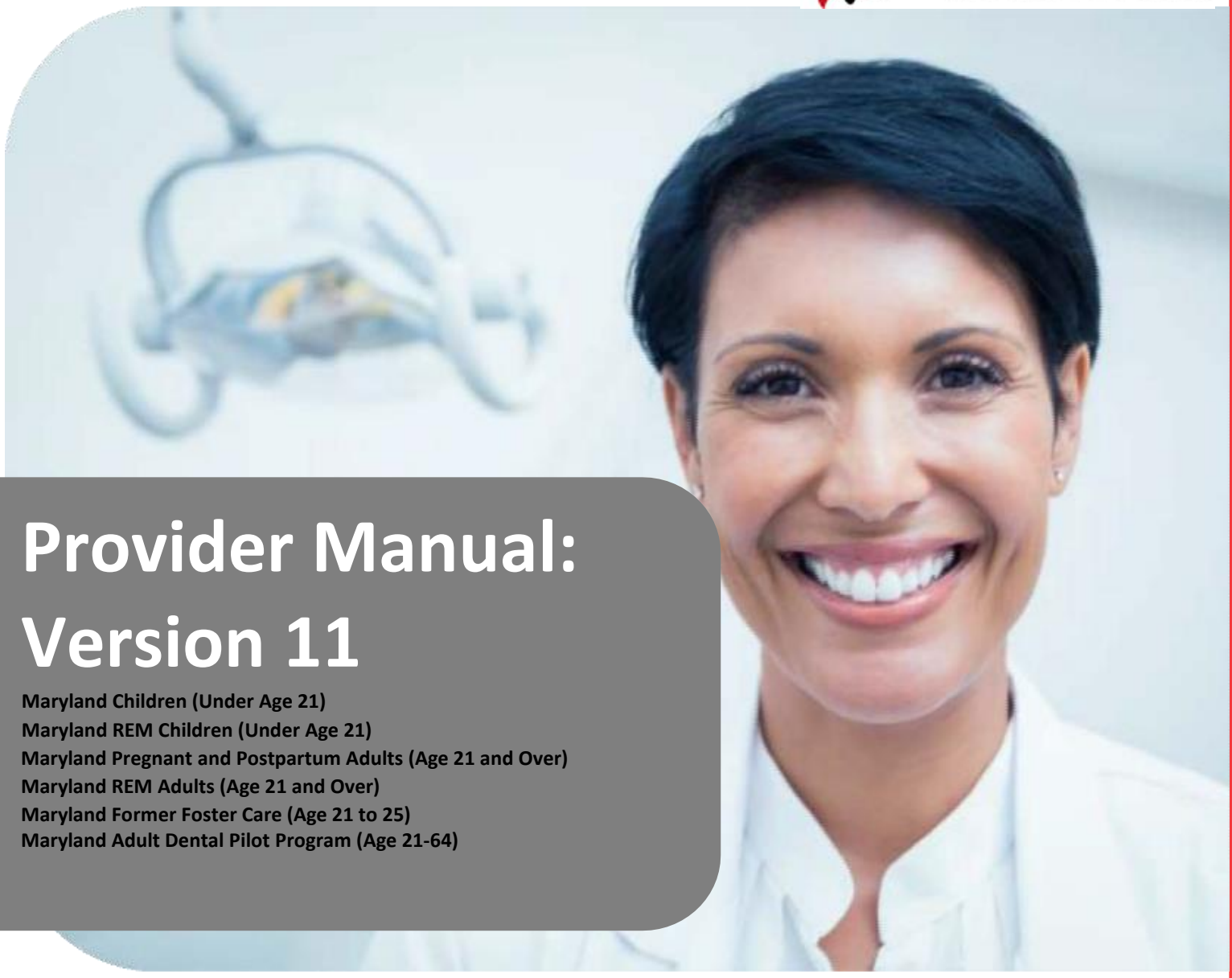
MARYLAND
Healthy Smiles
DENTAL PROGRAM



Provider Manual: Version 11

Maryland Children (Under Age 21)
Maryland REM Children (Under Age 21)
Maryland Pregnant and Postpartum Adults (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)

Program Effective: January 1, 2016

Maryland Healthy Smiles Dental Program

Revision Effective: November 15, 2021

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Quick Reference Guide

Provider Web Portal: Online, All the Time

Getting reimbursed for the high-quality care you've provided to patients should be quick, easy, and convenient. SKYGEN'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 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 and Quick Reference to Common Questions

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 Please Note: Corrected claims can be submitted via Provider Web Portal or EDI Clearinghouses.
Grievances, Reconsiderations & 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	844-809-9449 Email: fraud@SKYGENUSA.com
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. Refer to (Dental Services for Pregnant Women) in the Provider Manual. For help submitting authorizations via Provider Web Portal, call the SKYGEN 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 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: **Effective May 1, 2020 all claims must be submitted on the 2019 version of the claim form or the claim will be rejected** • Providers are responsible for asking women if they are pregnant, and then submitting claims accordingly. Refer to (Dental Services for Pregnant Women) in the Provider Manual.

Quick Reference to Common Questions

Grievances & Reconsiderations	To make a grievance or request reconsideration on behalf of the member, either: • Write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee WI 53201 • Call Provider Services: 844-275-8753
Authorization Reconsideration	A reconsideration can be submitted on behalf of a member with their written consent. This request must be filed within 30 days following the date the denial letter was mailed. SKYGEN issues a decision within 30 days of receiving the 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
Claim Reconsideration	A reconsideration request must be filed within 30 days following the date the denial letter was mailed. SKYGEN issues a decision within 30 days of receiving the request, unless an extension is granted. To request reconsideration of a claim denial, write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee WI 53201
EFT (Direct Deposit) Enrollment	To enroll in EFT payments you can either send a completed EFT Authorization Agreement form and voided check by either fax or email: • Fax: 262-721-0722 • Email: providerservices@SKYGENUSA.com Or you can enroll in EFT paperless through the Provider Web Portal. 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 on the Provider Web Portal, contact the SKYGEN Web Portal Team at providerportal@SKYGENUSA.com or call: 855-434-9239.
Additional Provider Resources	For information about additional provider resources: • Send email to Provider Services: providerservices@SKYGENUSA.com • Call Provider Services: **844-275-8753**

Quick Contacts for Credentialing	
Electronic Provider Revalidation and Enrollment Portal (ePREP)	Phone: 844-463-7768 or ePREP.health.maryland.gov Please contact ePREP for provider enrollment and credentialing related activities.
Provider Services	844-275-8753 Email: providerservices@SKYGENUSA.com
License Renewal	All license renewals must be completed with the Dental Board before the expiration date. Once you have received your renewed license you must submit a supplemental application to update your license expiration date through ePREP.health.maryland.gov. Please contact ePREP for assistance with updating your renewed license.
Disenrollment from Healthy Smiles	Provider disenrollment must be done through ePREP.health.maryland.gov. Please let your SKYGEN Field Representative know that you are disenrolling as a participating provider from the program.

Welcome

Welcome to the Maryland Healthy Smiles Dental Program provider network! We are committed to providing our providers the best support possible and our members the best possible care. We are pleased to have you on our team.

The State of Maryland has chosen SKYGEN to administer dental benefits for members enrolled in the Maryland Healthy Smiles Dental Program.

Throughout your ongoing relationship with SKYGEN, 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 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 as proprietary and confidential.

To see an overview of the changes made in *Provider Manual: Version 11*, please see the history revision section.

*This manual describes SKYGEN policies and procedures that govern our administration of dental benefits for the Maryland Department of Health (MDH). SKYGEN 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.*

Revision History: Version 11

Version 11 Revisions	Revision Effective Date
Postpartum Care	Updated 11/15/2021
Prophylaxis (D1110, D1120), Oral Health Exams (D0120) & Restoration (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 & D2394) frequency limits. See Benefit Plan Details & Authorization Requirements section.	Updated 11/15/2021
Orthodontia Benefit Guide	Updated 11/15/2021
Non-Covered Services Agreement	Updated 7/01/2021
Authorization Requirements – effective 11/15/2021 Codes D3310, D3320, D3330, D4355, D9951 and D9952 will require preauthorization. See clinical criteria descriptions and Benefit Plan Details & Authorization Requirements section.	Updated 11/15/2021
Scaling and Root Planing – D4341 & D4342 Limited to permanent dentition. See Benefit Plan Details & Authorization Requirements section.	Updated 11/15/2021

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 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 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 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 HIPAA policies, call Provider Services or send an email to providerservices@SKYGENUSA.com. To report a potential security issue, call our Hotline: **844-809-9449** or send an email to fraud@SKYGENUSA.com.

Utilization Management

Community Practice Patterns

To ensure fair and appropriate reimbursement, the SKYGEN 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 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'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'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 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'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 Utilization Management team bases their decisions on only appropriateness of care, service, and existence of coverage. SKYGEN 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 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 Fraud and Abuse Hotline: **844-809-9449**, email: fraud@SKYGENUSA.com or write to:

SKYGEN
Attention: Fraud and Abuse
N92 W14612 Anthony Ave
Menomonee Falls, WI 53051

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 Fraud and Abuse Hotline: 844-809-9449

Agency for Health Care Administration: 888-419-3456

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 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 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.

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.

Provider Rights & Responsibilities

The Maryland Healthy Smiles Dental Program/SKYGEN 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.
- **File an appeal or grievance** about the procedures of the Maryland Healthy Smiles Dental Program/SKYGEN.
- **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.
- **Discuss concerns and issues with members** by contacting their SKYGEN provider representative or the SKYGEN 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*).
- If a recommended treatment plan is not covered (not approved by the Maryland Healthy Smiles Dental Program/SKYGEN), 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).
- Providers wishing to terminate participation with the Maryland Healthy Smiles Dental Program provider network must follow 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 or an audit. Please review the Maryland Provider Agreement.
- 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.

Member Clinical Chart Notes

Providers are expected to maintain comprehensive Clinical Chart notes. The patients' record, which includes Clinical Chart notes, is essential to the provision of quality oral health care.

- The recording of patients' medical and dental history, present illness, clinical examination, diagnosis, completed treatment, overall prognosis and patient-homecare communications are fundamental to patient care.
- The record serves to determine the patients' baseline findings and treatment plan.
- In addition to being a legal record, it is a comprehensive accounting of what transpired during the dental visit, may be used in defense of malpractice allegations, and serves as the basis for insurance claims and forensic purposes.

Adequate documentation of registration information, which requires entry of these items:

- Patient first and last name
- Date of Birth
- Gender
- Address
- Telephone number
- Name and telephone number of the person to contact in case of emergency.

Per the Maryland Department of Health, the chart notes for each member should include the following:

- Registration data including a complete health history
- Initial examination data
- Periodontal and Occlusal status
- Treatment plan/alternative treatment plan.
- Tooth charting noting the presence or absence of teeth, existing restorations, areas of decay, fractured teeth, periodontal charting as applicable, and any other documentation that is pertinent
- Radiographs, which are identified by patient name and date.
- All informed consent forms must be signed and dated by parent and/or legal guardian and provider in their preferred language
- If interpreter is used, this must be noted in the record at every visit.
- Name of member and their birthdate on each chart note page
- Chart notes for every DOS to include diagnosis, progress notes, preventative services, treatment rendered, and medical/dental consultations.
- Medical necessity of the procedures completed for that DOS should be documented
- Tooth numbers and surfaces of teeth receiving treatment
- Name of provider (or initials) of the clinician providing the treatment, as well as that of the RDH
- Anesthesia administered, location and the amount given
- If nitrous oxide is used: the amount, duration, % oxygen flush, and statement that the patient tolerated the procedure well (status) and any complications
- If abbreviations are used, the must be widely accepted and used universally in the office.
- The documentation in the chart notes for each DOS should match the claims submitted for those procedures.

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

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

The design of the record must ensure that all permanent components are attached or secured within the record and must be readily identified to the patient (i.e., patient name and identification number on each page). The organization of the record system must require that the individual records be assigned to each patient.

An adequate health history that requires documentation of these items:

- Current medical treatment
- Significant past illnesses
- Current medications
- Drug allergies
- Hematologic disorders
- Respiratory disorders
- Endocrine disorders
- Communicable diseases
- Neurologic disorders
- Signature and date by patient
- Signature and date by reviewing dentist
- History of alcohol and/or tobacco usage including smokeless tobacco

An adequate update of health history at subsequent recall examinations, which requires documentation of these items:

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

A conspicuously placed medical alert inside the chart jacket that documents highly significant terms for health history. These items are:

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

Adequate documentation of the initial and subsequent clinical examination, which is dated and requires descriptions of findings in these items:

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

Radiographs, which are identified by patient name

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

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

Adequate documentation of the treatment plan (including any alternate treatment options) the specifically describes all the services planned for the patient by entry of these items:

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

An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

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

An adequate documentation of the patient's oral hygiene status and preventative efforts, which requires entry of these items:

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

An adequate documentation of medical and dental consultations within and outside the practice, which requires entry of these items:

- Provider to whom consultation is directed
- Information/services requested
- Consultant's response
- Date of service/procedure

Compliance:

- The patient record has one explicitly defined format that is currently in use.
- There is consistent use of each component of the patient record by all staff.
- The components of the record that are required for complete documentation of each patient's status and care are present.
- Entries in the records are legible.
- Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.
- All clinicians treating MDH members should be credentialed and have an active license in the state the services are being rendered.

Positive Provider Support

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, 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, 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. SKYGEN conducts monthly data analysis to provide the state information about current industry standards. Additionally, 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.
- 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 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).

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 Credentialing and Enrollment

Please note that all applications for enrollment, re-enrollment, revalidation, addition of locations, demographic changes, license renewal and affiliation of a rendering provider to a group will be required to be submitted in electronic Provider Revalidation and Enrollment Portal (ePREP).

Maryland Medicaid requires all dental providers who operate a group practice to have separate NPIs/Medicaid ID numbers for each location. Maryland Medicaid providers that wish to be directly reimbursed by Maryland Medicaid must obtain and provide their SDAT number for enrollment regardless of the state that services are provided from the Maryland State Department of Assessments and Taxation (SDAT). A separate SDAT number is required for each NPI number. All groups are required to provide verification of Federal Tax ID (TIN), or Employer Identification Number (EIN) from the IRS.

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 (844-463-7768) if you have any questions concerning your enrollment, credentialing or revalidation.

Please note that while SKYGEN 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 's Provider Services' department at 844-275-8753.

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 individual patient 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 Web Portal Team for assistance: **855-434-9239**.

Electronic Payments

Electronic Funds Transfer (EFT)

SKYGEN offers all providers the option of Electronic Funds Transfer (EFT) for claims payments. With EFT, we can pay claims more efficiently because funds are deposited directly into payee bank accounts, eliminating the steps of printing and mailing paper checks. **Although we can deposit the funds directly into your account we have no access to ever recoup any payments from your account.**

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 by Fax: **262-721-0722** or Email: providerservices@SKYGENUSA.com.
4. Or, providers can enroll in the EFT program through the Provider Web Portal.

Allow up to six weeks for the EFT program to be implemented after we receive your completed paperwork. Your Remittance Reports are 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 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. SKYGEN is not responsible for delays in payment if we are not properly notified, in writing, of banking changes.

Electronic Remittance Reports

Your Remittance Reports are available electronically from the Provider Web Portal. For help registering for the portal or accessing your Remittance Reports, call the SKYGEN Web Portal Team: **855-434-9239**.

EFT Authorization Agreement

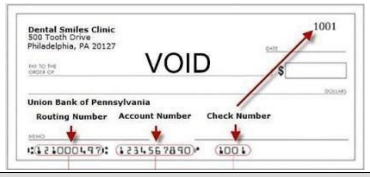
A copy of the SKYGEN EFT Authorization Agreement form is included on the following page. The form is also available for download from the Provider Web Portal: www.provider.MDhealthysmiles.com.

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 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 LLC by electronic funds transfer according to the terms of the EFT program. I agree to return to SKYGEN any EFT payment incorrectly disbursed by SKYGEN I agree to hold harmless SKYGEN 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 coverage groups include:

- Maryland Children (Under Age 21)
- Maryland REM Children (Under Age 21)
- Maryland REM Adults (Age 21 and Older)
- Maryland Pregnant and Postpartum Adult (Age 21 and Older)
- Maryland Former Foster Care (Age 21 to 25) *Eligible Effective: 1/1/17*
- Maryland Adult Dental Pilot (Age 21 to 64) *Eligible Effective: 6/1/19*

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 **"MD NO DENTAL"** have NO dental benefits or dental coverage.*

***Please note that for members whose eligibility indicates **"Dental Only If Pregnant or Postpartum"** claims must be submitted with pregnancy or postpartum indicator by using the instructions in the Dental Benefits for Pregnant Women section.*

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 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's Provider Web Portal and following these steps:

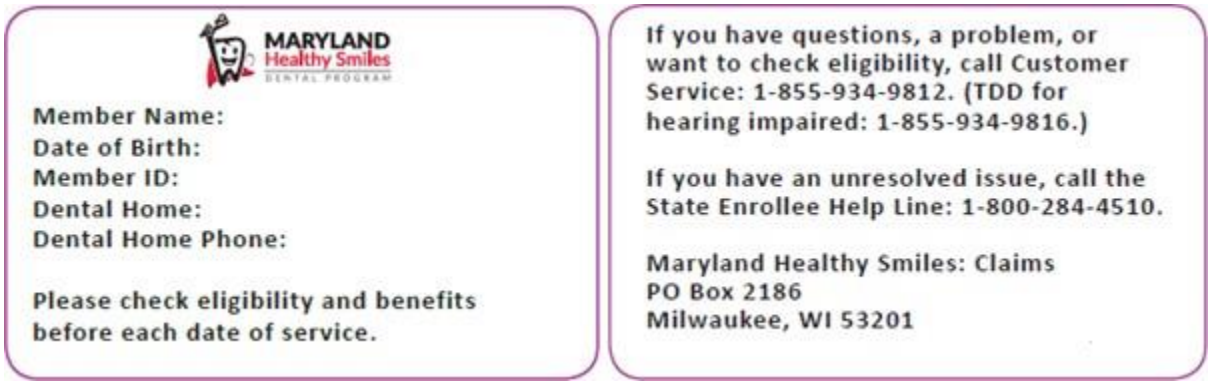
1. Click on Report at the top of the toolbar
2. Click Primary Care Assignments
3. Keep default at "All" for location and provider
4. Click Print Report to export to PDF or Excel

Member ID Card

Members receive Maryland Healthy Smiles Dental Program Member ID cards from SKYGEN. Providers are responsible for verifying that members are eligible prior to the services being rendered and for determining whether recipients have other dental insurance. It is possible for a member's eligibility status to change at any time without notice. The presence of a Member ID card does not guarantee a member's eligibility, nor does it guarantee provider payment.

> 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 should:

- 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 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. The dental specialist is responsible for obtaining pre-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.

SKYGEN will educate providers about appointment standards, monitor the adequacy of the process, and take corrective action if required. Dentists are expected to meet the following minimum standards for appointment availability:

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, 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.

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.

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

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.

The Missed Appointment Log should be used to track your members' missed appointments. This log can either be emailed to: outreachcoordinator@SKYGENUSA.com or faxed to SKYGEN at 410-624-5486. The frequency you submit the log is up to you, however, they are more effective when they are submitted as close to the missed appointment as possible. SKYGEN recommends submitting the Missed Appointment Log weekly, if applicable.

You can also call Provider Services 844-275-8753 to report a missed appointment. Our Provider Services Team will track the missed appointments by logging them in our Customer Service system. These records are forwarded to our Member Outreach team for follow-up. Member Outreach will contact the member personally and work with them to reschedule dental visits and provide education about the importance of keeping scheduled appointments.

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."

Maryland Healthy Smiles Dental Program Missed Appointments

Providers please complete the following columns below						SKYGEN 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

Provider-Member Termination

The Maryland Healthy Smiles Dental Program has established a policy regarding the dismissal of a Medicaid member. Dismissal of the member shall be evaluated on a case-by-case basis. Providers may dismiss a Medicaid member from their practice for cause at any time, and "cause" is defined as any of the following six reasons:

- A documented, ongoing pattern of failure on the part of the member to keep scheduled appointments or meet any other member responsibilities
- The member fails to follow the recommended treatment plan or medical instructions
- The provider cannot provide the level of care necessary to meet the member's needs
- The provider moves out of the service area
- The member and/or member's family is abusive to the provider and/or practice staff, or poses a serious threat of harm to the provider, staff, and/or other patients
- Other reasons determined to be satisfactory to the Maryland Department of Health (MDH)

Providers may not dismiss a Medicaid member based on the member's gender, race, religion, or sexual orientation. Further, a member covered under the Americans with Disabilities Act (ADA) may be dismissed only for reasons similar to those applied to a non-disabled member. A member may not be dismissed because of their disability or illness, or costs that the disability or illness might involve (e.g., providing an interpreter for a deaf member). The grounds for dismissal of a MHSDP member cannot be stricter than your policy for private or commercial patients.

Upon a decision to dismiss a MHSDP member, the provider must complete the Provider-Member Termination Form and follow the procedure as listed within the form. Give no less than a 30-day written notice of termination to both the member and SKYGEN (per COMAR 10.09.05.01(10)).

- Members must be notified in writing of provider's intent to terminate.
- Coverage of the member's urgent and emergency care needs should continue for up to 30 days, or until the member obtains a new dental provider (whichever occurs first)
- Medical records should be sent to the new provider upon receipt of written authorization from the member
- Provide the member with contact information to member services to obtain a list of providers within the MHSDP Network

Following the receipt of the Provider-Member Termination Form, a member outreach coordinator will contact the member to assist with finding a new dental provider. The Provider-Member Termination Form is included in the provider manual and can be found on the Provider Web Portal www.provider.MDhealthysmiles.com.

Payment for Non-Covered Services

Providers that are enrolled in the Maryland Healthy Smiles Dental Program shall hold members and SKYGEN 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, (b) the member agrees to have the service rendered and signs a **Non-Covered Services Agreement** form prior to the service being rendered.

If the member has appealed or intends to appeal the denied service, the provider should not begin services until Office of Hearing and Appeals has rendered a disposition. A signed copy of the Non-Covered Services Agreement must be kept in the member's chart. The provider should educate the member concerning which services they will be responsible to pay prior to the services 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 prior to the services being provided.

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 the patient will be financially liable for such services.

The Maryland Healthy Smiles Dental Program offers a Non-Covered Services Agreement form that should be used for this purpose. Your office can also use your own form, as long as it contains all of the required information listed above. The Maryland Healthy Smiles Non-Covered Services Agreement is included in the provider manual and can be found on the Provider Web Portal www.provider.MDhealthysmiles.com. The Maryland Healthy Smiles Dental Program or SKYGEN 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.-8:45 p.m. (Sat)	Hart to Heart 443-573-2073
Baltimore County	TransDev (Formerly Veolia) 410-783-2465 or 410-887-2828	9:00 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.-4:00 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

County	Number to call (LHD unless otherwise noted)	Call Hours	After Hours Transports (Please call after close of business)
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.-3:00 p.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 (stretcher) 410-823-0030 Falcon (Wheelchair Van) 240-595-0960
Queen Anne's	443-262-4462 or 410-758-0720 Ext. 4462	8:30 a.m.-12:30 p.m. 1:00 p.m. – 4:00 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. – 4:30 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	8:00 a.m.-4:30 p.m.	East Coast Ambulance 410-663-2012
Worchester	410-632-0092 or 0093 Cannot transport for appointments after 1:30 on western shore (i.e. Annapolis)	8:00 a.m.-4:00 p.m.	Best Care 410-476-5907 Lifestar 410-546-0809

Dental Services for Pregnant Women

Women eligible for Maryland Medicaid benefits qualify for dental services during their pregnancy and postpartum period. For information about covered services, see the Maryland Healthy Smiles Dental Program: Pregnant and Postpartum 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 's benefits management software system.

Postpartum Benefits

Beginning November 15, 2021 coverage for pregnant women will include postpartum care. This new postpartum coverage is an extension of the current pregnancy treatment coverage. Instead of coverage ending on the date the pregnancy ends, the new benefit extends coverage through the postpartum period. The postpartum period begins the day that the pregnancy ends and extends until the end of the second month after the end of the pregnancy. *As an example, if the patient delivered her child on December 10, dental coverage will continue for that patient until February 28.*

Submitting Claims and Authorizations for Pregnant Women and Postpartum Care

During pregnancy, please submit requests for authorizations and claims with the ICD-10-CM diagnostic code, ***Z3A.00 for women until the end of their pregnancy*** 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 for pregnant members without the Z3A.00 diagnosis code will deny.

Once the pregnancy has ended, the postpartum period begins, extending benefits until the end of the second month after the date the pregnancy ended. Please submit requests for authorizations and claims with the ICD-10-CM diagnostic code, ***Z39.2 for women during the postpartum period*** 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 during the postpartum period without the Z39.2 diagnosis code will deny.

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

- Eligible for dental benefits in ***"MD Pregnant Adult 21+"*** or ***"MD Dental Only If Pregnant",*** and are pregnant or in the postpartum period, they are eligible for dental benefits as listed in the Maryland Healthy Smiles Dental Program: Pregnant and Postpartum Women & REM Adults Age 21 and over section of this provider manual.
- For pregnant women, 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)
- For postpartum care, Providers will need to submit both claims and authorizations for women during the postpartum period with the following Diagnosis Code: Z39.2 (Box 29a and Box 34a of ADA form)
- Claims and authorizations submitted without Diagnosis Code Z3A.00 for pregnant women or Z39.2 for postpartum women will be denied.

Maryland Healthy Smiles Adult Dental Pilot Program

The Maryland Healthy Smiles Adult Dental Pilot Program (the Pilot) started on June 1, 2019. 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. The benefit allowance will reset on January 1st. The Pilot has a limited benefit package which includes 28 services. At each visit, the provider and member must sign a global treatment plan before any services are provided.

Verifying Eligibility and Funds Available:

Providers must verify the amount of funds available in the member's $800 annual benefit allowance prior to scheduling an appointment, as well as on the date of service. The member's eligibility, clinical history and funds remaining are viewable via the Provider Web Portal.

- 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 and select option 0 to speak with a representative. The representative will be able to tell you the member's remaining benefit allowance according to the claims submitted to date.
- The remaining benefit allowance is viewable via the benefit summary on the provider web portal.
- Eligible members will be identified as eligible for the Pilot with the following message: "Maryland Medicaid Medicare – Limited Dental $800 Maximum."

Claims Reimbursement:

Claims will be reimbursed in the order they are submitted to SKYGEN. It is very important to submit claims as soon as possible. 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. The rates for services are listed on the Adult Dental Pilot Program Fee Schedule and the Global Treatment Plan.

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.

Federally Qualified Health Center (FQHC) Billing

FQHC's should continue to bill for dental services using D0999 with the dental 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 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 her pregnancy and postpartum coverage ends, she will then be reinstated to the Adult Dental Pilot Program, as long as she remains eligible.

Claims for pregnant or postpartum women must be submitted as listed in the section Benefits for Pregnant and Postpartum Women section of this provider manual.

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 an agreement prior to services being rendered at each visit. Urgent issues should be prioritized.

- 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.
- 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.
- 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.

Both versions of The Global Treatment Plan (Spanish and English) are available from the Provider Web Portal: www.provider.MDhealthysmiles.com.

Global Treatment Plan Agreement

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

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.

Authorization Documentation Requirements & Clinical Criteria

Medical Necessity

SKYGEN 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.

Pre-Authorization for Treatment

The Maryland Healthy Smiles Dental Program/SKYGEN has specific utilization criteria, as well as an authorization review process, to manage the utilization of services. Information regarding services that require authorization and supporting documentation is found in the Benefit Plan Details & Authorization Requirements section.

Non-emergency services requiring authorization should not be started until the authorization request is reviewed and approved by a SKYGEN 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 provider will be financially responsible and may not balance bill the member, the Maryland Healthy Smiles Dental Program or SKYGEN 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 this manual.

Clinical Criteria Descriptions

SKYGEN 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 pre-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.

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 treatment (D3310-D3330)

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

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
  - Limited to permanent dentition
  - 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
  - Limited to permanent dentition
  - 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

Full mouth debridement (D4355)

- Extensive coronal calculus on 50% of teeth

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 (D7961-D7962)

- 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 submitted without D8080 and D8670
- D8660 will be denied when a D8080 is not approved due to mixed dentition (with the exceptions of a cleft palate, evidence of congenitally missing permanent dentition, or evidence that the ectopic position of a succedaneous tooth is resulting in the failed exfoliation of the associated primary tooth))
- Once D8080 and D8660 are approved, no additional D8660 will approve thereafter
- Documentation must show a fully erupted set of permanent teeth (with the exceptions of cleft palate, evidence of congenitally missing permanent dentition, or evidence that the ectopic position of a succedaneous tooth is resulting in the failed exfoliation of the associated primary tooth)

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 when the case was originally approved through the State of Maryland
- D8670 preauthorized services will be limited to a total of 24 payments regardless of the number of providers rendering treatment; however, if a D8090 has previously been paid, a cumulative maximum of 12 D8670 payments is available
- A provider may not bill for broken brackets, wires, or additional adjustments beyond the maximum of 24 (12 if D8090 previously paid)
- 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
- If it is deemed original State of Maryland contracted provider received D8670 payments in excess of expected treatment progress, payment recoupment may occur; D8999 must include a D8680 and D8670 (if remaining are available) on the Pre-Authorization

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

- D8080 is inclusive of banding, debanding, and retention, and adjunctive appliances such as, but not limited to, palatal expanders, habit appliances, fixed bite plates, and fixed functional appliances.
- D8080 is allowed one per lifetime per patient
- Maximum of 24 D8670's for comprehensive Orthodontic treatments per member per lifetime (or)
- Maximum of 12 D8670's for Self-Ligating Orthodontic treatments per member per lifetime
- 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 (or 12 if a D8090 has been paid)
- Providers may not characterize adjustments beyond the maximum of 24 (or 12 if a D8090 has been paid) as "cosmetic" services in order to bill the recipient for additional adjustments; billing for such adjustments constitutes balance billing and MAY NOT be done
- A Pre-Authorization submitted with D8080 or D8080/D8090 must include D8660 and D8670 on the same Pre-Authorization
- 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 (D8703, D8704) / re-bonding or re- cementation / repair of fixed retainer (D8698, D8699)

- Narrative of active orthodontic case with documentation of debanding date (One per arch per lifetime allowed within 24 months of debanding date)

Palliative (emergency) treatment (D9110)

- Documentation describes medical necessity for procedure

House/extended care facility call (D9410)

- 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

Occlusal adjustment – limited (D9951)

- Adjustment not done on same date as restorative, prosthetic or endodontic treatment

Occlusal adjustment – complete (D9952)

- Documentation describes medical necessity for complex case need (facebow, interocclusal records, tracings, diagnostic wax-up, etc.

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 and Postpartum Women 21 & Over
- Includes the Adult Dental Pilot program members

EPSDT Guidelines

For Maryland Healthy Smiles Dental Program members who are under the age of 21, if a service or CDT code is not listed as a covered benefit, please submit a prior authorization with the EPSDT box checked along with a letter of medical necessity for review. If the prior authorization is approved, the claim must be submitted for reimbursement with the EPSDT box selected. If the prior 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. If the Non-Covered Services Agreement is not signed, the member cannot be charged.

For non-covered orthodontic services to be considered under EPSDT guidelines, a prior authorization with the EPSDT box selected must be submitted ***prior*** to the authorization request for comprehensive orthodontic treatment. If the services are approved as medically necessary under EPSDT guidelines they must be completed ***prior*** to the authorization submission for comprehensive orthodontic treatment.

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 to ensure the services meet the medical necessity criteria for services rendered in an outpatient facility (hospital or ASC).

Submitting an Pre-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 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 documentation supporting the emergency and all required documentation along with the claim for services rendered. SKYGEN 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.

Pre-Authorization Requirement vs. Claim Submission Requirement

The Benefit Plan Details & Authorization Requirements section shows all of the covered services under the Maryland Healthy Smiles Dental Program and lists if each service requires a preauthorization, has a claim submission requirement or has no requirements. If a service has requirement for preauthorization, the preauthorization must be done prior to rendering services. For example: D2740 requires Pre-operative x-ray showing apex of tooth in order to be considered for authorization.

If a service has a claim submission requirement. The documentation must be submitted with the claim. For example: D0431 does not require a pre-authorization, but does require the lab/pathology report be submitted with the claim.

If you have any questions about preauthorization or claim submission requirements please contact Provider Services, 844-275-8753.

Authorization Submission Procedures

Information regarding services that require authorization and supporting documentation is found in the Benefit Plan Details & Authorization Requirements section.

If a service requires a prior authorization, the provider must submit an authorization to be approved prior to the date the service is rendered. Retro-authorizations are not permitted. All pre-authorizations expire six months after the date they are received. It is the responsibility of the provider to submit a subsequent authorization to continue treatment, if needed, upon the expiration of the authorization.

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. When an authorization is denied and due to missing the required documents it must be resubmitted with the required documents to obtain prior approval before services are rendered. Any claims submitted without the required approved authorization will be denied for reimbursement.

SKYGEN will make a decision on a request for authorization within 2 business days from the date we receive the request, provided all information is complete. SKYGEN will honor authorizations for six (6) months after the date of the receipt of approval. ***An authorization does not guarantee payment***. The member must be eligible for benefits at the time services are provided. SKYGEN 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.

When submitting a pre-authorization, the "Procedure Date/Tentative Service Date" should be listed for each service line. This tentative date listed must be at least one day after the date the authorization is received.

- The authorization will be denied if a Procedure Date/Tentative Service Date is older than the authorization received date.
- If Procedure Date/Tentative Service Date is in the future or left blank the pre-authorization will be processed

SKYGEN 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

Summary: Prior Authorization Timelines

Authorization Request	Timeline
Decision on authorization request	SKYGEN approves or denies request within 2 business days.
Prior authorization expiration	SKYGEN honors pre-authorizations for six (6) months after the date of the receipt of approval.

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 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

Submitting Claims via Provider Web Portal

Providers may submit claims directly to SKYGEN 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 a decision 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 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 .

The SKYGEN 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.

Clearinghouse Information:

Change Healthcare *(formerly Emdeon)* *Also contracted for attachment services	DentalXChange *(formerly EHG)* *Also contracted for attachment services	Vyne Dental *(dba Tesia Clearinghouse)* *Providers can use ***Fast Attach™*** for attachment services	SDS *Providers can use ***Fast Attach™*** for attachment services
www.changehealthcare.com	www.dentalxchange.com	https://vynedental.com/	https://sdata.us/
1-866-371-9066	1-800-576-6412	1-800-724-7240	1-855-297-4436

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, 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 see Coordination of Benefits for more details required for paper, web portal or electronic claims sent via clearing houses). 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 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.

ICD-10 Diagnosis codes for Maryland Healthy Smiles Dental Program (MHSDP) members are ONLY required if the member is pregnant or during the postpartum period. The ICD-10 diagnosis code for pregnancy claims is Z3A.00 during pregnancy. The ICD-10 diagnosis code for postpartum claims is Z39.2 beginning the date the pregnancy ends and extending until the end of the second month following the end of pregnancy.

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 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

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

If SKYGEN 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 request reconsideration or appeal the decision. The requesting provider will also receive notice of the decision.

To request reconsideration or appeal a denied authorization decision with SKYGEN , see the Grievances, Reconsiderations & Appeals section of this provider manual.

Coordination of Benefits (COB)

The Maryland Healthy Smiles Dental Program/SKYGEN 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 is the secondary insurance carrier, submit a copy of the primary carrier's Explanation of Benefits (EOB) with the claim.

An EOB should include the following pieces if information: The name of the insurance company that paid the claim, the name of the patient, the date of service, an itemized list of the services performed, and information relating to how the payment was determined such as deductible, coinsurance, copay and remarks codes. Some key rules to follow in order to ensure a claim submitted with COB is processed correctly are:

- EOB must be legible
- The member information (name/DOB) listed on the EOB must match what is submitted on the claim
- All services listed on the claim must be on the EOB (Please note that all services on EOB do not need to be on the claim)
- Date of service on the claim must match the EOB
- Submitted charges on the claim must match the EOB
- If EOB shows non-payment of a service code, there must be a valid explanation of non-payment present on the EOB. (A denial reason "this is a duplicate of a previously processed claim" is an example of an invalid reason for non-payment)

For paper claims the primary payer information/EOB must be included and attached.

For claims submitted through the provider web portal, the EOB must be attached/uploaded and the COB fields completed.

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 the Maryland Healthy Smiles Fee Schedule amount, the Maryland Healthy Smiles Dental Program/SKYGEN will consider the claim paid in full and no further payment will be made on the claim.

Timely Filing Limits

SKYGEN 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 is not the primary carrier, the claim still must be received within 365 days from the date of service.

Resubmitting a Denied Claim

To resubmit a claim that has been denied with additional information, follow the Claim Submission Procedures section of this provider manual. The timely filing limitation of 12 months from the date of service does apply when a claim is resubmitted for reprocessing.

The following are examples of when a denied claim should be resubmitted as a new claim with the updated information per your normal claim submission channels:

- If a claim or service was denied due to missing tooth or surface;
- incomplete or incorrect information;
- or you have since obtained authorization for services

If you received a claim or service denial which you do not agree with, including denials for no authorization, please see the Grievances & Reconsiderations section of this provider manual for information on submitting a request for reconsideration.

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 "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. Please see Submitting a Corrected Claim section for more information.

Submitting a Corrected Claim

When Should I Submit a Corrected Claim? A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information. A Corrected Claim must be submitted in order for the original claim to be adjusted with the correct information. As part of this process, the original claim will be recouped and a new claim processed in its place with any necessary changes.

If a claim or service originally denied due to incorrect or missing information, or was not previously processed for payment, DO NOT submit a corrected claim. Please review the Resubmitting a Denied Claim section for instructions. Denied services have no impact on member tooth history or service accumulators, and, as such, do not require reprocessing.

What Scenarios are subject to the Corrected Claim Process? A corrected claim should only be submitted if the original service(s) PAID based on incorrect information. Some examples of correction(s) that need to be made to a prior PAID claim are:

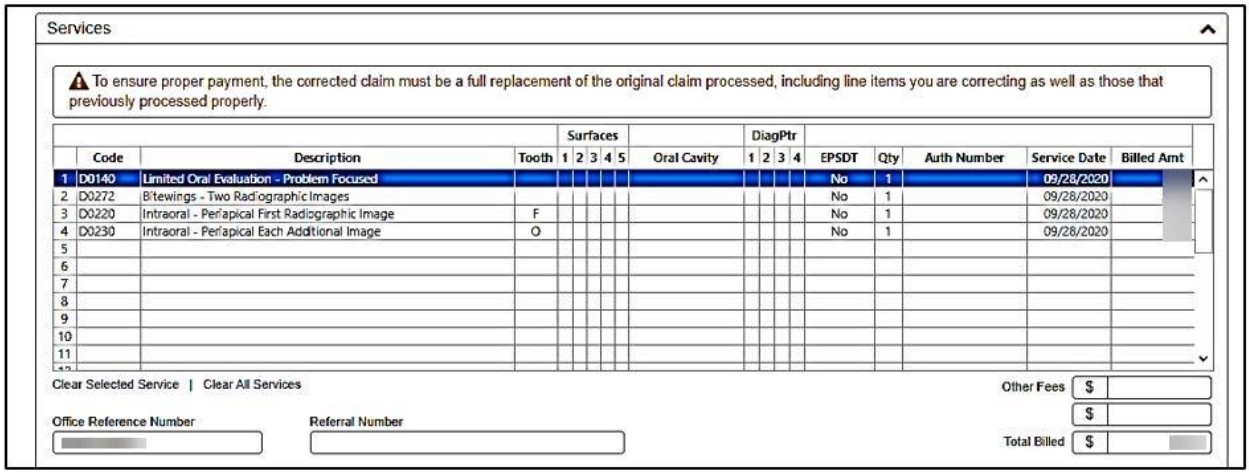
- Incorrect Provider NPI or location, Payee Tax ID, Incorrect Member, Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

Providers can submit their corrected claims via the Provider Web Portal or through clearinghouse files.

Submitting Corrected Claims via the Web Portal

Providers will be able to make corrections on original claims via the Provider Web Portal. Providers will have the ability to:

- Edit or correct ADA dental claim form fields



- Review attachments/documents associated with the original claim to determine if they should remain attached to the corrected claim
- Remove attachments/documents that either no longer apply to the corrected claim, or were originally attached in error
    - Note: By default, all original documents will be attached to the new, corrected claim. Providers will have to select the option to remove document(s) as needed.

Corrections will be allowed one time on an original dental claim when submitted via PWP.

- If additional corrections are required after a corrected claim is submitted, the provider will need to submit the correction based on the most recently submitted corrected claim, not the original claim.
- The portal will provide a message stating the claim can no longer be corrected if the provider attempts to correct the original claim more than once.

Submitting Corrected Claims via EDI

Corrected claims via Clearinghouse File will be accepted when a specific set of criteria is met to ensure the original claim can be identified. In order for a submission to be considered a corrected claim, it must include:

- Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF*F8 element
- Original claim in a paid status.
- Original claim does not have previously resubmitted services or a corrected claim already processed.
- Original claim does not have associated service adjustments or refunds
- Corrected claim must have a data match to original claim on at least three of the four items: Enrollee ID, Provider ID, Location ID, and/or Tax ID.

If a corrected claim submitted via Clearinghouse File does not meet these requirements, our system will consider the submission to be a new claim.
The provider would then need to send another submission on the file that does meet the above requirements for consideration.

Submitting Corrected Claims via Paper

SKYGEN will continue to accept paper corrected claims but encourage providers to submit electronically going forward. Paper corrected claim submissions must be submitted on a 2019 ADA Dental Claim Form to the corrected claims PO Box for proper processing and include the following:

- 2019 ADA form and all required information.
- The ADA form must be clearly noted "Corrected Claim" across the top of the form
- In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.
- Attach supporting documentation, and send documentation in the same package with the Corrected paper claim form. *NOTE: If all information does not fit in Box 35, please attach an outline of corrections to the claim form.*
- Submit 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 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 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 pre-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.

Grievances, Reconsiderations & Appeals

The Maryland Healthy Smiles Dental Program and SKYGEN 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, reconsideration requests and appeals.

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

- Ensure fair, just, and speedy resolutions by working cooperatively with providers and supplying any documentation related to grievances and/or reconsiderations, upon request.
- Treat providers and members with dignity and respect at all levels of the grievances and reconsiderations resolution process.
- Inform providers and members of their full rights as they relate to grievance, reconsideration and appeal resolutions, including their rights of appeal at each step in the process.
- Resolve grievances and reconsiderations in a satisfactory and acceptable manner within the Maryland Healthy Smiles Dental Program/SKYGEN protocol.
- 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 Specialist is dedicated to the expedient, satisfactory resolution of both provider and member grievances and reconsiderations.

Grievances

If your office has an unpleasant experience with SKYGEN or the Maryland Healthy Smiles Dental Program and you would like to file a complaint/grievance, we would like to hear about it. SKYGEN 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 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, Complaints and Grievances department for review and resolution. SKYGEN 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 Specialist gathers clinical documentation and routes it to a licensed Dental Consultant for review and determination. To handle emergency clinical situations, the 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 Specialist works closely with the Appeals, Complaints and Grievances team to obtain necessary information and clarifications from providers.

Reconsiderations

Participating providers who disagree with claim payment or authorization decisions made by SKYGEN reviewers have two options available to dispute the decision: Peer-to-peer request, or request for reconsideration.

Peer to Peer Request

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 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.

Reconsiderations

Participating providers who disagree with claim payment decisions or authorization decisions made by SKYGEN reviewers may submit a written request for reconsideration on the member's behalf within 30 days of the original denial date. SKYGEN will review the request and render a decision within 30 to 45 days. SKYGEN will deliver expedited resolutions within 3 business days.

When submitting a request for reconsideration, 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 request, such as x-rays, treatment plans, medical records, etc.
Send written request for reconsiderations to:

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

Member Appeals

If the member disagrees with the authorization decisions made by SKYGEN reviewers, the member may file an appeal within 90 days of the original denial date, by requesting a Fair Hearing through the Maryland Department of Health OAH. As noted in COMAR 10.09.05.10 and 10.01.04, the request for an OAH Fair Hearing should be in writing to request a Fair Hearing.

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

Once the member's appeal has been received and date stamped, it will be forwarded to the Maryland Department of Health. The member will then receive a Fair Hearing date via mail from the Maryland Department of Health OAH. Please note that the scheduling of a Fair Hearing could take up to 1 year. If you have questions about filing a reconsideration request or an appeal contact Provider Services, 844-275-8753.

Summary: Grievance, Reconsideration & Appeal Timelines

Grievance, Reconsideration & Appeal Action	Timeline
Grievance related to clinical issue—emergency	SKYGEN investigates and resolves within 24 hours of receipt or by close of the next business day.
Grievance related to clinical issue—non-emergency	SKYGEN investigates and resolves within 5 days of receipt.
Grievance related to non-clinical issue	SKYGEN investigates and resolves within 30 days of receipt.
Reconsideration acknowledgement	SKYGEN acknowledges receipt of request for reconsideration within 5 business days.
Claim reconsiderations	Providers must request reconsideration within 30 days of the notice of decision. SKYGEN renders decision within 30 days of receiving the request.
Authorization reconsiderations—Members	Members must request reconsideration within 30 days of the original authorization denial date.
Authorization reconsiderations—Providers	Providers must request reconsideration 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 reconsiderations—Non-expedited	SKYGEN renders decision within 30 days of receiving the requests.
Authorization reconsiderations—Expedited	SKYGEN renders decision within 3 business days of receiving the expedited request.
Authorization Appeal to OAH—Members	Members must appeal within 90 days of the original authorization denial date.

Orthodontia

Orthodontic Coverage Criteria

Comprehensive orthodontic treatment is a considered benefit under Maryland Healthy Smiles Dental Program (MHSDP) if it is found to meet clinical criteria. The member must present with the following conditions:

- A fully erupted set of permanent teeth, with the exception of documentation showing congenitally missing or impacted teeth, or severe traumatic deviations (i.e., facial accidents);
- A score of at least 15 points on the Handicapping Labio-Lingual Deviations Index (HLD);
- Dentofacial abnormalities that severely compromise the member's physical health; and
- A handicapping malocclusion.

*Orthodontic services for cosmetic purposes are not a covered benefit.

Covered Orthodontic Services

The following services are the only orthodontic treatments that are considered as a covered benefit under the Maryland Healthy Smiles Dental Program (please note the CDT codes listed below are in order of authorization and claims submission):

- D8660 - Pre-orthodontic treatment examination to monitor growth and development
- D8080 - Comprehensive orthodontic treatment
- D8080 with D8090 – Comprehensive orthodontic treatment (self-ligating)
- D8670 – Periodic orthodontic treatment visit
- D8703 – Replacement of lost or broken retainer (maxillary)
- D8704 – Replacement of lost or broken retainer (mandibular)
- D8698 – Re-cement or re-bond fixed retainer (maxillary)
- D8699 – Re-cement or re-bond fixed retainer (mandibular)
- D8999 – Orthodontic continuation of care
- D8680 – Orthodontic retention (removal of appliances, construction and placement of retainer(s)

For a complete, comprehensive list of these orthodontic services with the age limitations, frequency limitations and authorization requirements by plan, please see the Benefit Plan Details & Authorization Requirements section.

Prior Authorization of Comprehensive Orthodontic Treatment

All orthodontic services require prior authorization and must be rendered by a participating MHSDP provider. Prior authorization approval is required prior to rendering treatment. For comprehensive orthodontic treatment, the following documentation is required:

- Treatment Plan;
- 6 - 8 Diagnostic quality photos;
- X-rays (Panoramic or FMX and Cephalometric);
- Completed HLD Index;
- Clinical summary with diagnosis; and
- 2019 ADA form requesting prior authorization for the following procedure codes:
    - D8660;
    - D8080 for comprehensive orthodontia with up to 24 D8670s or;
    - D8080 with D8090 for self-ligating orthodontia with up to 12 D8670s

All pre-authorizations for services under MHSDP have a 6 month expiration date, with the exception of pre-authorization for periodic orthodontic treatment, which is valid for:

- 24 months for D8670s submitted with traditional comprehensive orthodontic treatment (D8080); or
- 12 months for D8670s submitted with self-ligating braces (D8080 with D8090)

If the treatment is not completed before the expiration date, a subsequent authorization for the remaining amount of D8670's must be submitted.

If a prior authorization for comprehensive orthodontic treatment is denied, providers are still able to receive payment for D8660, if the D8660 was approved on the prior authorization.

Orthodontic Claim Submission Guidelines

Claims should be submitted with the date of the service rendered. It is important to review the prior authorization approval expiration date and make sure any subsequent prior authorizations needed for the ongoing treatment are up to date prior to rendering services. Payment will not be made if there is not an active prior authorization on file.

Claims should be submitted following the procedures listed below:

- The claim for D8660 includes the diagnostic workup, clinical evaluation, x-rays (D0330, D0340), photographs (D0350), diagnostic casts if taken (D0470), orthodontic treatment plan, and completion of the HLD form.
- The claim for D8080 (or D8080 with D8090 for self-ligating orthodontia) should be submitted once the patient has been fully banded.
- A claim for D8670 may not be submitted with the same DOS as D8080. The initial claim for D8670 will occur on the first visit for a periodic adjustment following the banding visit
- Claims for D8670 are only to be submitted for the date the member was in the office for their periodic adjustment. Claims for monthly adjustments should never be submitted if the member is not seen that month.
- Claims may not be submitted for broken brackets, wires or bands.

When a claim is submitted for D8080 (or D8080 with D8090 for self-ligating orthodontia) it will receive the full contracted orthodontic case rate payment. The case rate payment will cover:

- Comprehensive or self-ligating orthodontic treatment;
- Banding or placement of orthodontic appliances (brackets, wires, bands);
- Debanding or removal of orthodontics;
- Orthodontic retention (construction and placement);
- Broken brackets, wires or bands; and
- Any additional hardware such as expanders and functional appliances etc., needed to bring the patient to functional dentition.

Orthodontic Continuation of Care and Requirements

Members of MHSDP are eligible to continue orthodontic treatment with a different provider if the original provider who initially banded them is unable to complete treatment. This is also an option for members who began orthodontic treatment under a different insurance and have recently become eligible for MHSDP. Members are eligible for continuation of orthodontic care once per lifetime. Prior authorization for continuation of care is required. Please submit the prior authorization request with the following documentation:

- Maryland Healthy Smiles Continuation for Care Request Form
- 6-8 diagnostic quality intra-oral/extra-oral photos
- The name and address of the previous orthodontist
- Reason for the continuation of care request and treatment plan
- Remaining amount of monthly adjustment required to complete treatment
- 2019 ADA claim form which includes the CDT codes:
    - D8999 – COC transfer fee
    - D8670 – periodic orthodontic treatment (quantity needed for the 6 month authorization period)
    - D8680 – debanding and retention

Prior authorization requests for continuation of orthodontic care can be submitted via the Provider Web Portal or mailed to:

Maryland Healthy Smiles:
Continuation of Care
PO Box 422
Milwaukee, WI 53201

Please be advised that under comprehensive orthodontic treatment, each member has a maximum quantity of D8670 allowed. The COC request will be denied if the quantity of D8670 requested exceeds the amount the member has available. In order to obtain the amount of D8670 the patient has exhausted you can review the member's clinical history on the Provider Web Portal or contact Provider Services at 844-275-8753.

Request Form: Continuation of Care

To transition a member's benefits to the Maryland Healthy Smiles Dental Program, SKYGEN 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

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

For the Maryland Healthy Smiles Dental Program, SKYGEN'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.

MARYLAND Healthy Smiles DENTAL PROGRAM

SKYGEN USA

HLD Index No. 4 | Handicapping Labio-Lingual Deviations **Provider** 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
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**	

Non-Covered Services Agreement

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. For members under 21 years of age the provider must submit a pre-authorization request for the non-covered services under EPSDT prior to requiring member sign a **Non-Covered Services Agreement.** A copy of the signed form must be kept in the member's chart.

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. Providers also have the option of using their own Non Covered Service Agreement as long as it states the procedure code, description of service, and the fee for the non-covered service. For your convenience, you can also download an electronic copy as well as the Spanish version of the form from the Provider Web Portal: www.provider.MDhealthysmiles.com.

MARYLAND Healthy Smiles DENTAL PROGRAM

Maryland Healthy Smiles Dental Program
Non-Covered Services Agreement

This sample "non-covered services agreement" is being suggested by the Medicaid program for the sole purpose of minimizing a Medicaid provider's risk of non-compliance with the laws that govern provision of Medicaid services. The Medicaid program makes no warranties or guarantees that this sample contract meets all requirements of a legally valid contract.

Provider _____

Address_____ **City, State, Zip**_____

Telephone_____ **Fax**_____

Email_____ **Website**_____

Provider MA# _____

Patients please note: Please read the below statement carefully before signing this agreement.

I,_____, understand that I have the right to appeal a denied authorization within 90 days from the date of the denial. I further understand that if I appeal a denied authorization, I should not sign this Non-Covered Services Agreement until a decision is made on my appeal. I have been advised that the following procedures are excluded from coverage under the Maryland Healthy Smiles Dental Program and, by signing this agreement, I agree to accept full financial responsibility for all costs associated with non-covered dental services.

Date of Service	Code	Description of Service	Cost
Total Amount Due by Patient:			

_____/_____
Patient Name/Patient MA#

_____/_____
Patient/Guardian/Authorized Representative Name – Relationship to Patient

_____/_____
Patient/Guardian/Authorized Representative Signature **Date**

_____
Dentist Name

_____/_____
Dentist Signature **Date**

SKYGEN USA

Provider-Member Termination Form

Under the Maryland Healthy Smiles Dental Program, a provider may dismiss a member for cause at any time. Cause is defined using any of the reasons as described in the Provider-Member Termination Section. Please review the 2-page form carefully and follow the procedure guidelines.

A copy of the 2-page **Provider-Member Termination 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 from the Provider Web Portal: www.provider.MDhealthysmiles.com.

Maryland Healthy Smiles Dental Program

Provider-Member Termination Form

Fill in the following information and continue with the **Procedure** *and* **Required Documents** *sections on the back page.*

Member Termination Date *(Day notification letter sent to the member)*	
Anticipated End Date *(30 days from the above date)*	

Provider/Location Information		
Location Name		**Phone Number**
Provider Name		**Email Address**
City	**State**	**Zip Code**

Member Information		
Name	**Member ID/MA Number**	**Phone Number**
City	**State**	**Zip Code**

Today's Date	
Provider's Signature	

Providers may not dismiss a Medicaid member based on the member's gender, race, religion, or sexual orientation. Further, a member covered under the Americans with Disabilities Act (ADA) may be dismissed only for reasons similar to those applied to a non-disabled member. A member may not be dismissed because of their disability or illness, or costs that the disability or illness might involve (e.g., providing an interpreter for a deaf member).

Procedure

1. Compose and *SEND* a notification letter to the members mailing address to initiate a pending termination. This notice *MUST* include the following five requirements:

   a. An agreement by the provider to give *no less than a 30-day written notice* of termination to *BOTH* the member and SKYGEN USA (per *COMAR 10.09.05.01(10)*)

   b. An agreement by the provider to continue coverage of the member's urgent and emergency care needs for *up to 30 days*, or until the member obtains a new dental provider (whichever occurs first)

   c. A request for SKYGEN USA to provide the member with options of providers within the Maryland Healthy Smiles Dental Program (MHSDP) Network

   d. A notice that the member's medical records will be sent to the new provider upon receipt of written authorization from the member

   e. The following phone number to assist the member in finding a new dental provider

      Member Services: **855-934-9812**

2. Complete this form to transition the member's dental care to another provider in the MHSDP Network.

(Continued in the next column.)

3. Fax or email this form and all **Required Documentation** to SKYGEN USA at the following:

   Provider Services Fax Number: 262-721-0722

   Email: providerservices@skygenusa.com

Required Documentation

Submit all required documents with this form to SKYGEN USA to request your provider-member termination.

- ❑ Completed **Provider–Member Termination Form**
- ❑ Duplicate copy of the member notification letter for SKYGEN USA's reference

Note: In addition, please be sure to *send* the original member notification letter to the member's mailing address.

Policy and necessary "cause" for dismissal

The Maryland Department of Health has established a policy regarding dismissal of a Medicaid member. Dismissal of the member shall be evaluated on a case-by-case basis. Providers may dismiss a Medicaid member from their practice *for cause* at any time, and "*cause*" is defined as any of the following six reasons:

Please select a checkbox to indicate the qualifying "cause" or reason that applies to this member.

1. A documented, ongoing pattern of failure on the part of the member to keep scheduled appointments or meet any other member responsibilities	
2. The member fails to follow the recommended treatment plan or medical instructions	
3. The provider cannot provide the level of care necessary to meet the member's needs	
4. The provider moves out of the service area	
5. The member and/or member's family is abusive to the provider and/or practice staff, or poses a serious threat of harm to the provider, staff, and/or other patients	
6. Other reasons determined to be satisfactory to the Maryland Department of Health (MDH) NOTE: FOR THE CAUSE #6 CHECKBOX, PLEASE WRITE THE OTHER REASON OR "CAUSE" BELOW	

Facility Referral Form: Confirmation of Medical Necessity

In order to render services outside the dental office, either in an outpatient department of a hospital or at an ASC, the provider must submit a request and be approved by SKYGEN 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

Maryland Healthy Smiles Dental Program

Facility Referral Form

Confirmation of Medical Necessity

Member Name_____ **Member ID/MA#**_____

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 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

The Maryland Healthy Smiles Dental Program 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, avoidingor controlling apprehension, or upon provider or member convenience (Please be sure to 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 requirespecial 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 USA

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 and Postpartum Adult (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 Revision History: Version 11 section.

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

Benefit Plan Details & Authorization Requirements

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 prophylaxis, 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 prophylaxis, debridement, and fluoride application and two bitewings.

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 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. For more information about the Authorization Submission Process and Requirements please see the Authorization Documentation Requirements and Clinical Criteria section of this provider manual.

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 *update	Periodic oral evaluation-established patient	0-25		Two of (D0120) per 12 months. Two of (D0120, D0145, D0150, D0160) per 12 months. Minimum of 120 days between services.	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 *update	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0-25		Two of (D0145) per 12 months per provider OR location. Two of (D0120, D0145, D0150, D0160) per 12 months per provider OR location. Minimum of 120 days between services.	No	
D0150 *update	Comprehensive oral evaluation-new or established patient	0-25		One of (D0150) per 1 lifetime per provider OR location. Two of (D0120, D0145, D0150, D0160) per 12 months per provider OR location. Minimum of 120 days between services.	No	
D0160 *update	Detailed and extensive oral evaluation-problem focused, by report	0-25		One of (D0160) per 1 lifetime per provider OR location. Two of (D0120, D0145, D0150, D0160) per 12 months per provider OR location. Minimum of 120 days between services.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0210	Intraoral-complete series of radiographic images	0-25		One of (D0210) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider.	No	
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. Non orthodontic cases.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D0340	Cephalometric radiographic image	0-25		One of (D0340, D8660) per 36 months per patient. Non orthodontic cases.	No	Narrative of medical necessity submitted with claim
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**: Payment for 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 submitted with claim
D0460	Pulp vitality tests	0-25		One per visit. Includes multiple teeth and contralateral comparison(s), as indicated.	No	
D1110 *update	Prophylaxis-adult	14-25		One of (D1110, D1120) per 3 months per patient only for REM Children Under 21. Two of (D1110, D1120) per 12 months per patient for all other Children Under 21. Minimum of 120 days between services. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	No	
D1120 *update	Prophylaxis-child	0-13		One of (D1110, D1120) per 3 months per patient only for REM Children Under 21. Two of (D1110, D1120) per 12 months per patient for all other Children Under 21. Minimum of 120 days between services.	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
				Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.		
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	
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	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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	
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 ***update**	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 24 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 ***update**	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 24 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
D2160 *update	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 24 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 *update	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 24 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 *update	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 24 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 *update	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 24 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 *update	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 24 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 *update	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 24 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	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2391 *update	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 24 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 *update	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 24 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 *update	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 24 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 *update	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 24 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
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

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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
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	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D2920	Re-cement or re-bond crown	0-25	1-32, A-T	Not allowed within 6 months of initial placements.	No	
D2928	Prefabricated porcelain/ceramic crown-permanent tooth	0-25	1-5, 12-21, 28-32	One of (D2928) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2929	Prefabricated porcelain/ceramic crown-primary tooth	0-25	C-H, M-R	One of (D2929) per 36 months per patient per tooth.	**Yes**	Pre-operative x-ray showing apex of tooth
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	
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.	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	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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.	No	
D2951	Pin retention-per tooth, in addition to restoration	0-25	1-32		No	
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.	No	
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.	**Yes**	
D2980	Crown repair, by report	0-25	1-32		No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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	
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 *update	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.	**Yes**	Pre-operative x-rays rays (excluding bitewings) Post-operative x-rays (excluding bitewings) submitted with the claim
D3320 *update	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.	**Yes**	Pre-operative x-rays rays (excluding bitewings) Post-operative x-rays (excluding bitewings) submitted with the claim

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D3330 *update	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.	**Yes**	Pre-operative x-rays rays (excluding bitewings) Post-operative x-rays (excluding bitewings) submitted with the claim
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)

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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.	**Yes**	Pre-operative x-rays (excluding bitewings)
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.	**Yes**	Date of initial visit
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.	**Yes**	Date of initial visit
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

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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)
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
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

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D4341 *update	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. Limited to permanent dentition.	**Yes**	Pre-operative x-rays, periodontal charting
D4342 *update	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. Limited to permanent dentition.	**Yes**	Pre-operative x-rays, periodontal charting
D4355 *update	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.	**Yes**	Pre-operative x-rays or photos
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 periodontal 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
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

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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	
D5622	Repair cast partial framework, maxillary	0-25			No	
D5630	Repair or replace broken	0-25			No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
	clasp					
D5640	Replace broken teeth-per tooth	0-25	1-32		No	
D5650	Add tooth to existing partial denture	0-25	1-32		**Yes**	Date of service
D5660	Add clasp to existing partial denture	0-25			**Yes**	Date of service
D5710	Rebase complete maxillary denture	0-25		One of (D5710) per 24 months per patient. Not covered within 6 months of placement.	**Yes**	Date of service
D5711	Rebase complete mandibular denture	0-25		One of (D5711) per 24 months per patient. Not covered within 6 months of placement.	**Yes**	Date of service
D5720	Rebase maxillary partial denture	0-25		One of (D5720) per 24 months per patient. Not covered within 6 months of placement.	**Yes**	Date of service
D5721	Rebase mandibular partial denture	0-25		One of (D5721) per 24 months per patient. Not covered within 6 months of placement.	**Yes**	Date of service
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	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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	
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	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7140	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	
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)

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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)
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		**Note**: Payment for D7285 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7285 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.	No	Copy of pathology report submitted with claim
D7286	Incisional biopsy of oral tissue-soft	0-25		**Note**: Payment for D7286 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7286 rendered must be submitted and accompanied with a copy of: Lab	No	Copy of pathology report submitted with claim

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
				results/pathology report, or narrative of medical necessity.		
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.	No	Pre-operative x-rays (excluding bitewings) submitted with claim
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)
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		**Note**: Payment for D7410 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7410 rendered must be submitted and accompanied with a copy of: Lab results/pathology	No	Copy of pathology report submitted with claim

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
				report, or narrative of medical necessity.		
D7440	Excision of malignant tumor-lesion diameter up to 1.25cm	0-25		**Note**: Payment for D7440 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7440 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.	No	Copy of pathology report submitted with claim
D7450	Removal of odontogenic cyst or tumor-lesion diameter up to 1.25cm	0-25		**Note**: Payment for D7450 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7450 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.	No	Copy of pathology report submitted with claim
D7451	Removal of odontogenic cyst or tumor-lesion greater than 1.25cm	0-25		**Note**: Payment for D7451 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7451 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.	No	Copy of pathology report submitted with claim
D7460	Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25cm	0-25		**Note**: Payment for D7460 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7460 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.	No	Copy of pathology report submitted with claim

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7461	Removal of nonodontogenic cyst or tumor-lesion greater than 1.25cm	0-25		**Note**: Payment for D7461 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7461 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.	No	Copy of pathology report submitted with claim
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	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D7961	Bucal / Labial Frenulectomy – separate procedure not incidental to another procedure	0-25		One of (D7961) per 1 lifetime 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
D7962	Lingual Frenulectomy – separate procedure not incidental to another procedure	0-25		One of (D7962) per 1 lifetime 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
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 or adult dentition. Inclusive of banding, debanding, adjunctive appliances and retention.	0-25		One of (D8080) per 1 lifetime per provider OR location. Inclusive of adjunctive appliances such as, but not limited to, palatal expanders, habit appliances, fixed bite plates, and fixed functional appliances. 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**	Pretreatment documentation of D8660 along with the quantity of adjustments D8670 requested, Ceph x-ray, Panorex or FMX, 6-8 diag quality extra-oral/intra-oral photos, clinical summary with diagnosis, completed HLD score sheet, and treatment plan.

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D8090	Comprehensive orthodontic treatment of the adolescent or adult dentition using self-ligating appliances	0-25		Code allowed only for comprehensive orthodontic cases where self-ligating appliances are used. Not a separately reimbursable service. One of (D8090) per 1 lifetime per provider OR location.	**Yes**	Pretreatment documentation of D8660, D8080along with the quantity of adjustments D8670 requested,(maximum of 12) Ceph x-ray, Panorex or FMX, 6-8 diag quality extra-oral/intra-oral photos, clinical summary with diagnosis, completed HLD score sheet, and treatment plan.
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.	No	D8660 will be denied if billed without D8080. D8660 will be denied when a D8080/D8090 is not approved due to mixed dentition (with the exceptions of cleft palate, evidence of congenitally missing permanent dentition, or evidence that the ectopic position of a succedaneous tooth is resulting in the failed exfoliation of the associated primary tooth). 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		24 of (D8670) per 1 lifetime per patient. Maximum of 24 visits reimbursed. For comprehensive orthodontic treatment using self-ligating appliances (D8090), a maximum of 12 of (D8670) per 1 lifetime per patient.	**Yes**	Approved D8080 or D8080/D8090. The number of D8670's needed must be submitted on the authorization with D8660, D8080, (and D8090 if applicable) for the initial comprehensive treatment. The number of D8670's needed must be submitted on the authorization with D8999 and D8680 for continuation of care. All subsequent authorization requests for D8670 must be accompanied by the original approved authorization determination letter for D8080, D8080/D8090, or D8999 with the quantity requested.
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.	**Yes**	Narrative of active orthodontic case with date of debanding indicated
D8699	Re-cement or re-bond fixed retainer- Mandibular	0-25		One of (D8699) allowed per patient within 24 months of date of debanding.	**Yes**	Narrative of active orthodontic case with date of debanding indicated
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 orthodontic case with date of debanding indicated
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 orthodontic case with date of debanding indicated

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D8999	Orthodontic Continuation of Car	0-25		The provider submitting for continuation of care must be different than the provider who originally banded the member when the case was originally approved through the state of Maryland	**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. Pre-Authorization must include a D8680 and the additional number of months that D8670 is requested (if remaining are available)
D9110	Palliative (emergency) treatment of dental pain-minor procedure	0-25		Not allowed with any other services other than radiographs.	No	Narrative of medical necessity submitted with claim
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	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
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.	No	
D9248	Non-intravenous moderate (conscious) sedation	0-25		One of (D9248) will not be paid with D9230, or D9243.	No	
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 ***update**	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.	**Yes**	Tooth treated

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
D9952 *update	Occlusal adjustment-complete	0-25		One of (D9952) per 12 months per patient. Not covered with any restorative procedure on same date of service.	**Yes**	Full mouth x-rays, periodontal charting, restoration treatment plan, narrative of medical necessity
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, Postpartum & 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 prophy, debridement, and D0272 two bitewings.

Code	Description	Age	Tooth/Quad /Arch	Limitations	Auth Req	Requirement
D0120 *update	Periodic oral evaluation-established patient	21 and older		Two (D0120) per 12 months. Two (D0120, D0150) per 12 months. Minimum of 120 days between services.	No	
D0140	Limited oral evaluation-problem focused	21 and older		Can only be billed on evaluation to alleviate pain. Cannot be billed in conjunction with routine or planned services	No	
D0150 *update	Comprehensive oral evaluation-new or established patient	21 and older		One of (D0150) per 1 lifetime per provider OR location. Two of (D0120, D0150) per 12 months per provider OR location. Minimum of 120 days between services.	No	
D0210	Intraoral- complete series of radiographic images	21 and older		One of (D0210) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider.	No	
D0220	Intraoral-periapical first radiographic image	21 and older			No	
D0230	Intraoral-periapical each additional radiographic image	21 and older			No	
D0270	Bitewing-single radiographic image	21 and older			No	

Code	Description	Age	Tooth/Quad /Arch	Limitations	Auth Req	Requirement
D0272	Bitewings-two radiographic images	21 and older		One of (D0272) per 6 months per patient for REM Adults 21 & Over. One of (codeset: D0270, D0272, D0273, D0274) per 12 months per patient for Pregnant or Postpartum Adult 21 & Over.	No	
D0273	Bitewings-three radiographic images	21 and older		One of (D0273) per 6 months per patient for REM Adults 21 & Over. One of (codeset: D0270, D0272, D0273, D0274) per 12 months per patient for Pregnant or Postpartum Adult 21 & Over.	No	
D0274	Bitewings-four radiographic images	21 and older		One of (D0274) per 6 months per patient for REM Adults 21 & Over. One of (codeset: D0270, D0272, D0273, D0274) per 12 months per patient for Pregnant or Postpartum Adult 21 & Over.	No	
D0330	Panoramic radiographic image	21 and older		One of (D0210) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider.	No	
D1110 ***update**	Prophylaxis-adult	21 and older		One of (D1110) per 3 months per patient for REM Adults 21 & Over. Two of (D1110) per 12 months per patient for Pregnant or Postpartum Adult 21 & Over. Minimum of 120 days between services. 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 or Postpartum Adult 21 & Over.	No	

Code	Description	Age	Tooth/Quad /Arch	Limitations	Auth Req	Requirement
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 or Postpartum Adult 21 & Over.	No	
D2140 *update	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 **24** 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 *update	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 **24** 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 *update	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 **24** months per patient per tooth, per surface. 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
D2161 *update	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 **24** 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 *update	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 **24** 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 *update	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 **24** 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
D2332 *update	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 24 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 *update	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 24 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 *update	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 24 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 *update	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 **24** 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 *update	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 **24** 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 *update	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 **24** 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	
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

Code	Description	Age	Tooth/Quad /Arch	Limitations	Auth Req	Requirement
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
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

Code	Description	Age	Tooth/Quad /Arch	Limitations	Auth Req	Requirement
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	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	
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 *update	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.	**Yes**	Pre-operative x-rays rays (excluding bitewings) Post-operative x-rays (excluding bitewings) submitted with the claim
D3320 *update	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.	**Yes**	Pre-operative x-rays rays (excluding bitewings) Post-operative x-rays (excluding bitewings) submitted with the claim

Code	Description	Age	Tooth/Quad /Arch	Limitations	Auth Req	Requirement
D3330 *update	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.	**Yes**	Pre-operative x-rays rays (excluding bitewings) Post-operative x-rays (excluding bitewings) submitted with the claim
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
D4341 *update	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. Limited to permanent dentition.	**Yes**	Pre-operative x-rays, periodontal charting
D4355 *update	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 or Postpartum Adult 21 & Over. Not allowed with D1110 on same date of service.	**Yes**	Pre-operative x-rays or photos
D4910	Periodontal maintenance procedures	21 and older		Two of (D4910) per 12 months per patient. Must follow active periodontal treatment.	**Yes**	Date of previous periodontal surgical or SRP service
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	

Code	Description	Age	Tooth/Quad /Arch	Limitations	Auth Req	Requirement
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	
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		**Note**: Payment for D7285 will not be approved if the accompanying	No	Copy of pathology report submitted with claim

Code	Description	Age	Tooth/Quad /Arch	Limitations	Auth Req	Requirement
				documentation is not included. The 2019 ADA claim form with D7285 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.		
D7286	Incisional biopsy of oral tissue-soft	21 and older		**Note**: Payment for D7286 will not be approved if the accompanying documentation is not included. The 2019 ADA claim form with D7286 rendered must be submitted and accompanied with a copy of: Lab results/pathology report, or narrative of medical necessity.	No	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	Pre-operative x-rays (excluding bitewings) submitted with claim
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.	**Yes**	Pre-operative x-rays (excluding bitewings)
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	Narrative of medical necessity submitted with claim

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. 5 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**	Facility Referral Form: Confirmation of Med 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 are listed below. *Please note Providers must complete, and keep a copy in the member chart of, the Global Treatment Plan and any Non-Covered Services Agreements completed for all services rendered and signed 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		Two of (D0120 or D0150) per patient per 12 month period. Minimum of 120 days between services.	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. Two of (D0120 or D0150) per patient per 12 month period. Minimum of 120 days between services.	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		Two of (D1110) per patient per 12 month period. Minimum of 120 days between services.	No	
D2140	Amalgam- One Surface, Permanent	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 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, Permanent	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331,	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
				D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.		
D2160	Amalgam- Three Surfaces, Permanent	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 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 24 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 24 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 24 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 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 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 24 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 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331,	No	

Code	Description	Age	Tooth / Quad / Arch	Limitations	Auth Req	Requirement
				D2332, D2335, D2391, D2392, D2393, D2394) per 6 months per patient per tooth regardless of surface.		
D2392	Resin-based composite-two surfaces, posterior	21 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 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 24 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 - 64		One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 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.	Yes	Pre-operative x-rays or photos
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 LLC

Provider Manual: Version 11

Program Effective: January 1, 2016

Revision Effective: October 1, 2021