed.

Submitting a Corrected Claim

To reverse and correct a payment that should not have been made, submit a corrected claim on the paper 2019 ADA Dental Claim Form via postal mail.

- Identify the claim as **Corrected** by writing "**Corrected**" across the top of a paper claim form.
- In the remarks field (Box 35) of the ADA Claim form you must indicated the original paid encounter number **and** record all corrections you are requesting to be made.
- NOTE: if all information does not fit in Box 35, please attach an outline of the corrections to the claim form.
- Attach supporting documentation, and send documentation in the same package with the paper claim form.
- Send paper forms and documents to:

  Maryland Healthy Smiles: Corrected Claims
  P.O. Box 541
  Milwaukee, WI 53201

Receipt & Audit of Claims

To ensure timely, accurate payment to each participating provider, SKYGEN USA audits claims for completeness as they are received. This audit validates member eligibility, procedure codes, and provider identification information. A Dental Reimbursement Analyst reviews any claim conditions that would result in nonpayment. When potential problems are identified, your office may be asked to help resolve the issue. For questions about claims submission or remittances, call Provider Services: **844-275-8753.**

Claims Adjudication & Payment

The SKYGEN USA benefits administration software system imports claim and authorization data, evaluates and edits the data for completeness and correctness, analyzes the data for clinical appropriateness and coding correctness, audits against plan and benefit limits, calculates the appropriate payment amounts, and generates payments and remittance summaries. The system also evaluates and automatically matches claims and services that require prior authorizations and matches the claims and services to the appropriate member record for efficient and accurate claims processing.

As soon as the system prices and pays claims, checks and electronic payments are generated, and remittance summaries are posted and available for online review from the Provider Web Portal: www.provider.MDhealthysmiles.com. To appeal a reimbursement decision, submit the appeal in writing within 30 days of the decision date, along with any necessary documentation to:

Maryland Healthy Smiles: Grievances/Appeals
P.O. Box 393
Milwaukee, WI 53201

Grievances & Appeals

The Maryland Healthy Smiles Dental Program and SKYGEN USA are committed to providing high-quality dental services to all members. As part of that commitment, we work to ensure all members and providers have every opportunity to exercise their rights to a fair and timely resolution to any grievances and appeals.

Our procedures for handling and resolving grievances (complaints) and appeals are designed to:

- Ensure fair, just, and speedy resolutions by working cooperatively with providers and supplying any documentation related to grievances and/or appeals, upon request.
- Treat providers and members with dignity and respect at all levels of the grievances and appeals resolution process.
- Inform providers and members of their full rights as they relate to grievance and appeal resolutions, including their rights of appeal at each step in the process.
- Resolve grievances and appeals in a satisfactory and acceptable manner within the Maryland Healthy Smiles Dental Program/SKYGEN USA protocol.
- Comply with all regulatory guidelines and policies with respect to grievances (complaints) and appeals.
- Efficiently monitor the resolution of grievances, to allow for tracking and identifying unacceptable patterns of care over time.

Differences sometimes arise between dental providers and insurers or their benefit administrators regarding prior authorization determinations and payment decisions. Since many of these issues result from misunderstanding of service coverage, processing policy, or payment levels, we encourage providers to contact us for explanations and education. For assistance, call Provider Services: 844-275-8753.

A designated SKYGEN USA Appeals Specialist is dedicated to the expedient, satisfactory resolution of both provider and member grievances and appeals.

Making a Grievance

SKYGEN USA takes an active role assisting providers and members who have grievances. If you have a grievance, you can either:

- Send a written grievance to:

  Maryland Healthy Smiles: Grievances/Appeals
  PO Box 393
  Milwaukee, WI 53201;

- Call Provider Services: 844-275-8753

Grievance Investigation & Resolution

SKYGEN USA logs all grievances we receive, whether received verbally or in writing, in our Customer Service system. The system automatically routes all grievances to our Appeals department for review and resolution.

SKYGEN USA investigates and resolves grievances within the following time frames:

- **Emergency, clinical issues**: within 24 hours of receipt or by close of the next business day.
- **Non-emergency clinical issues**: within 5 days of receipt.
- **Non-clinical issues**: within 30 days of receipt.

A licensed Dental Consultant reviews and resolves any quality of care issue that is related to a clinical issue. For all inquiries that are clinical in nature, the Appeals Specialist gathers clinical documentation and routes it to a licensed Dental Consultant for review and determination. To handle emergency clinical situations, the Appeals Specialist follows department protocol to expedite the resolution, which includes immediately notifying an on-call Dental Consultant.

All clinical documentation is available for Dental Consultants to review online through our web-based benefits management system. Electronic copies of clinical documents are attached to the inquiry in the Customer Service system and to any related authorization records in the integrated Authorization Determination system. To ensure Dental Consultants have the information they need to make complete and fair determinations, the Appeals staff works closely with the Provider Relations team to obtain necessary information and clarifications from providers.

Appeals Investigation & Resolution

The SKYGEN USA Appeals department is dedicated to identifying and promptly resolving member and provider appeals. Appeals are available to any member or provider who disagrees with a decision to deny services or payment for services. Appeals can also be requested by representatives who are authorized to appeal on behalf of a member, such as a lawyer, parent or guardian, dental provider, etc. SKYGEN USA provides both the member and the provider a copy of their appeal rights with each pre- or post-service denial.

Submitting Provider Appeals

Participating providers who disagree with claim payment decisions or authorization decisions made by SKYGEN USA reviewers or dental consultants may submit a written appeal within 30 days of the original denial date.

As a provider, you may file an authorization appeal on a member's behalf, with their written consent. When submitting a written appeal, include your name and your clinic address, member's name and Member ID, reasons you disagree with the decision, and additional documentation that supports your appeal, such as x-rays, treatment plans, medical records, etc. Send written appeals to:

Maryland Healthy Smiles:
Grievances/Appeals P.O. Box 393
Milwaukee, WI 53201

Submitting Member Appeals

A member may appeal any SKYGEN USA decision which denies or reduces services. Member appeals are reviewed under our administrative appeal procedure. Appeals regarding authorization determinations must be filed within 30 days of the authorization denial date. SKYGEN USA will review the appeal and render a decision within 30 days if an extension (of up to 14 days) is not requested and granted. SKYGEN USA will deliver expedited resolutions within 3 business days. Send written member appeals to:

Maryland Healthy Smiles:
Grievances/Appeals P.O. Box 393
Milwaukee, WI 53201

Summary: Grievance & Appeal Timelines

Grievance/Appeal Action	Timeline
Grievance related to clinical issue—emergency	SKYGEN USA investigates and resolves within 24 hours of receipt or by close of the next business day.
Grievance related to clinical issue—non-emergency	SKYGEN USA investigates and resolves within 5 days of receipt.
Grievance related to non-clinical issue	SKYGEN USA investigates and resolves within 30 days of receipt.
Appeal acknowledgement	SKYGEN USA acknowledges receipt of appeal within 5 business days.
Authorization decision appeal—Members	Members must appeal within 30 days of the original authorization denial date.
Authorization decision appeal—Providers	Providers must appeal within 30 days of the original authorization denial date. Providers must have the member's written consent to appeal a decision on the member's behalf.
Authorization appeal decision—Non-expedited	SKYGEN USA renders decision within 30 days of receiving the appeal.
Authorization appeal decision—Expedited	SKYGEN USA renders decision within 3 business days of receiving the expedited appeal.
Claim appeal	Providers must appeal within 30 days of the notice of decision. SKYGEN USA renders decision within 30 days of receiving the appeal.

Provider Credentialing and Enrollment

Effective 8/27/18, SKYGEN USA is no longer responsible for enrollment, revalidation or credentialing of dental providers in the Maryland Health Smiles provider network. All Medicaid credentialing, enrollment and revalidation activities are now required to be completed in ePREP, Maryland's electronic Provider Revalidation and Enrollment Portal. Please note that all applications for enrollment, re-enrollment, revalidation, additional locations, demographic changes, license renewal and affiliation of a rendering provider to a group will be required to be submitted in ePREP.

Maryland Medicaid requires all dental providers who operate a group practice to have separate NPIs/Medicaid ID numbers for each location.

For more information about ePREP please visit: https://mmcp.health.maryland.gov/Pages/ePREP.aspx.

You may also contact the ePREP call center at 1-844-4MD-PROV (1-844-463-7768) if you have any questions concerning your enrollment, credentialing or revalidation.

Please note that while SKYGEN USA is not affiliated with ePREP, we are still available for assisting Maryland Health Smiles dental providers with other provider related issues or questions. For assistance please call SKYGEN USA's Provider Services' department at 844-275-8753.

Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, if you transmit any health information electronically, your office is required to comply with all aspects of the Health Insurance Portability and Accountability Act (HIPAA) regulations that have gone/will go into effect as indicated in the final publications of the various rules covered by HIPAA.

SKYGEN USA has implemented numerous operational policies and procedures to ensure we comply with all HIPAA Privacy Standards, and we intend to comply with all Administrative Simplification and Security Standards by their compliance dates. We also expect all providers in our networks to work cooperatively with us to ensure compliance with all HIPAA regulations.

Together, you (the provider) and SKYGEN USA agree to conduct our respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

When you contact Provider Services, you will be asked to supply your Tax ID or NPI number. When you call regarding member inquiries, you will be asked to supply specific member identification such as Member ID or Social Security Number, date of birth, name, and/or address.

As regulated by the Administrative Simplification Standards, the benefit tables included in this provider manual reflect the most current CDT coding standards recognized by the American Dental Association (ADA). Effective as of the date of this manual, the Maryland Healthy Smiles Dental Program/SKYGEN USA require providers to submit all claims with the proper CDT codes listed in this manual. In addition, all paper claims must be submitted on the paper 2019 ADA Dental Claim Form.

To request copies of SKYGEN USA HIPAA policies, call Provider Services or send an email to providerservices@skygenusa.com. To report a potential security issue, call our Hotline: **877-378-5292**.

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the adoption of a standard unique provider identifier for healthcare providers. An NPI number is required for all claims submitted to SKYGEN USA for payment. All providers must register as an individual practitioner and get an individual NPI. If you own and operate a group practice, you must also register as a group and obtain a group or organizational NPI.

To apply for an NPI, do one of the following:

- Complete the application online at https://nppes.cms.hhs.gov.
- Download and complete a paper copy from https://nppes.cms.hhs.gov.
- Call **800-465-3203** to request an application.

Utilization Management

Community Practice Patterns

To ensure fair and appropriate reimbursement, the SKYGEN USA Utilization Management philosophy recognizes the relationships between the dentist's treatment planning, treatment costs, and outcomes. The dynamics of these relationships are typically influenced by community practice patterns. With this in mind, our Utilization Management guidelines are designed to ensure healthcare dollars are distributed fairly and appropriately, as defined by the regionally based community practice patterns of local dentists and their peers.

All Utilization Management analysis, evaluations, and outcomes are related to these community practice patterns. SKYGEN USA Utilization Management recognizes individual dentist variance within these patterns among a community of dentists and accounts for such variance. To ensure fair comparisons within peer groups, our Utilization Management evaluates specialty dentists as a separate group and not with general dentists, since the types and nature of treatment may differ.

Evaluation

SKYGEN USA's Utilization Management evaluates claims submissions in such areas as:

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

Results

With the objective of ensuring fair and appropriate reimbursement to providers, SKYGEN USA's Utilization Management helps identify providers whose treatment patterns show significant deviation from the normal practice patterns of the community of their peers (typically less than 5% of all dentists). SKYGEN USA is contractually obligated to report suspected fraud, waste, abuse, or misuse by members and participating dental providers to the Maryland Department of Health.

Non-Incentivization Policy

It is SKYGEN USA's practice to ensure our contracted providers make treatment decisions based on medical necessity for individual members. Providers are never offered, nor shall they ever accept, any kind of financial incentives or any other encouragement to influence their treatment decisions. The SKYGEN USA Utilization Management team bases their decisions on only appropriateness of care, service, and existence of coverage. SKYGEN USA does not specifically reward practitioners or other individuals for issuing denials of coverage or care. If financial incentives exist for Utilization Management decision makers, they do not include or encourage decisions which result in underutilization.

Fraud, Waste & Abuse

SKYGEN USA conducts our business operations in compliance with ethical standards, contractual obligations, and all applicable federal and state statutes, regulations, and rules. We are committed to detecting, reporting, and preventing potential fraud, waste, and abuse, and we look to our providers to assist us. We expect our dental partners to share this same commitment, conduct their businesses similarly, and report suspected noncompliance, fraud, waste or abuse.

Definitions

Fraud, waste, and abuse are defined as:

Fraud. Fraud is intentional deception or misrepresentation made by a person with knowledge the deception could result in some unauthorized benefit to themselves or some other person or entity. It includes any act which constitutes fraud under federal or state law.

Waste. Waste is the unintentional, thoughtless, or careless expenditures, consumption, mismanagement, use, or squandering of federal or state resources. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse. Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and that result in the unnecessary cost to the government healthcare program or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. Abuse includes intentional infliction of physical harm, injury caused by negligent acts, or omissions, unreasonable confinement, sexual abuse, or sexual assault. Abuse also includes beneficiary practices that result in unnecessary costs to the healthcare program.

Provider Fraud. Provider fraud is any deception or misrepresentation committed intentionally, or through willful ignorance or reckless disregard, by a person or entity in order to receive benefits or funds to which they are not entitled. This may include deception by improper coding or other false statements by providers seeking reimbursement or false representations or other violations of federal healthcare program requirements, its associates, or contractors.

Reporting suspected fraud, waste, or abuse

To report a suspected case of noncompliance, fraud, waste, or abuse, call the SKYGEN USA Fraud and Abuse hotline: **877-378-5292** or write to:

SKYGEN USA
Attention: Fraud and Abuse
10201 N Port Washington Rd
Mequon, WI 53092

Deficit Reduction Act: The False Claims Act

Section 6034 of the Deficit Reduction Act of 2005 signed into law in 2006 established the Medicaid Integrity Program in section 1936 of the Social Security Act. The legislation directed the Secretary of the United States Department of Health and Human Services (HHS) to establish a comprehensive plan to combat provider fraud, waste, and abuse in the Medicaid program, beginning in 2006. The Comprehensive Medicaid Integrity Plan is issued for successive five-year periods.

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment of government funds are liable for up to three times the government's damages plus civil penalties of $5,500 to $11,000 for each false claim.

The False Claims Act allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the False Claims Act, the person bringing the suit may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may exclude them from future participation in federal healthcare programs or impose additional obligations against the individual.

The False Claims Act is the most effective tool U.S. taxpayers have to recover the billions of dollars stolen through fraud every year. Billions of dollars in healthcare fraud have been exposed, largely through the efforts of whistleblowers acting under federal and state false claims acts.

For more information about the False Claims Act visit www.TAF.org.

Whistleblower Protection

The False Claims Act (FCA) provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA 31 U.S.C. § 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Fraud and Abuse Hotlines

SKYGEN USA Fraud and Abuse Hotline: 877-378-5292

Agency for Health Care Administration: 888-419-3456

Practice Guidelines

The State of Maryland accepts the dental periodicity schedule developed by the American Academy of Pediatric Dentistry (AAPD) as the dental schedule for the Maryland Healthy Smiles Dental Program.

The EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) program is a federally mandated program for children from birth through 20 years that emphasizes the importance of prevention, early detection, risk assessment, and timely treatment of conditions identified as a result of dental screening. Children enrolled in Medicaid or CHIP are eligible for full EPSDT benefits in Maryland. Participants have coverage under the program through the end of the month that they turn 21.

All EPSDT services provided to children enrolled in the Maryland Healthy Smiles Dental Program must be medically necessary. These include:

- **Early**. A child's dental health is assessed as early as possible in the child's life by the Primary Care Dentist (PCD) in order to prevent or find potential diseases and/or disabilities in their early stages, when they are most effectively treated.
- **Periodic**. The PCD will assess a child's dental health at regularly scheduled intervals to assure that a condition, illness, or injury is not incipient or present.
- **Screening**. A dental health assessment to determine if a child is at risk and/or has a condition, illness, or injury that requires more definitive evaluation and/or treatment.
- **Diagnosis**. The definitive evaluation by appropriate dental practitioners to determine the nature, extent or cause of a condition, illness, or injury.
- **Treatment**. The dental services determined to be medically necessary for problems identified during screening or diagnostic evaluations.

Dental services should be provided at intervals that meet reasonable standards of dental practice.

AAPD Periodicity Schedule

Service	6-12 months	12-24 months	2-6 years	6-12 years	12+ years
Clinical oral examination (1, 2)	●	●	●	●	●
Assess oral growth (3)	●	●	●	●	●
Caries risk assessment (4)	●	●	●	●	●
Radiographic assessment (5)	●	●	●	●	●
Prophylaxis and topical fluoride (4, 5)	●	●	●	●	●
Fluoride supplementation (6, 7)	●	●	●	●	●
Anticipatory counseling	●	●	●	●	●
Oral hygiene counseling (9)	**Parent**	**Parent**	**Patient/parent**	**Patient/parent**	**Patient**
Dietary counseling (10)	●	●	●	●	●
Injury prevention counseling (11)	●	●	●	●	●
Counseling for nonnutritive habits (12)	●	●	●	●	●
Counseling for speech/language development	●	●	●		
Substance abuse counseling				●	●
Counseling for oral piercing				●	●
Assessment and treatment of developing malocclusion			●	●	●
Assessment for pit and fissure sealants (13)			●	●	●
Assessment and/or removal of third molars					●
Transition to adult dental care					●

(1) First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

(2) By clinical examination.

(3) Must be repeated regularly and frequently to maximize effectiveness.

(4) Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

(5) Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

(6) Appropriate discussion and counseling should be an integral part of each visit for care.

(7) Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

(8) At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

(9) Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouth-guards.

(10) At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

(11) For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

Clinical Criteria

Medical Necessity

SKYGEN USA defines medical necessity as accepted healthcare services and supplies provided by healthcare entities appropriate to the evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care.

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore form and function to the dentition, and to correct facial disfiguration or dysfunction. Medical necessity is the reason why a test, a procedure, or an instruction is performed.

Medical necessity is different for each person and changes as the individual changes. The dental team must provide consistent methodical documentation of medical necessity for coding.

Prior Authorization of Treatment

Some procedures require prior authorization before treatment can begin. When submitting these procedures for review, also submit supporting documentation, if required. Prior authorization requirements and documentation requirements are summarized in the **Benefit Plan Details & Authorization Requirements** section of this provider manual. For information about submitting prior authorizations and required documentation, see the **Authorization Submission Procedures section**.

Dental Surgery Services

Reimbursement of the facility charges for dental services performed in the outpatient department of a hospital or at an ambulatory surgical center (ASC) are part of the dental carve out and will be covered by the Maryland Medicaid Program.

The anesthesiologist services related to those dental services are also part of the dental carve out and will be covered and reimbursed by the Maryland Medicaid Program.

The Medicaid Program does not require preauthorization for services rendered in the outpatient department of a hospital or in an ASC. Additionally, there are no anesthesiology procedure codes that must be preauthorized.

However, dental services that are to be performed outside your office, either in an outpatient department of a hospital or at an ASC, must be approved by SKYGEN USA to ensure the services meet the medical necessity criteria for services rendered in an outpatient facility (hospital or ASC).

Submitting an Authorization for Dental Surgery Services

To ensure services rendered in a hospital operating room or outpatient facility meet the criteria for medical necessity, submit an authorization for procedure code D9999 and include the following required documentation:

- Completed Facility Referral Form: Confirmation of Medical Necessity.
- Narrative describing the health complication or conduct disorder identified on the Facility Referral Form.
- Treatment plan supporting the health complication or conduct disorder identified on the Facility Referral Form (if applicable).
- Documentation supporting the treatment plan (x-rays, photographs, etc.), if available.

Providers may submit authorizations along with any required documentation directly to SKYGEN USA through our Provider Web Portal: www.provider.MDhealthysmiles.com.

Alternately, mail paper authorizations along with all required documentation to:

Maryland Healthy Smiles: Authorizations
P.O. Box 422
Milwaukee, WI 53201

In an emergency, fax the authorization request for D9999 (submitted on a paper 2019 ADA Dental Claim Form), along with all required documentation to: 877-276-1336.

Emergency Treatment

Should a procedure need to be initiated to relieve pain and suffering in an emergency situation, you are to provide treatment to alleviate the patient's condition. To receive reimbursement for emergency treatment, submit all required documentation along with the claim for services rendered. SKYGEN USA uses the same clinical criteria (and requires the same supporting documentation) for claims submitted after emergency treatment as it would have used to determine prior authorizations for the same services.

Clinical Criteria Descriptions

SKYGEN USA criteria and guidelines for determining medical necessity were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements. A number of procedures require prior authorization before initiating treatment. When submitting authorization requests for these procedures, please note the documentation requirements, and include required documentation when submitting authorizations to SKYGEN USA.

Diagnostic Imaging (D0340)

- Documentation describes medical necessity for non-orthodontic purposes

Crowns/onlays/coping (D2721, D2740-D2752, D2780-D2783, D2790-D2794)

- Root canals
  - Clinically acceptable RCT
  - Minimum 50% bone support
  - No periodontal furcation
  - No subcrestal caries
- Non-root canals
  - Anterior – 50% incisal edge/4+ surfaces involved
  - Bicuspid – 1 cusp/3+ surfaces involved
  - Molar – 2 cusps/4+ surfaces involved
  - Minimum 50% bone support
  - No periodontal furcation
  - No subcrestal caries
- Pre-operative x-ray showing apex of tooth

Post removal (D2955)

- Presence of post on pre-operative x-ray

Root canal retreatment (D3346-D3348)

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Evidence of apical pathology/fistula
- Pain from percussion/temp

Apicoectomy / periradicular surgery / retrograde filling / root amputation (D3410, D3421, D3425, D3426, D3430, D3450)

- Minimum 50% bone support
- No caries below bone level
- Repair of root perforation or resorptive defect
- Exploratory curettage for root fractures
- Removal of extruded filling materials or instruments
- Removal of broken tooth fragments
- Sealing of accessory canals, etc.

Intentional reimplantation (D3470)

- Documentation supports procedure

Hemisection (D3920)

- Documentation supports procedure

Gingivectomy or gingivoplasty (D4210, D4211)

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5 mm or more pocketing indicated on the perio charting

Anatomical crown exposure (D4230, D4231)

- Documentation supports procedure, need to remove tissue/bone to provide anatomically correct gingival relationship

Gingival flap procedure (D4240, D4241)

- Perio classification of Type III or IV
- Lack of attached gingiva

Crown lengthening (D4249)

- Documentation supports procedure
- Greater than 50% bone support after surgery due to coronal fracture/caries
- Not on same day as restoration preparation

Osseous surgery (D4260, D4261)

- History of periodontal scaling and root planing
- No previous recent history of osseous surgery
- Perio classification of Type III or IV

Provisional splinting (D4320, D4321)

- Documentation indicates periodontal mobility Type III or IV
- Documentation shows treatment plan of planned or completed periodontal therapy

Scaling and root planing (D4341, D4342)

- D4341
  - Four or more teeth in the quadrant
  - 5 mm or more pocketing on 2 or more teeth indicated on the perio chart and
  - Presence of root surface calculus and/or noticeable loss of bone support on x-rays
- D4342
  - One to three teeth in the quadrant
  - 5 mm or more pocketing on 1 or more teeth indicated on the perio charting and
  - Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Periodontal maintenance (D4910)

- Periodontal surgical or scaling and root planing procedure more than 90 days previous

Unscheduled dressing change (D4920)

- Documentation describes medical necessity

Full dentures (D5110, D5120)

- Existing denture greater than 5 years old and unserviceable
- Remaining teeth do not have adequate bone support or are not restorable

Partial dentures (D5211, D5212, D5225, D5226)

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding 3rd molars)
- Existing partial denture greater than 5 years old and unserviceable
- Remaining teeth have greater than 50% bone support and are restorable

Overdenture (D5863-D5866)

- Remaining tooth roots supporting overdenture have healthy bone and periodontal support

Maxillofacial prosthetics (D5992, D5993)

- Documentation describes accident, facial trauma, disease, facial reconstruction, or other medical necessity needed

Impacted teeth – (asymptomatic impactions will not be approved (D7241))

- Documentation describes pain, swelling, etc. around tooth (must be symptomatic) and documentation noted in patient record
- Tooth impinges on the root of an adjacent tooth, is horizontal impacted, or shows a documented enlarged tooth follicle or potential cystic formation
- Documentation supports procedure for unusual surgical complications
- X-rays match type of impaction code described

Surgical removal of residual tooth roots (D7250)

- Tooth root is completely covered by tissue on x-ray and/or documentation indicates cutting of soft tissue and bone, removal of tooth structures and closure

Coronectomy (D7251)

- Documentation describes neurovascular complication if entire impacted tooth is removed

Oroantral fistula closure / sinus perforation (D7260)

- Due to extraction, oral infection, or sinus infection

Tooth reimplantation / transplantation (D7270, D7272)

- Documentation describes accident and/or medical necessity

Surgical access of an unerupted tooth (D7280)

- Documentation supports impacted/unerupted tooth
- Tooth is beyond one year of normal eruption pattern

Biopsy / exfoliative cytological sample collection (D7285, D7286)

- Copy of pathology report or test results

Surgical repositioning of teeth (D7290)

- Documentation supports need for procedure

Alveoloplasty with extractions (D7310, D7311)

- In preparation for a prosthesis
- Other treatments such as radiation therapy and transplant surgery

Alveoloplasty without extractions (D7320, D7321)

- In preparation for a prosthesis
- Other treatments such as radiation therapy and transplant surgery

Vestibuloplasty (D7340, D7350)

- Documentation supports lack of ridge for denture placement

Exision of lesion / tumor (D7410, D7440, D7450, D7461)

- Copy of pathology report

Exision of bone tissue (D7471-D7473)

- Necessary for fabrication of a prosthesis

Frenulectomy (D7960)

- Documentation describes removal or release of mucosal and muscle of a buccal, labial or lingual frenum to treat such conditions as tongue-tied, diastema, tissue pull condition, etc.

Pre-orthodontic treatment examination to monitor growth and development (D8660)

- One of (D8660) per 12 months per patient
- D8660 will be denied if billed without D8080
- D8660 will be denied when a D8080 is not approved due to mixed dentition (with the exception of a cleft palate or evidence of congenitally missing permanent dentition)
- Once D8080 and D8660 are approved, no additional D8660 will approve thereafter
- Documentation must show a fully erupted set of permanent teeth
- Documentation must show a mixed dentition and cleft palate or severe traumatic deviation
- D8660 must include a D8670 on the Pre-Authorization as well

Orthodontic Continuation of Care (D8999)

- Completed Request Form: Continuation of Care
- The provider submitting for continuation of care must be different than the provider who originally banded the member
- A provider may not bill for broken brackets, wires, or additional adjustments beyond the maximum of 24
- Providers may not characterize adjustments beyond the maximum of 24 as “cosmetic” services in order to bill the recipient for additional adjustments. Billing for such adjustments constitutes balance billing and MAY NOT be done
- Member in treatment moving to Maryland from out-of-state
- Member in treatment moving within Maryland such distance where impractical to continue treatment with previous provider
- Exceptional conditions where current provider is unable to complete treatment
- Cumulative D8670 payments benefitted from the State of Maryland program will be limited to a cumulative maximum of 24 payments regardless of the number of providers rendering treatment; if it is deemed original State of Maryland contracted provider received D8670 payments in excess of expected treatment progress, payment recoupment may occur
- D8670 must include on the Pre-Authorization along with D8999, and D8680 as well

Comprehensive orthodontic treatment (HLD Score) (D8080, D8090)

- D8080 is inclusive of banding, debanding, and retention
- D8080 is allowed one per lifetime per patient per provider or office location
- Documentation shows current / historical cleft palate condition with treatment recommendation in either mixed or full dentition
- Documentation shows severe traumatic deviations caused by facial accidents rather than congenital deformity and does not include traumatic occlusions or cross bites
- If there is planned use of self-ligating braces, D8090 MUST be submitted with an authorization request for D8080
- Documentation supports HLD Index Form score sheet total of 15 points or greater
- Approved D8080 / D8090 Comprehensive Orthodontic Treatment cases are based on the member's dentition and include all necessary treatment at the time, and providers should not request or bill for any additional treatment services
- A provider may not bill for broken brackets, wires, or additional adjustments beyond the maximum of 24
- Providers may not characterize adjustments beyond the maximum of 24 as "cosmetic" services in order to bill the recipient for additional adjustments; billing for such adjustments constitutes balance billing and MAY NOT be done
- Maximum of 24 D8670's for comprehensive Orthodontic treatments, Maximum of 12 D8670's for Self-Ligating Orthodontic treatments per member per lifetime
- D8670 must include on the Pre-Authorization along with the D8660 and D8080 or D8080/D8090 as well
- D8080 is comprehensive and includes treatment for broken, repaired, or replacement of brackets or wires (Members may not be billed for this treatment)
- If a member's pre-authorization is denied for orthodontic services based on medical necessity criteria (COMAR 10.09.05.04)—a score of at least 15 points on the Handicapping Labio-Lingual Deviations Index (HLD)—the service is deemed not medically necessary, and therefore, a non-covered service

Orthodontic retention (D8680)

- Debanding by a provider / location other than the provider / location that was paid for initial banding (D8080, D8090)
- Only payable when original provider differs from the provider performing the continuation of care for de-banding and retention

Orthodontic repair / replacement of lost or broken retainer / re-bonding or re- cementation / repair of fixed retainer (D8692)

- Narrative of active ortho case

House/extended care facility call (9410)

- Includes visits to nursing home, long-term care facilities, hospice sites, institutions, etc.
- Report required in addition to reporting appropriate CDT codes for actual services performed

Hospital operating room or outpatient facility request (D9999)

- Completed Facility Referral Form: Confirmation of Medical Necessity
- Narrative describing the health complication or conduct disorder (See the Facility Referral Form for details)
- Treatment plan or narrative if uncertain
- Documentation (x-rays, photographs, etc.) supporting the treatment plan (if applicable)
- **D9999** entered on the claim form
- Not covered for Pregnant Women 21 & Over

Request Form: Continuation of Care

To transition a member's benefits to the Maryland Healthy Smiles Dental Program, SKYGEN USA requires a Request Form: Continuation of Care to request reimbursement. Please submit all required supporting documentation along with the completed form.

A copy of the Request Form: Continuation of Care for the Maryland Healthy Smiles Dental Program is included on the following page of this provider manual. You can also download an electronic copy of the form from the Provider Web Portal: www.provider.MDhealthysmiles.com.

MARYLAND
Healthy Smiles
DENTAL PROGRAM

Request Form - Continuation of Care

Member Name _____

Member ID _____

Member Date of Birth _____

Banding Date _____

Total Dollars Paid to Date for Existing Case _____

Remaining Monthly Visits _____

Previous Carrier or Managed Care Organization _____

Provider Name _____

Provider NPI _____

Provider Address _____ **City, State, Zip** _____

Procedure

1. Complete this form to transition the above listed member's benefits to the Maryland Healthy Smiles Dental Program.
2. Submit this form and all required documentation, along with a claim form noting CDT Code D8999, # of D8670's, and D8680 (request form) to SKYGEN USA.
3. Send all documents to the following address to avoid any disruption in compensation:

   Maryland Healthy Smiles: Continuation of Care
   P.O. Box 422
   Milwaukee, WI 53201

Required Documentation

Submit documentation with the following information for your reimbursement.

- ❑ 6–8 Diagnostic quality extra-oral/intra-oral photos
- ❑ Name and address of previous dentist
- ❑ Reason for COC request
- ❑ Additional number of months that D8670 is requested

Notes _____

SKYGEN USA

Non-Covered Services Agreement Form

For the Maryland Healthy Smiles Dental Program, a provider may bill a patient for non-covered services if the provider obtains written agreement from the patient in advance, before rendering the service.

A copy of the Non-Covered Services Agreement form for the Maryland Healthy Smiles Dental Program is included on the following page of this provider manual. You can also download an electronic copy of the form from the Provider Web Portal: www.provider.MDhealthysmiles.com.

MARYLAND Healthy Smiles DENTAL PROGRAM

Non-Covered Services Agreement

Provider _____

Address _____ **City, State, Zip** _____

Telephone _____ **Fax** _____

Email _____ **Website** _____

Provider MA# _____

I,_____, understand that the following procedures are excluded under the Maryland Healthy Smiles Dental Program. I further understand that by signing this agreement, I am agreeing in advance, in writing, to accept full financial responsibility for all costs associated with these non-covered dental services.

Date of Service	Code	Description of Service	Cost
Total Amount Due by Recipient			

_____/_____

Patient Name/Patient MA#

_____

Patient/Guardian/Beneficiary Name – Relationship to Patient

_____

Patient/Guardian/Beneficiary Signature **Date**

_____

Dentist Name

_____

Dentist Signature **Date**

This form must be kept on file and a copy of which available upon request.

SKYGEN USA

HLD Index No. 4|Handicapping Labio-Lingual Deviations Form

For the Maryland Healthy Smiles Dental Program, SKYGEN USA's clinical criteria for comprehensive orthodontics requires documentation on an HLD Index Form, with a total score of 15 points or higher. Please submit all required supporting documentation along with the completed form.

A copy of the HLD Index No. 4 form for the Maryland Healthy Smiles Dental Program is included on the following page of this provider manual. You can also download an electronic copy of the form from the Provider Web Portal: www.provider.MDhealthysmiles.com.

HLD Index No. 4 | Handicapping Labio -Lingual Deviations Form

Patient Name:_____ **ID Number**: _____

Treating Dentist (Signature) / Date_____/_____

Procedure

1. Occlude patient or models in centric position.
2. Record all measurements in the order given, rounded off to nearest millimeter.
3. If condition is absent, enter score of "0."
4. Start by measuring overjet of the most protruding incisor.
5. Measure overbite from the labio-incisal edge of the overlapped front tooth (or teeth) to the point of maximum coverage.
6. Do not double-score ectopic eruption and anterior crowding. Record only the more serious condition.

Required Documents

Submit all required documents with this form.

- ❑ Ceph films
- ❑ Panorex/FMX x-rays
- ❑ 6-8 diagnostic quality extra-oral/intra-oral photos
- ❑ Narratives (clinical summary with diagnosis, treatment plan, etc.)

Conditions Observed	HLD Score		
	Treating Dentist	**1st Review***	**2nd Review***
Cleft palate. Submit a cleft palate in mixed dentition only if you can justify in a report why a child should be treated before full dentition. Will intermittent treatment be required? **Score 15**			
Severe traumatic deviations. Refers to facial accidents, not congenital deformity (does not include traumatic occlusions or crossbites). **Score 15**			
Overjet. Measure overjet in millimeters and subtract 2mm from your score. Two millimeters of overjet considered normal. **Overjet_____minus 2 mm**			
Overbite. Measure overbite in millimeters and subtract 3 mm from your score. Three millimeters of overbite considered normal. **Overbite_____minus 3 mm**			
Mandibular protrusion. Measure in millimeters, multiply by 5. **Protrusion_____x 5**			
Open bite. Measure opening between maxillary and mandibular incisors in millimeters, multiply by 4. **Opening_____x 4**			
Labio-lingual spread. Measure total spacing between anterior teeth in millimeters.			
Anterior crowding. Anteriors so crowded that extractions are prerequisite to treatment. Arch length insufficiency must exceed 3.5 mm to score points. If crowding exceeds 3.5 mm in an arch, score 5 for the arch. **Maxilla_____ Mandibular _____**			
Ectopic eruption. Unusual pattern of eruption, such as high labial cuspids. Do not score if teeth are scored under anterior crowding. Multiply teeth by 3. **Teeth_____x 3**			
Posterior crossbite. Score 5 points for left or right posterior crossbite. **Max score 5**			
A score of 15 or higher indicates a physical handicap. **TOTAL**			

SKYGEN USA Internal Use Only | * HLD Reviewers

1st Reviewer Signature / Date_____/_____ ❑ **Approved** | ❑ **Denied**

Comments _____

2nd Reviewer Signature / Date_____/_____ ❑ **Approved** | ❑ **Denied**

Comments _____

Facility Referral Form: Confirmation of Medical Necessity

Dental services that are to be performed outside your office, either in an outpatient department of a hospital or at an ASC, must be approved by SKYGEN USA to ensure the services meet the medical necessity criteria for services rendered in an outpatient facility (hospital or ASC).

A copy of the Facility Referral Form for the Maryland Healthy Smiles Dental Program is included on the following page of this provider manual. You can also download an electronic copy of the form from the Provider Web Portal: www.provider.MDhealthysmiles.com.

MARYLAND Healthy Smiles DENTAL PROGRAM

Facility Referral Form

Confirmation of Medical Necessity

Member Name _____ **Member ID** _____

Treating Provider Name/NPI _____/_____

Provider Contact Person Name/Phone _____/_____

Procedure

1. Complete this form to indicate why it is medically necessary for dental services to be performed in a hospital operating room or other outpatient facility.
2. Submit this form and all required documentation, along with an authorization for procedure code D9999 (facility referral), to SKYGEN USA for review and determination.
3. Send all documentation via the Provider Web Portal at www.provider.MDhealthysmiles.com or mail to:
   Maryland Healthy Smiles: Authorizations
   PO Box 422
   Milwaukee, WI 53201

Required Documentation

Submit documentation that confirms in-office treatment is not appropriate for the patient.

- ❑ Narrative describing health complication or conduct disorder (If option #1 is checked below, this documentation is required for ages 6 and older; for options #2–6, it is always required.)
- ❑ Treatment plan (always required)
- ❑ Documentation that supports the treatment plan (x-rays, photographs, etc.), if available

Medically necessary reasons for dental treatment in a hospital or outpatient facility

SKYGEN USA considers the use of hospital or outpatient facilities during the delivery of dental services to be medically necessary when documentation (including narrative, radiographs, etc.) demonstrates the presence of any one of the following health complications or conduct disorders.

Select the qualifying health complication or conduct disorder that applies to this patient

1. Young children requiring extensive operative procedures such as multiple restorations, treatment of abscesses and/or oral surgical procedures, if authorization documentation indicates that in-office treatment (nitrous oxide, conscious sedation, or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon provider or member convenience (Please review *Required Documentation* above.)	❑
2. Patients requiring extensive dental procedures and classified by the American Society of Anesthesiologists (ASA) as class III or class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patients with severe systemic disease that is a constant threat to life)	❑
3. Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures	❑
4. Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate	❑
5. Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment	❑
6. Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate	❑

Diagnostic-quality preoperative radiographs and/or photographs taken before the patient is admitted to the hospital or outpatient facility or before treatment begins must be present in the patient's chart. Documentation examined as part of a retrospective review must substantiate the treatment rendered. If treatment cannot be confirmed as medically necessary during an audit, paid claims may be recouped.

SKYGEN

Revision History: Version 8

Revisions: Version 8

Version 8 Revisions	Revision Effective Date
2019 ADA Claim Form (page 38-39, 40)	1/1/2020
Pregnant Women Claims and Authorizations Section (page 37 and 42)	Updated 1/1/2020
Reporting Missed Appointments Section (pages 27-28)	Updated 1/1/2020
Payment for Non-Covered Services Section (page 29)	Updated 1/1/2020
Local Transportation Contact section (pages 31-32)	Updated 1/1/2020
Prior Authorization & Documentation Requirements Section (page 33)	Updated 1/1/2020
Determined Authorizations: Peer to Peer Requests Section (page 34)	Updated 1/1/2020
Attaching Electronic Documents Section (page 36-40, 41)	Updated 1/1/2020
Coordination of Benefits (COB) Section (page 43)	Updated 1/1/2020
Continuation of Care Form (page 67)	Updated 1/1/2020
D1510 and D1520 Maintainers- update to billing by Quadrant(page 79)	1/1/2020
D1553 and D1556 Space Maintainers- New* (page 79-80)	1/1/2020
D8698 and D8699 Re-cement or re-bonding of fixed retainers- New* (page 102)	1/1/2020
D8703 and D8704 Replacement of lost or broken retainer- New* (page 102)	1/1/2020

Maryland Healthy Smiles Benefit Plan Details & Authorization Requirements

The following benefit plan details and related authorization requirements apply to the Maryland Healthy Smiles Dental Program benefit plans:

- Maryland Children (Under Age 21)
- Maryland REM Children (Under Age 21)
- Maryland REM Adults (Age 21 and Older)
- Maryland Pregnant Women (Age 21 and Older)
- Maryland Former Foster Care (Age 21 to 25) *Eligible Effective 1/1/17*
- Maryland Adult Dental (Age 21 to 64) with Medicaid and Medicare *Eligible Effective 6/1/2019*

Note: If *update appears beneath a code number in the table, the code is revised. The revision and effective date are available in the "CDT Code Revisions" table in the Revision History: Version 8 section.

**Please note that members whose eligibility indicates "Maryland NO DENTAL Adult Medicaid" have NO dental benefits or dental coverage.

Plan Comparisons

For children under age 21, the benefits, limitations, and authorization requirements are identical between the two plans, except the REM plan for children allows for more frequent prophy, fluoride, and debridement. For adults age 21 and over, the benefits, limitations, and authorization requirements are identical between the two plans, except the REM plan for adults allows for more frequent prophy, debridement, and fluoride application and two bitewings. For authorizations requiring a biopsy report as the clinical criteria documentation, a post authorization (known as a "P" authorization) must be submitted after the service is rendered along with the biopsy report and claim.

In the following tables, if **Yes** is indicated in the **Auth Req** column, then a service requires a prior authorization. If documentation is indicated in the **Requirement** column, then supporting documentation is required before the authorization can be approved or the claim can be paid. When a prior authorization is required, submit it (along with any required documentation) to SKYGEN USA for approval before beginning non-emergency or routine treatment. If immediate treatment is required in an emergency situation, submit required documentation after treatment with the claim.

Children/REM Children (under 21), Former Foster Care (21 to 25)

For children under age 21, the benefits, limitations, and authorization requirements are identical between the Medicaid and REM plans, except the REM plan for children allows for more frequent prophy, fluoride, and debridement.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0120	Periodic oral evaluation-established patient	0-25		One of (D0120) per 6 months per provider OR location. One of (D0120, D0145, D0150, D0160) per 6 months per provider OR location.	No	
D0140	Limited oral evaluation-problem focused	0-25		Not reimbursable on the same day as D0120, D0150 or D0160. Not allowed with Routine Services.	No	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		One of (D0145) per 6 months per provider OR location. One of (D0120, D0145, D0150, D0160) per 6 months per provider OR location.	No	
D0150	Comprehensive oral evaluation-new or established patient	0-25		One of (D0150) per 1 lifetime per provider OR location. One of (D0120, D0145, D0150, D0160) per 6 months per provider OR location.	No	
D0160	Detailed and extensive oral evaluation-problem focused, by report	0-25		One of (D0160) per 1 lifetime per provider OR location. One of (D0120, D0145, D0150, D0160) per 6 months per provider OR location.	No	
D0210	Intraoral-complete series of radiographic images	6-25		One of (D0210) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0220	Intraoral-periapical first radiographic image	0-25			No	
D0230	Intraoral-periapical each additional radiographic image	0-25			No	
D0240	Intraoral-occlusal radiographic image	0-25		Two of (D0240) per 12 months per patient.	No	
D0250	Extraoral-first radiographic image	0-25			No	
D0270	Bitewing-single radiographic image	2-25			No	
D0272	Bitewings-two radiographic images	2-25		One of (D0272, D0273, D0274) per 6 months per provider.	No	
D0273	Bitewings-three radiographic images	10-25		One of (D0272, D0273, D0274) per 6 months per provider.	No	
D0274	Bitewings-four radiographic images	10-25		One of (D0272, D0273, D0274) per 6 months per provider.	No	
D0310	Sialography	0-25			No	
D0320	Temporomandibular joint arthogram, including injection	0-25			No	
D0321	Other temporomandibular joint films, by report	0-25			No	
D0330	Panoramic radiographic image	6-25		One of (D0330) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider.	No	
D0340	Cephalometric radiographic image	0-25		One of (D0340, D8660) per 36 months per patient. Non orthodontic cases.	**Yes**	Narrative of medical necessity

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0431	Adjunctive pre-diagnostic test that: aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	0-20		One D0431 per 12 months per patient. **Note**: D0431 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D0431 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.	No	Lab results/pathology report Narrative of medical necessity
D0460	Pulp vitality tests	0-25		One per visit. Includes multiple teeth and contralateral comparison(s), as indicated.	No	
D1110	Prophylaxis-adult	14-25		One of (D1110, D1120) per 3 months per patient only for REM Children Under 21. One of (D1110, D1120) per 6 months per patient for all other Children Under 21. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	No	
D1120	Prophylaxis-child	0-13		One of (D1110, D1120) per 3 months per patient only for REM Children Under 21. One of (D1110, D1120) per 6 months per patient for all other Children Under 21. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	No	
D1206	Topical application of fluoride varnish	0-5		Four of (D1206) per 12 months per patient per provider. Maximum eight of (D1206) per 12 months per patient regardless of provider. Minimum of 30 days required between applications.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D1206	Topical application of fluoride varnish	6-25		Four of (D1206) per 12 months per patient. Minimum of 30 days required between applications.	No	
D1208	Topical application of fluoride-excluding varnish	0-25		One of (D1208) per 3 months per patient for REM Children Under 21 only. One of (D1208) per 6 months per patient for all other Children Under 21.	No	
D1330	Oral hygiene instructions	0-25		One of (D1330) per 12 months per patient.	No	
D1351	Sealant-per tooth	0-25	2-5, 12-15, 18-21, 28-31	One of (D1351, D1352) per 1 lifetime per patient per tooth. Covered only for the occlusal surfaces of posterior permanent teeth without restorations or decay.	No	
D1352	Preventive resin restoration	0-25	2-5, 12-15, 18-21, 28-31	One of (D1351, D1352) per 1 lifetime per patient per tooth. Covered only for the occlusal surfaces of posterior permanent teeth without restorations or decay.	No	
D1510	Space maintainer-fixed-unilateral	0-25	LL,LR,UR, UL	One of (D1510) per 24 months per patient per quadrant	No	
D1516	Space maintainer – fixed – bilateral, maxillary	0-25		One per 24 months for D1516 or D1526	No	
D1517	Space maintainer – fixed – bilateral, mandibular	0-25		One per 24 months for D1517 or D1527	No	
D1520	Space maintainer-removable- unilateral	0-25	LL,LR,UR, UL	One of (D1520) per 24 months per patient per quadrant	No	
D1526	Space maintainer – removable– bilateral, maxillary	0-25		One per 24 months for D1516 or D1526	No	
D1527	Space maintainer – removable– bilateral, mandibular	0-25		One per 24 months for D1517 or D1527	No	
D1553	Re-cement or re-bond unilateral space maintainer- per quadrant	0-25	LL,LR,UR, UL	Not covered within 6 months of initial placement.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D1556	Removal of fixed unilateral space maintainer- per quadrant	0-25	LL, LR, UR, UL	Not allowed by dental office that provided initial placement.	No	
D2140	Amalgam-one surface, primary or permanent	0-25	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2150	Amalgam - two surfaces, primary or permanent	0-25	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2160	Amalgam-three surfaces, primary or permanent	0-25	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2161	Amalgam-four or more surfaces, primary or permanent	0-25	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2330	Resin-based composite-one surface, anterior	0-25	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2331	Resin-based composite-two surfaces, anterior	0-25	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2332	Resin-based composite-three surfaces, anterior	0-25	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)	0-25	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2390	Resin-based composite crown, anterior	0-25	6-11, 22-27, C-H, M-R	Not payable on the same day of service as D3310-D3348.	No	
D2391	Resin-based composite-one surface, posterior	0-25	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2392	Resin-based composite-two surfaces, posterior	0-25	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2393	Resin-based composite-three surfaces, posterior	0-25	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2394	Resin-based composite-four or more surfaces, posterior	0-25	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2721	Crown-resin with predominantly base metal	0-25	1-32	One of (D2721) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2740	Crown-porcelain/ceramic substrate	0-25	1-32	One of (D2740) per 60 months per patient per Tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2750	Crown-porcelain fused to high noble metal	0-25	1-32	One of (D2750) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2751	Crown-porcelain fused to predominantly base metal	0-25	1-32	One of (D2751) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2752	Crown-porcelain fused to noble metal	0-25	1-32	One of (D2752) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2780	Crown-¾ cast high noble metal	0-25	1-32	One of (D2780) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2781	Crown-¾ cast predominantly base metal	0-25	1-32	One of (D2781) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2782	Crown-¾ cast noble metal	0-25	1-32	One of (D2782) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2783	Crown-¾ porcelain/ceramic	0-25	1-32	One of (D2783) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2790	Crown-full cast high noble metal	0-25	1-32	One of (D2790) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2791	Crown-full cast predominantly base metal.	0-25	1-32	One of (D2791) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2792	Crown-full cast noble metal	0-25	1-32	One of (D2792) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2794	Crown-titanium	0-25	1-32	One of (D2794) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-25	1-32		No	
D2920	Re-cement or re-bond crown	0-25	1-32, A-T	Not allowed within 6 months of initial placements.	No	
D2929	Prefabricated porcelain/ceramic crown-primary tooth	0-25	C-H, M-R	One of (D2929) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348.		
D2930	Prefabricated stainless steel crown - primary tooth	0-25	A-T	One of (D2930) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2931	Prefabricated stainless steel crown-permanent tooth	0-25	1-32	One of (D2931) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2932	Prefabricated resin crown	0-25	6-11, 22-27, C-H, M-R	One of (D2932) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348	No	
D2933	Prefabricated stainless steel crown with resin window	0-25	6-11, 22-27, C-H, M-R	One of (D2933) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2934	Prefabricated esthetic coated stainless steel crown-primary tooth	0-25	A-T	One of (D2934) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2940	Protective restoration	0-25	1-32, A-T	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	No	
D2950	Core buildup, including any pins when required	0-25	1-32	One of (D2950) per 60 months per patient per tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same day of service as D3310-D3348.		
D2951	Pin retention-per tooth, in addition to restoration	0-25	1-32		No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2952	Cast post and core in addition to crown	0-25	1-32	One of (D2952) per 60 months per patient per tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.		
D2954	Prefabricated post and core in addition to crown	0-25	1-32	One of (D2954) per 60 months per patient per No tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2955	Post removal (not in conjunction with endodontic therapy)	0-25	1-32	Not covered with D3346, or D3347, or D3348 on same day of service.	Yes	Pre-operative x-rays
D2960	Labial veneer (laminate)-chair	0-25	6-11	One of (D2960) per 60 months per patient per tooth.	No	
D2961	Labial veneer (resin laminate)-laboratory	0-25	6-11	One of (D2961) per 60 months per patient per tooth.	No	
D2962	Labial veneer (porcelain laminate)- laboratory	0-25	6-11	One of (D2962) per 60 months per patient per tooth.		
D2980	Crown repair, by report	0-25	1-32		No	
D3110	Pulp cap-direct (excluding final restoration)	0-25	1-32		No	
D3120	Pulp cap-indirect (excluding final restoration)	0-25	1-32, A-T		No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D3220	Therapeutic pulpotomy (excluding final restoration)-removal of pulp coronal to the dentinocemental junction and application of medicament	0-25	1-32, A-T		No	
D3221	Pulpal debridement, primary and permanent teeth	0-25	1-32, A-T		No	
D3230	Pulpaltherapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-25	C-H, M-R	One of (D3230) per 1 lifetime per patient per tooth.	No	
D3240	Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)	0-25	A, B, I-L, S, T	One of (D3240) per 1 lifetime per patient per tooth.	No	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	0-25	6-11, 22-27	One of (D3310) per 1 lifetime per patient per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	No	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	0-25	4, 5, 12, 13, 20, 21, 28, 29	One of (D3320) per 1 lifetime per patient per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	No	
D3330	Endodontic therapy, molar (excluding final restoration)	0-25	1-3, 14-19, 30-32	One of (D3330) per 1 lifetime per patient per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D3346	Retreatment of previous root canal therapy-anterior	0-25	6-11, 22-27	One of (D3346) per 1 lifetime per patient per tooth. Not allowed within 24 months of initial treatment by same dentist or dental office per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3347	Retreatment of previous root canal therapy-bicuspid	0-25	4, 5, 12, 13, 20, 21, 28, 29	Not allowed within 24 months of initial treatment by same dentist or dental office per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3348	Retreatment of previous root canal therapy-molar	0-25	1-3, 14-19, 30-32	One of (D3348) per 1 lifetime per patient per tooth. Not allowed within 24 months of initial treatment by same dentist or dental office per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3351	Apexification/recalcification-initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-25	1-32	One of (D3351) per 1 lifetime per patient per tooth. Not allowed within 24 months of initial treatment by same dentist or dental office per tooth. Not allowed after a D3310, D3320, D3330, D3346, D3347, or D3348.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D3352	Apexification/recalcification-interim medication replacement	0-25	1-32	One of (D3352) per 1 lifetime per patient per tooth. Not allowed after a D3310, D3320, D3330, D3346, D3347, or D3348.	No	
D3353	Apexification/recalcification-final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)	0-25	1-32	One of (D3353) per 1 lifetime per patient per tooth. Not allowed after a D3310, D3320, D3330, D3346, D3347, or D3348.	No	
D3410	Apicoectomy-anterior	0-25	6-11, 22-27	One of (D3410) per 1 lifetime per patient per tooth.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3421	Apicoectomy-bicuspid (first root)	0-25	4, 5, 12, 13, 20, 21, 28, 29	One of (D3421) per 1 lifetime per patient per tooth.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3425	Apicoectomy-molar (first root)	0-25	1-3, 14-19, 30-32	One of (D3425) per 1 lifetime per patient per tooth.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3426	Apicoectomy (each additional root)	0-25	1-5, 12-21, 28-32	One of (D3426) per 1 lifetime per patient per tooth.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3430	Retrograde filling-per root	0-25	1-32	One of (D3430) per 1 lifetime per patient per tooth.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3450	Root amputation-per root	0-25	1-32	One of (D3450) per 1 lifetime per patient per tooth.	**Yes**	Pre-operative x-rays (excluding bitewings)
D3470	Intentional reimplantation	0-25	1-32	One of (D3470) per 1 lifetime per patient per tooth.	**Yes**	Narrative of medical necessity, pre-operative x-rays
D3920	Hemisection (including any root removal), not including root canal therapy	0-25	1-3, 14-19, 30-32	One of (D3920) per 1 lifetime per patient per tooth.	**Yes**	Pre-operative x-rays (excluding bitewings)

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4210) per 24 months per patient per quadrant. One of (D4210, D4211) per 24 months per patient per quadrant. One of each quadrant per 24 months, a minimum of four teeth in the affected quadrant. Limited to two quadrants per 12 months.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional
D4211	Gingivectomy or gingivoplasty-one to three contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4211) per 24 months per patient per quadrant. One of (D4210, D4211) per 24 months per patient per quadrant. One of each quadrant per 24 months, a minimum of four teeth in the affected quadrant. Limited to two quadrants per 12 months.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional
D4230	Anatomical crown exposure-4+ teeth per quad	0-25		One of (D4230) per 1 lifetime per patient.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional
D4231	Anatomical crown exposure-1 to 3 teeth per quad	0-25		One of (D4231) per 1 lifetime per patient.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4240) per 24 months per patient per quadrant. One of (D4240, D4241) per 24 months per patient per quadrant. A minimum of four teeth in the affected quadrant.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional
D4241	Gingival flap procedure, including root planing-one to three contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4241) per 24 months per patient per quadrant. One of (D4240, D4241) per 24 months per patient per quadrant. A minimum of four teeth in the affected quadrant.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional
D4249	Clinical crown lengthening-hard tissue	0-25	1-32	One of (D4249) per 24 months per patient per tooth. Crown lengthening requires reflection of a flap.	**Yes**	Narrative of medical necessity, pre-operative x-rays, periodontal charting; photos optional
D4260	Osseous surgery (including elevation of a full thickness flap and closure)-four or more contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4260) per 24 months per patient per quadrant. One of (D4260, D4261) per 24 months per patient per quadrant. Minimum of four teeth in the affected quadrant.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional
D4261	Osseous surgery (including elevation of a full thickness flap and closure)-one to three contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4261) per 24 months per patient per quadrant. One of (D4260, D4261) per 24 months per patient per quadrant. Minimum of four teeth in the affected quadrant.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D4320	Provision splinting-intracoronal	0-25	Per Arch (01, 02, LA, UA)		**Yes**	Narrative of medical necessity
D4321	Provision splinting-extracoronal	0-25	Per Arch (01, 02, LA, UA)		**Yes**	Narrative of medical necessity
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4341, D4342) per 24 months per patient per quadrant. A minimum of four (4) teeth in the affected quadrant.	**Yes**	Pre-operative x-rays, periodontal charting
D4342	Periodontal scaling and root planning - one to three teeth per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4341, D4342) per 24 months per patient per quadrant. A minimum of four (4) teeth in the affected quadrant.	**Yes**	Pre-operative x-rays, periodontal charting
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0-25		One of (D4355) per 12 months per patient for REM Children Under 21 only. One of (D4355) per 24 months per patient for all other Children Under 21. Not allowed on same day as D1110.	No	
D4910	Periodontal maintenance procedures	0-25		Two of (D4910) per 12 months per patient. (not allowed within 90 days of D4341 and D4342)	**Yes**	Date of previous perio surgical or SRP service
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	0-25		Not payable to original treating dentist.	**Yes**	Narrative of medical necessity, name of original treating dentist
D5110	Complete denture-maxillary	0-25	Per Arch (01, UA)	One of (D5110) per 60 months per patient.	**Yes**	Full mouth x-rays or panorex
D5120	Complete denture-mandibular	0-25	Per Arch (02, LA)	One of (D5120) per 60 months per patient.	**Yes**	Full mouth x-rays or panorex

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	0-25		One of (D5211, D5225) per 60 months per patient.	**Yes**	Full mouth x-rays or panorex
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)	0-25		One of (D5212, D5226) per 60 months per patient.	**Yes**	Full mouth x-rays or panorex
D5225	Maxillary partial denture-flexible base	0-25		One of (D5211, D5225) per 60 months per patient.	**Yes**	Full mouth x-rays or panorex
D5226	Mandibular partial denture-flexible base	0-25		One of (D5212, D5226) per 60 months per patient.	**Yes**	Full mouth x-rays or panorex
D5410	Adjust complete denture-maxillary	0-25		Not covered within 6 months of placement.	No	
D5411	Adjust complete denture-mandibular	0-25		Not covered within 6 months of placement.	No	
D5421	Adjust partial denture-maxillary	0-25		Not covered within 6 months of placement.	No	
D5422	Adjust partial denture-mandibular	0-25		Not covered within 6 months of placement.	No	
D5511	Repair broken complete denture base, mandibular	0-25			No	
D5512	Repair broken complete denture base, maxillary	0-25			No	
D5520	Replace missing or broken teeth-complete denture (each tooth)	0-25	1-32		No	
D5611	Repair resin partial denture base, mandibular	0-25			No	
D5612	Repair resin partial denture base, maxillary	0-25			No	
D5621	Repair cast partial framework, mandibular	0-25			No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D5622	Repair cast partial framework, maxillary	0-25			No	
D5630	Repair or replace broken clasp	0-25			No	
D5640	Replace broken teeth-per tooth	0-25	1-32		No	
D5650	Add tooth to existing partial denture	0-25	1-32		No	
D5660	Add clasp to existing partial denture	0-25			No	
D5710	Rebase complete maxillary denture	0-25		One of (D5710) per 24 months per patient. Not covered within 6 months of placement.	No	
D5711	Rebase complete mandibular denture	0-25		One of (D5711) per 24 months per patient. Not covered within 6 months of placement.	No	
D5720	Rebase maxillary partial denture	0-25		One of (D5720) per 24 months per patient. Not covered within 6 months of placement.	No	
D5721	Rebase mandibular partial denture	0-25		One of (D5721) per 24 months per patient. Not covered within 6 months of placement.	No	
D5750	Reline complete maxillary denture (laboratory)	0-25		One of (D5750) per 24 months per patient. Not covered within 6 months of placement.	No	
D5751	Reline complete mandibular denture (laboratory)	0-25		One of (D5751) per 24 months per patient. Not covered within 6 months of placement.	No	
D5760	Reline maxillary partial denture (laboratory)	0-25		One of (D5760) per 24 months per patient. Not covered within 6 months of placement.	No	
D5761	Reline mandibular partial denture (laboratory)	0-25		One of (D5761) per 24 months per patient. Not covered within 6 months of placement.	No	
D5850	Tissue conditioning, maxillary	0-25		Prior to new denture impression only.	No	
D5851	Tissue conditioning, mandibular	0-25		Prior to new denture impression only.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D5863	Overdenture-complete maxillary	0-25		One of (D5863) per 60 months per patient.	**Yes**	Narrative of medical necessity, pre-operative x-rays
D5864	Overdenture-partial maxillary	0-25		One of (D5864) per 60 months per patient.	**Yes**	Narrative of medical necessity, pre-operative x-rays
D5865	Overdenture-complete mandibular	0-25		One of (D5865) per 60 months per patient.	**Yes**	Narrative of medical necessity, pre-operative x-rays
D5866	Overdenture-partial mandibular	0-25		One of (D5866) per 60 months per patient.	**Yes**	Narrative of medical necessity, pre-operative x-rays
D5992	Adjust maxillofacial prosthetic appliance, by report	0-25	Per Arch (01, 02, LA, UA)	One of (D5992) per 6 months per patient per arch.	**Yes**	Narrative of medical necessity
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	0-25	Per Arch (01, 02, LA, UA)	One of (D5993) per 6 months per patient per arch.	**Yes**	Narrative of medical necessity
D6930	Re-cement or re-bond fixed partial denture	0-25			No	
D7111	Extraction, coronal remnants-deciduous tooth	0-25	A-T		No	
D7410	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	
D7220	Removal of impacted tooth-soft tissue	0-25	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7230	Removal of impacted tooth-partially bony	0-25	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7240	Removal of impacted tooth-completely bony	0-25	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	0-25	1-32, 51-82	Removal of asymptomatic tooth not covered.	**Yes**	Narrative of medical necessity, pre-operative x-rays (excluding bitewings)
D7250	Surgical removal of residual tooth roots (cutting procedure)	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Will not be paid to the dentist or group that removed the tooth.	**Yes**	Narrative of medical necessity, pre-operative x-rays (excluding bitewings)
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7251) per 1 lifetime per patient per tooth.	**Yes**	Narrative of medical necessity, pre-operative x-rays (excluding bitewings)

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7260	Oroantral fistula closure	0-25			**Yes**	Narrative of medical necessity
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-25	1-32	Includes splinting and/or stabilization.	**Yes**	Narrative of medical necessity
D7272	Tooth transplantation (includes reimplantation from one site to another)	0-25	1-32	One of (D7272) per 1 lifetime per patient per tooth.	**Yes**	Narrative of medical necessity
D7280	Surgical access of an unerupted tooth	0-25	1-32	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.	**Yes**	Narrative of medical necessity, pre-operative x-rays
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	0-25			**Yes**	Copy of pathology report submitted with claim
D7286	Incisional biopsy of oral tissue-soft	0-25			**Yes**	Copy of pathology report submitted with claim
D7290	Surgical repositioning of teeth	0-25	1-32	One of (D7290) per 1 lifetime per patient per tooth. Includes all teeth on same day of service.	**Yes**	Narrative of medical necessity, pre-operative x-rays
D7310	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310, D7311) per 1 lifetime per patient per quadrant. Minimum of three extractions in the affected quadrant.	**Yes**	Pre-operative x-rays (excluding bitewings)
D7311	Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310, D7311) per 1 lifetime per patient per quadrant.	**Yes**	Pre-operative x-rays (excluding bitewings)

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7320	Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7320, D7321) per 1 lifetime per patient per quadrant. No extractions performed in an edentulous area.	**Yes**	Narrative of medical necessity, pre-operative x-rays (excluding bitewings)
D7321	Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7320, D7321) per 1 lifetime per patient per quadrant. No extractions performed in an edentulous area.	**Yes**	Narrative of medical necessity, pre-operative x-rays (excluding bitewings)
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)	0-25	Per Arch (01, 02, LA, UA)		**Yes**	Narrative of medical necessity, pre-operative x-rays (excluding bitewings)
D7350	Vestibuloplasty-ridge extension	0-25	Per Arch (01, 02, LA, UA)		**Yes**	Narrative of medical necessity, pre-operative x-rays (excluding bitewings)
D7410	Radical excision-lesion diameter up to 1.25cm	0-25			**Yes**	Copy of pathology report submitted with claim
D7440	Excision of malignant tumor-lesion diameter up to 1.25cm	0-25			**Yes**	Copy of pathology report submitted with claim
D7450	Removal of odontogenic cyst or tumor-lesion diameter up to 1.25cm	0-25			**Yes**	Copy of pathology report submitted with claim
D7451	Removal of odontogenic cyst or tumor-lesion greater than 1.25cm	0-25			**Yes**	Copy of pathology report submitted with claim
D7460	Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25cm	0-25			**Yes**	Copy of pathology report submitted with claim
D7461	Removal of nonodontogenic cyst or tumor-lesion greater than 1.25cm	0-25			**Yes**	Copy of pathology report submitted with claim

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7471	Removal of exostosis-per site	0-25	Per Arch (01, 02, LA, UA)		**Yes**	Narrative of medical necessity, x-rays or photos optional
D7472	Removal of torus palatinus	0-25			**Yes**	Narrative of medical necessity, x-rays or photos optional
D7473	Removal of torus mandibularis	0-25			**Yes**	Narrative of medical necessity, x-rays or photos optional
D7510	Incision and drainage of abscess-intraoral soft tissue	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	
D7520	Incision and drainage of abscess-extraoral soft tissue	0-25			No	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		No	
D7960	Frenulectomy–also known as frenectomy or frenotomy–separate procedure not incidental to another procedure	0-25	Per Arch (01, 02, LA, UA)	One of (D7960) per 1 lifetime per arch per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	**Yes**	Narrative of medical necessity, x-rays or photos optional

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7970	Excision of hyperplastic tissue-per arch	0-25	Per Arch (01, 02, LA, UA)	For removal of tissue over a previous edentulous denture bearing area to improve prognosis of a proposed denture.	No	
D7971	Excision of pericoronal gingiva	0-25	1-32	One of (D7971) per 1 lifetime per patient per tooth.	No	
D8080	Comprehensive orthodontic treatment of the adolescent dentition. Inclusive of banding, debanding, and retention.	0-25		One of (D8080) per 1 lifetime per provider OR location. Inclusive of phase I and phase II treatment including palatal expanders. One of (D8080) is comprehensive and includes treatment for broken, repaired, or replacement of brackets or wires. Members may not be billed for this treatment.	**Yes**	Ceph x-ray, Panorex or FMX, 6-8 diag quality extra-oral/intra-oral photos, clinical summary with diagnosis, completed HLD score sheet
D8090	Comprehensive orthodontic treatment of the adult dentition	0-25		Code allowed only for comprehensive orthodontia cases where self-ligating appliances are used. Not a separately reimbursable service. One of (D8090) per 1 lifetime per provider OR location.	**Yes**	Ceph x-ray, Panorex or FMX, 6-8 diag quality extra-oral/intra-oral photos, clinical summary with diagnosis, completed HLD score sheet
D8660	Pre-orthodontic treatment examination to monitor growth and development	0-25		Only reimbursable in conjunction with request for comprehensive orthodontic treatment (D8080). One of (D8660) per 12 months per patient.	**Yes**	D8660 will be denied if billed without D8080. D8660 will be denied when a D8080 is not approved due to mixed dentition (with the exception of a cleft palate or evidence of congenitally missing permanent dentition). Once D8080 and D8660 are approved, no additional D8660 will approve thereafter.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D8670	Periodic orthodontic treatment visit	0-25		Twenty-Four of (D8670) per 1 lifetime per patient. Maximum of 24 visits reimbursed. For comprehensive orthodontic treatment, maximum of 12 of (D8670) per lifetime per member for self-ligating.	**Yes**	Approved D8080 or D8080/D8090. The number of D8670's needed must be submitted on the authorization with D8660, D8080, D8080/D8090 for comprehensive treatment. The number of D8670's needed must be submitted on the authorization with D8999 and D8680 for continuation of care
D8680	Orthodontic retention (removal of appliances)	0-25		One of (D8680) per 1 lifetime per provider OR location. Only payable when original provider differs from the provider performing the continuation of care for debanding and retention.	**Yes**	6-8 diagnostic quality extra-oral / intra-oral photos
D8698	Re-cement or re-bond fixed retainers-Maxillary	0-25		One of (D8698) allowed per patient within 24 months of date of debanding.	No	
D8699	Re-cement or re-bond fixed retainer-Mandibular	0-25		One of (D8699) allowed per patient within 24 months of date of debanding.	No	
D8703	Replacement of lost or broken retainer- Maxillary	0-25		One per arch per lifetime-Allowed within 24 months of date of debanding.	**Yes**	Narrative of active ortho case
D8704	Replacement of lost or broken retainer- Mandibular	0-25		One per arch per lifetime- Allowed within 24 months of date of debanding.	**Yes**	Narrative of active ortho case

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D8999	Unspecified orthodontic procedure, by report	0-25			**Yes**	Completed Request Form: Continuation of Care, 6-8 diagnostic quality extra-oral/ intraoral photos, name and address of previous dentist, reason for COC request, additional number of months that D8670 is requested
D9110	Palliative (emergency) treatment of dental pain-minor procedure	0-25		Not allowed with any other services other than radiographs.	No	
D9222	Deep sedation/general anesthesia – first 15 minutes. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration	0-25		One per day.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D9223	Deep sedation/general anesthesia-each 15 minutes	0-25		Maximum of 90 minutes (6 units). Will not be paid with D9230, D9243, D9248. Five per day (must have approved D9222) – existing code service edits.	No	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	0-25		Will not be paid with D9248.	No	
D9239	Intravenous moderate (conscious) sedation/analgesia—first 15 minutes Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.	0-25		One per day.	No	
D9243	Intravenous moderate (conscious) sedation/analgesia-each 15 minutes	0-25		Maximum of 90 minutes (6 units). Will not be paid with D9223, D9230, D9248. Five per day (must have approved D9239) – existing code service edits.		
D9248	Non-intravenous moderate (conscious) sedation	0-25		One of (D9248) will not be paid with D9230, or D9243.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D9310	Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician	0-25		Diagnostic service provided by dentist other than practitioner providing treatment. Not covered within 90 days of D0120, D0140, or D0150.	No	
D9410	House/extended care facility call	0-25			Yes	Yes report required
D9420	Hospital or ambulatory surgical center call	0-25			No	Only billable with service when provider has been approved to provide services outside of their office in ASC or OP dept. of a hospital
D9910	Application of desensitizing medicament	0-25		One per visit. Not to be used for bases, liners or adhesives used under restorations.	No	
D9941	Fabrication of athletic mouth-guard	0-25		One of (D9941) per 12 months per patient.	No	
D9944	occlusal guard – hard appliance, full arch	0-25		One per 24 months for codes (D9944-D9946)	No	
D9945	occlusal guard – soft appliance, full arch	0-25		One per 24 months for codes (D9944-D9946)	No	
D9946	occlusal guard – hard appliance, partial arch	0-25		One per 24 months for codes (D9944-D9946)	No	
D9951	Occlusal adjustment-limited	0-25		One of (D9951) per 12 months effective 6/1/18 Not covered with any restorative procedure on same date of service.	No	
D9952	Occlusal adjustment-complete	0-25		One of (D9952) per 12 months per patient. Not covered with any restorative procedure on same date of service.	No	
D9999	Unspecified adjunctive procedure by report	0-25			Yes	Completed Facility Referral Form, Confirmation of Medical Necessity: Narrative #1 (6 or older) #2 (ages 2-6), Treatment plan, x-rays, photos, etc., D9999 on claim form

Pregnant Women & REM Adults Age 21 and Over

For adults age 21 and over, the benefits, limitations, and authorization requirements are identical between the Medicaid and REM plans, except the REM plan for adults allows for more frequent phrophy, debridement, and D0272 two bitewings.

Code	Description	Age	Tooth / Quad /Arch	Limitations	Auth Req	Requirement
D1110	Prophylaxis-adult	21 and older		One of (D1110) per 3 months per patient for REM Adults 21 & Over. One of (D1110) per 6 months per patient for Pregnant Women 21 & Over. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains	No	
D1206	Topical application of fluoride varnish	21 and older		One of (D1206/D1208) per 6 months per patient for Pregnant Women 21 & Over.	No	
D1208	Topical application of fluoride-excluding varnish	21 and older		One of (D1208) per 3 months per patient for REM Adults 21 & Over. One of (D1208) per 6 months per patient for Pregnant Women 21 & Over.	No	
D2140	Amalgam-one surface, primary or permanent	21 and older	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2150	Amalgam-two surfaces, primary or permanent	21 and older	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface	No	
D2160	Amalgam-three surfaces, primary or permanent	21 and older	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2161	Amalgam-four or more surfaces	21 and older	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2330	Resin-based composite-one surface	21 and older	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2331	Resin-based composite - two surfaces, anterior	21 and older	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393,D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2332	Resin-based composite-three surfaces, anterior	21 and older	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)	21 and older	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2391	Resin-based composite-one surface, posterior	21 and older	1-5, 12-21, 28-32, A, B, I-L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2392	Resin-based composite-two surfaces, posterior	21 and older	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2393	Resin-based composite-three surfaces, posterior	21 and older	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2394	Resin-based composite-four or more surfaces, posterior	21 and older	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2740	Crown-porcelain/ceramic substrate	21 and older	1-32	One of (D2740) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2750	Crown-porcelain fused to high noble metal	21 and older	1-32	One of (D2750) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2751	Crown-porcelain fused to predominantly base metal	21 and older	1-32	One of (D2751) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2752	Crown-porcelain fused to noble metal	21 and older	1-32	One of (D2752) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2780	Crown-¾ cast high noble metal	21 and older	1-32	One of (D2780) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2781	Crown-¾ cast predominantly base metal	21 and older	1-32	One of (D2781) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2782	Crown-¾ cast noble metal	21 and older	1-32	One of (D2782) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2783	Crown-¾ porcelain/ceramic	21 and older	1-32	One of (D2783) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2790	Crown-full cast high noble metal	21 and older	1-32	One of (D2790) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2791	Crown-full cast predominantly base metal	21 and older	1-32	One of (D2791) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2792	Crown-full cast noble metal	21 and older	1-32	One of (D2792) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative x-ray showing apex of tooth
D2794	Crown-titanium	21 and older	1-32	One of (D2794) per 60 months per patient per tooth. Not payable on the same day of service as D3310, D3320, or D3330.	**Yes**	Pre-operative x-ray showing apex of tooth
D2920	Re-cement or re-bond crown	21 and older	1-32, A-T	Two of (D2920) per 1 lifetime per patient per tooth. Not allowed within 6 months of initial placement.	No	
D2931	Prefabricated stainless steel crown-permanent tooth	21 and older	1-32	One of (D2931) per 60 months per patient per tooth. Not payable on the same day of service as D3310, D3320, or D3330.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2940	Protective restoration	21 and older	1-32, A-T	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	No	
D2951	Pin retention-per tooth, in addition to restoration	21 and older	1-32		No	
D3110	Pulp cap-direct (excluding final restoration)	21 and older	1-32		No	
D3120	Pulp cap-indirect (excluding final restoration)	21 and older	1-32, A-T		No	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	21 and older	6-11, 22-27	One of (D3310) per 1 lifetime per patient per tooth. Not payable on the same day of service as D2740-D2794, or D2931.	No	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	21 and older	4, 5, 12, 13, 20, 21, 28, 29	One of (D3320) per 1 lifetime per patient per tooth. Not payable on the same day of service as D2740-D2794, or D2931.	No	
D3330	Endodontic therapy, molar (excluding final restoration)	21 and older	1-3, 14-19, 30-32	One of (D3330) per 1 lifetime per patient per tooth. Not payable on the same day of service as D2740-D2794, or D2931.	No	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	A minimum of four teeth in the affected quadrant. Limit of two Quadrants per 12 months.	**Yes**	Pre-operative x-rays, periodontal charting, narrative of medical necessity; photos optional

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D4341	Periodontal scaling and root planing-four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL,UR)	One of (D4341) per 12 months per patient per quadrant. A minimum of four teeth in the affected quadrant. Limit of four quadrants per 12 months.	**Yes**	Pre-operative x-rays, periodontal charting
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	21 and older		One of (D4355) per 12 months per patient for REM Adults 21 & Over. One of (D4355) per 24 months per patient for Pregnant Women 21 & Over. Not allowed with D1110 on same date of service.	No	
D4910	Periodontal maintenance procedures	21 and older		Two of (D4910) per 12 months per patient. Must follow active periodontal treatment.	No	
D5410	Adjust complete denture-maxillary	21 and older		Not covered within 6 months of placement.	No	
D5411	Adjust complete denture-mandibular	21 and older		Not covered within 6 months of placement.	No	
D5421	Adjust partial denture-maxillary	21 and older		Not covered within 6 months of placement.	No	
D5422	Adjust partial denture-mandibular	21 and older		Not covered within 6 months of placement.	No	
D6930	Re-cement or re-bond fixed partial denture	21 and older		Two of (D6930) per 1 lifetime per patient per bridge.	No	
D7111	Extraction, coronal remnants-deciduous tooth	21 and older	A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	
D7220	Removal of impacted tooth-soft tissue	21 and older	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7230	Removal of impacted tooth-partially bony	21 and older	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7240	Removal of impacted tooth-completely bony	21 and older	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7250	Surgical removal of residual tooth roots (cutting procedure)	21 and older	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Will not be paid to the dentist or group that removed the tooth. Removal of asymptomatic tooth not covered.	**Yes**	Narrative of medical necessity, pre-operative x-rays (excluding bitewings)
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	21 and older			**Yes**	Copy of pathology report submitted with claim

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7286	Incisional biopsy of oral tissue-soft	21 and older			**Yes**	Copy of pathology report submitted with claim
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310) per 1 lifetime per patient per quadrant. Minimum of three extractions in the affected quadrant.	No	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7320) per 1 lifetime per patient per quadrant. No extractions performed in an edentulous area.	No	
D7510	Incision and drainage of abscess - intraoral soft tissue	21 and older	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Not allowed with extraction.	No	
D9110	Palliative (emergency) treatment of dental pain-minor procedure	21 and older		Not allowed with any other services other than radiographs. Not allowed in relation to recently rendered services.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D9222	Deep sedation/general anesthesia – first 15 minutes. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration	21 and older			No	
D9223	Deep sedation/general anesthesia- each 15 minutes	21 and older		Maximum of 90 minutes (6 units). Will not be paid with D9230, D9243, D9248. Five per day (must have approved D9222) – existing code service edits.	No	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Will not be paid with D9248.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D9239	Intravenous moderate (conscious) sedation/analgesia-first 15 minutes Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.	21 and older			No	
D9243	Intravenous moderate (conscious) sedation/analgesia-each 15 minutes	21 and older		Maximum of 90 minutes (6 units). Will not be paid with D9223, D9230, D9248. Five per day (must have approved D9239) – existing code service edits.	No	
D9248	Non-intravenous moderate (conscious) sedation	21 and older		One of (D9248) will not be paid with D9230, or D9243.	No	
D9999	Unspecified adjunctive procedure, by report	21 and older		Not covered for Pregnant Women 21& Over.	**Yes**	Completed Facility Referral Form: Confirmation of Medical Necessity (Narrative for #1 (only ages 6 or older), narrative for #2-6), treatment plan, x-rays, photos, etc., D9999 on claim form

Adult Dental Pilot Program

For adults ages 21 through 64 who have Medicare and Medicaid, the benefits, limitations, and authorization requirements listed below, must be accompanied by a completed Global Treatment Plan for all services rendered by the provider at each dental visit. * Please note Providers must complete, and keep a copy in the member chart, a Global Treatment Plan and any Non-Covered Services Agreements completed for all services rendered by Provider and Member at each visit.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0120	Periodic oral evaluation- established patient	21 - 64		One of (D0120 or D01250) per patient per 6 month period.	No	
D0140	Limited oral evaluation	21 - 64		One of (D0140) per patient per 12 month period.	No	
D0150	Comprehensive oral evaluation - new or established patient	21 - 64		One of (D0150) per patient per 36 month period. One of (D0120 or D01250) per patient per 6 month period.	No	
D0210	Intraoral- Complete series of radiographic images	21 - 64		One of (D0210, D0330) per 36 months per patient.	No	
D0220	Intraoral- Periapical First Radiographic Image	21 - 64		One of (D0220) per patient per 12 month period.	No	
D0230	Intraoral- Periapical Each Additional Radiographic Image	21 - 64		Limit of 6 (D0230) per patient per 12 month period.	No	
D0270	Bitewing- Single Radiographic Image	21 - 64		One of (D0270, D0272, D0273, D0274) per patient per 12 month period.	No	
D0272	Bitewing- Two Radiographic Images	21 - 64		One of (D0270, D0272, D0273, D0274) per patient per 12 month period.	No	
D0273	Bitewings- Three Radiographic Images	21 and older		One of (D0270, D0272, D0273, D0274) per patient per 12 month period.	No	
D0274	Bitewings- Four Radiographic Images	21 - 64		One of (D0270, D0272, D0273, D0274) per patient per 12 month period.	No	
D0330	Intraoral - Complete Series of Radiographic Images	21 - 64		One of (D0210, D0330) per 36 months per patient.	No	
D1110	Prophylaxis- Adult (Permanent Dentition)	21 - 64		One of (D1110) per patient per 6 month period.	No	
D2140	Amalgam- One Surface, Permanent	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2150	Amalgam- Two Surfaces, Permanent	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2160	Amalgam- Three Surfaces, Permanent	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2161	Amalgam- Four or More Surfaces, Permanent	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2330	Resin-based composite- One Surface, Anterior	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2331	Resin-based composite-Two Surfaces, Anterior	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patien per tooth regardless of surface	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2332	Resin-based composite- Three Surfaces, Anterior	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2335	Resin-based composite-Four or More Surfaces or Involving Incisal Angle (Anterior)	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface	No	
D2391	Resin-based composite-one surface, posterior			One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	
D2392	Resin-based composite-two surfaces, posterior	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface	No	
D2393	Resin-based composite-three surfaces, posterior	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2394	Resin-based composite-Four or more surfaces, posterior	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.		
D4355	Full Mouth Debridement to Enable a Comprehensive Evaluation and Diagnosis On a Subsequent Visit	21 - 64		One of (D4355) per patient per 24 month period.	No	
D7140	Extraction, Erupted Tooth or Exposed Root	21 - 64			No	
D7210	Surgical Removal- Erupted Tooth, Removal of Bone/ Sectioning of Tooth	21 - 64			No	
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	21 - 64			No	

MARYLAND Healthy Smiles DENTAL PROGRAM

SKYGEN USA LLC

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