Hawki

Dentist Office Manual

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Hawki
Iowa HHS

Thank you for being a Hawki Participating Dentist

Delta Dental of Iowa is pleased to present you with this Dentist Office Manual. We hope it is a useful source of information for you and your office staff. Please take the opportunity to review the Manual in its entirety. We look forward to serving you in the future and continuing our mutually supportive relationship.

Table of Contents

Delta Dental of Iowa (DD) is a dental administrator for the Hawki Program. This Office Manual covers Hawki benefits.

1 Hawki

The Hawki plan (HAWKI) provides comprehensive dental benefits to children ages one to 19 years old.

1.1 Hawki Benefit Design

Below is a high-level summary of benefits.

- Dental Exams
- X-Rays
- Cleanings
- Fluoride
- Fillings for Cavities
- Root Canals
- Dentures/Partials
- Crowns
- Exactions/Tooth Replacement
- Deep Cleanings
- Surgical Gum Treatment

1.2 Orthodontics

Orthodontics is a covered benefit for Hawki members that meet medical necessity requirements. Comprehensive orthodontic treatment can be approved for members with malocclusion scores of 26 or above on the index from “Handicapping Malocclusion Assessment to Establish Treatment Priority”, by J. A. Salzmann, D.D.S. All orthodontic treatment requires a prior authorization before treatment begins.

For more information regarding Hawki orthodontic services, please refer to the Hawki Orthodontic Administrative Guide that will be available on the Delta Dental Dentist Connection.

1.3 Annual Benefit Maximum (ABM)

As of June 1, 2025, the Hawki plan does not have an Annual Benefit Maximum. Please contact Delta Dental Provider Services at 800-544-0718 if you have questions..

1.4 Billing for Emergent Services

For both electronic and paper claims submitted to DD emergency dental service claims must include an indicator from the provider upon submission in box 35: Remarks section. Example of an indicator would be Emergency or Urgent Services Provided.

Emergency or palliative dental care services include the following:

- Procedures used to control bleeding
- Procedures used to relieve pain
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen
- Operative procedures that are required to prevent pulpal death and the imminent loss of teeth (e.g., excavation of decay and placement of appropriate temporary fillings)

- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth

1.5 Billing for Medical Necessity

For both electronic and paper claims submitted to DD for medical necessity, use box 35: Remarks, to document the medical reason the services were needed for the member. The documentation must include a diagnosis with signs and symptoms, description of treatment provided and x-rays.

1.6 Member Pay

Provider must complete a patient financial responsibility form if Hawki member chooses to pay for services. The form must include the services that are being performed and cost to the members before any services are rendered.

A provider can bill a member their provider billed charges in the following examples:

- Non-covered services

1.6.1 Single Case Agreement

Non-network participating providers must complete a single case agreement for members they see when care needed by the member is not able to be completed by a participating provider. This agreement is established between the provider and DD on an individual basis.

1.6.2 Transition of Care

DD will honor all Iowa Medicaid approved prior authorization for children on Medicaid for 90 days after their enrollment with DD starts. DD will also pay non-participating, Iowa Medicaid enrolled providers to help members transition care during the first 90 days.

2 Important Terms and Definitions

Term	Definition
Adverse Benefit	The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
Agreement	The document that specifies the contractual obligations of a Participating Dentist.
Allowed Amount	Allowed Amount is the total dollar amount allowed for a specific dental service or procedure, under the payment arrangement stipulated by the Hawki Program, determined as specified in the Agreement signed by the Participating Dentist.
Annual Benefit Maximum	There will be no Hawki ABM starting June 1, 2025.

Term	Definition
Appeal	An appeal is a request for a review of an action. A member or member's authorized representative may request an appeal following a decision made by DD. Members may file an appeal directly with DD. If the member is not happy with the outcome of the appeal, they may file an appeal with the Department of Health and Human Services or they may ask for a state fair hearing.
Approved Amount	The total fee a Participating Dentist agrees to accept as payment in full for a procedure. Participating Dentists agree not to collect from the member any difference between the Approved Amount and their actual billed charge for the procedure.
Benefit Period	The Benefit Period is 12 months starting on July 1 and ending June 30.
Billed Charge	The Billed Charge is the amount the dentist bills for a specific dental service or procedure.
Covered Enrollee (also known as Member)	A member means an individual eligible and enrolled to receive dental services under the Hawki Program through DD.
Clinical Criteria	Clinical Criteria is used to determine what services or supplies are needed for the diagnosis and treatment of a condition. They must meet the standards of good medical practice.
Covered Services	Covered Services means dental services covered under the Hawki plan provided to a member by a Participating Dentist (excluding emergency services, which may be provided by a Non-Participating Dentist).
Denied	If the Billed Charge for a procedure or service is denied, the procedure or service is not a Covered Service of the member's benefit plan. The billed charge is collectible from the member, if the appropriate informed consent has been signed, prior to the delivery of the service.
Hawki Fee Schedule	Hawki Participating Dentists agree to accept as payment in full the lesser of the Hawki Fee Schedule or the Billed Charge for Covered Services rendered.
Dentally Necessary	Procedures are considered dentally necessary if the diagnosis is proper; the treatment is necessary to address disease or dysfunction of the teeth and the health of the gums, bone, and other tissues, which support the teeth; it is the most appropriate procedure, service or supply for the member's individual circumstances; and it is consistent with and meets professionally recognized standards of care and complies with criteria adopted by DD

Term	Definition
Not Billable to the Member	If the Billed Charge for a service is not billable to the member, reimbursement for the services was either included as part of a payment of a more global service provided and/or the services are still within the time frame for which it should be warranted by the Participating Dentist and/or the Participating Dentist did not follow rules and regulations per the Agreement. Fees not billable to the member cannot be collected by a Participating Dentist.
Emergent Care	An emergent condition means a medical/dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health, could reasonably expect the absence of immediate medical/dental attention to result in the following: • Placing the health of the individual in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part.
Grievance	A member has the right to file a grievance with DD. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination.
Medical Necessity	Defined in Iowa Administrative Code Chapter 78, as a service reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.
Member Handbook	A document intended for members that contains a general explanation of the benefits and related provisions of the Hawki.
Member Pay	Hawki members may pay for services due to frequency limitations, exceeding the ABM and/or if the member has agreed to pay for non-covered or covered services. Providers are required to have signed documentation on file that includes the out-of-pocket amount due from the member prior to services being rendered. In addition, the member should be educated that if they went to a participating network provider, the covered services would likely be paid for.
Non-Participating Dentist	A Non-Participating Dentist is a dentist who is enrolled with Iowa Medicaid as provider but has not entered into an Agreement with DD for the Hawki Program.
Participating Dentist	A Participating Dentist is a dentist who holds a current license to practice dentistry, has completed all credentialing

Term	Definition
	requirements, and has entered into an Agreement with Hawki.
Post Stabilization	Post stabilization care services mean covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition.
Prior Authorization (PA)	Some services require prior approval from DD for them to be covered. This must be done before a member gets that service. Refer to the Covered CDT Procedure Code document (Appendix 1) for all services requiring a PA.
Uniform Regulations	Uniform Regulations is a document that specifies the mutual operational rules between the Participating Dentist and DD.

3 Dentist Participation

When a dentist signs an agreement with DD for the Hawki they agree to:

- Abide by the Hawki rules, regulations, Uniform Regulations and this Dentist Office Manual
- Fully enroll with Iowa Medicaid.
- Not require Hawki members to prepay a portion of Covered Services. If the member has agreed to pay for services, member financial liability forms should be completed and kept in record.
- Accept from DD as payment in full for Covered Services the lesser of: (i) the applicable amount set forth in the Fee Schedule or (ii) Participating Dentist's Billed Charges for such Covered Services.
- Furnish DD credentialing information by completing a Professional Application and Credentialing Form when requested.
- File claims for completed services to DD within 180 days of the date-of- service and include all documentation necessary to review, process and finalize the claim. Documentation includes, but is not limited to, clinical rationale, narrative, radiographs, periodontal chart, member's treatment record, and coordination of benefits information, as applicable. If the claim is not received and finalized within this time period, the claim will then be the Participating Dentist's responsibility and not billable to the member.
- Follow the Hawki processing policies and claim filing guidelines.
- Provide information and member office records for the purpose of conducting reviews and/or in-office audits, when required.
- Furnish services that meet Hawki criteria for dental necessity and dental appropriateness of care as defined in the Hawki Uniform Regulations.

- Comply with the latest Occupational Safety and Health Administration (OSHA) requirements and the Centers for Disease Control (CDC) infection control guidelines.
- Conduct business in accordance with the principles and ethics of the American Dental Association (ADA) and Iowa Dental Board (IDB).
- Comply with all applicable state and federal laws and regulations (e.g. Health Insurance Portability and Accountability Act (HIPAA)).

Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships.

Provider agrees to check the HHS OIG -OIG website (http://exclusions.oig.hhs.govorwww.hhs.gov/hipaa/index) by the name of any individual or entity for their exclusion status before the Provider hires or enters into any contractual relationship with the person or entity. In addition, Provider agrees to check the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Provider must report to DD and Iowa Medicaid any exclusion information discovered through such service.

Delta Dental is generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. This payment ban applies to any items or services reimbursable under the Medicaid/Dental Wellness program that are furnished by an excluded individual or entity, and extends to (1) all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system, (2) payment for administrative or management services not directly related to member care, but that are a necessary component of providing items and services to Medicaid/Hawki members, when those payments are reported on a cost report or are otherwise payable by the Medicaid/Hawki program; and (3) payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct member care, when those payments are reported on a cost report or are otherwise payable by the Medicaid/Hawki program. In addition, no Medicaid/Hawki payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid/Hawki payment itself is made to another provider, practitioner or supplier that is not excluded. 42 C. F. R. § 1001.1901(b).

3.1 Credentialing

Participating Dentists need to complete credentialing at least once every three years.

3.2 Hawki Participating Dentists

Hawki Participating Dentists agree to provide the following credentialing elements:

- Accurately and thoroughly complete the Professional Application & Credentialing Form as requested.
- Have an active state issued dental license.

- Have adequate malpractice liability coverage and provide a copy of the liability declaration page.
- Disclose any licensing board actions, malpractice claims and other adverse personal background information, including exclusions from a state or federal health care program.
- Comply with Centers for Disease Control (CDC) infection control guidelines.
- Provide a copy of certification of specialty training or education, if applicable.
- Provide a professional work history or curriculum vitae with explanation for any gaps in work history.
- Complete and provide the federally mandated Ownership & Control Disclosure Form.
- Complete and provide W-9 form with the business name and tax identification number.

Network participation will only be backdated 30 days prior to the date that all required credentialing and signed contract information is received.

Separate credentialing or re-credentialing may not be required if you are already a DD Participating Dentist in the Premier· Network.

You are required to notify Professional Relations immediately of any changes in your credentialing elements at 888-472-1205 or email provrelations@deltadentalia.com. Examples include providers leaving your office, new providers at your office, and updating your tax id number.

Providers and/or front office staff must confirm that their office information is correct in our system one time each quarter to maintain directory accuracy. The Provider directory will list the date the office last attested to their information being correct.

3.3 Federally Mandated Ownership Control Form

Centers for the Medicare & Medicaid Services (CMS) and the Iowa Department of Health and Human Services require that all Participating Dentists complete and provide a Federally Mandated Ownership & Control Disclosure Form.

3.3.1 What disclosures must be provided?

Participating Dentists must provide the following disclosures:

- The name and address of any person (individual or corporation) with an ownership or control interest in disclosing entity (Participating Dentist practice).
- The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
- In the case of an individual, date of birth and social security number are required.
- Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5 percent or more interest. Whether the person (individual or corporation) with an ownership of control interest in the disclosing entity is

related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest in the disclosing entity as a spouse, parent, child, or sibling.

- The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- The name, address, date of birth, and social security number of any managing employee of the disclosing entity.

3.3.2 When must disclosures be provided?

Participating Dentists need to provide disclosure information in regard to the disclosing entity at any of the following times:

- Upon completion of participating credentialing application and execution of the Participating Dentist agreement.
- Upon request of the Department of Health and Human Services during the re-validation of enrollment process.
- Within 35 Days after any change in ownership of the disclosing entity (Participating Dentist's practice).

3.3.3 Participating Dentist Must Disclose Information Related to Business Transactions

What a Participating Dentist must do to disclose information related to business transactions:

- A Participating Dentist must submit, within 35 days of the date on a request by the Secretary, Department of Health and Human Services or the plan, full and complete information about the ownership of any subcontractor with whom the Participating Dentist has had business transactions totaling more than $25,000 during a 12-month period ending on the date of the request; and
- Any significant business transactions between the Participating Dentist and any wholly owned supplier, or between the Participating Dentist and any subcontractor, during the five-year period ending on the date of the request.

3.3.4 Participating Dentists Must Disclose Information on Persons Convicted of Crimes

What information must be disclosed:

- Before the plan enters into or renews a Participating Dentist agreement, or at any time upon written request by the Department of Health and Human Services, or the plan the Participating Dentist must disclose to DD and the Department of Health and Human Services the identity of any person who:
- Has ownership or control interest in the Participating Dentist, or is an agent or managing employee of the Participating Dentist practice; and

- Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XIX services program since the inception of those programs.

3.4 Locum Tenens

Locum tenens is a term used to describe a person who temporarily fulfills the duties of another. If you utilize a locum tenens dentist and they treat Hawki members it is imperative the temporary dentist completes a Professional Application and Credentialing form and signs a DD, Hawki Dentist's Agreement. If the temporary dentist chooses not to participate with the Hawki Program the claim will not be billable to the member and the member may not be billed. It is misrepresentation and a form of fraud to submit claims of a treating locum tenens dentist under the name of another dentist. Please contact Professional Relations at 888-472-1205 or email provrelations@deltadentalia.com for participating information for a locum tenens dentist practicing in your office.

3.5 Dentist Termination

3.5.1 Dentist Terminates Participating Agreement

A dentist may terminate the Hawki Dentist's Agreement by giving at least sixty (60) days written notice to DD by certified mail, return receipt requested. DD will send a letter of acknowledgement to the dentist confirming the termination effective date.

DD may notify members of the dentist's network termination. The dentist must also inform their members when there is a termination of the Hawki Participating Dentist's Agreement.

Terminating the Hawki Dentist's Agreement does not terminate any other DD Participating Dentist Agreement.

3.5.2 Delta Dental of Iowa Terminates Participating Agreement

Any notice of termination ("Notice of Termination") required or permitted to be given to a Participating Dentist under the Uniform Regulations shall be in writing and shall be deemed given when delivered personally, placed in the mail (postage prepaid) and sent certified or registered, return receipt requested, or delivered to a recognized overnight courier service for the next day delivery (delivery charges prepaid), and addressed to the Participating Dentist at the address set forth on the Participating Dentist's Agreement, or to such other address for Notices of Termination as provided in writing to DD by the Participating Dentist's Agreement, or to such other address for Notices of Termination as provided in writing to DD by the Participating Dentist.

3.5.3 Termination for Cause

DD may terminate a Participating Dentist's Agreement if Participating Dentist breaches or violates any of the provisions of the Participating Dentist's Agreement or these Uniform Regulations, Participating Dentist's license to practice dentistry issued by the IDB is suspended or terminated, other sanctions issued by the IDB, lack of adherence to published national clinical dental standards, or Participating Dentist's conduct is determined by DD to be unprofessional and/or such conduct could be detrimental to DD, its Contract holders, or Covered Persons.

Any such termination shall be effective on the date designated by DD in the Notice of Termination (which may be immediate), as determined by DD. The Notice of Termination will state the reasons for such termination and that the Participating Dentist has a right to request a hearing on the termination.

3.5.4 Appealing a Termination Notice

A Participating Dentist may appeal a termination of participation for cause as set forth in the Uniform Regulations.

4 Interpretation and Translation Services

DD facilitates access to dental services for non-English speaking and hearing-impaired members. DD's population is culturally and linguistically diverse, and we recognize that this diversity sometimes serves as a barrier to members, effecting their willingness to access all available services.

DD makes the following services available at no cost to you.

- Free language translation services from Transperfect Connect and sign language interpretation services from Life Interpretation, Inc.

4.1 Transperfect Connect

DD provides a language translation services to all participating Hawki Participating Dentists at no cost. Charges are billed directly to DD. If you have a language barrier with a member, Transperfect Connect will provide translation. You can either conference Transperfect Connect or use a speaker phone, if the non- English speaking member is in your office. Call Transperfect Connect, request the language needed and an interpreter will promptly assist communication between you and your member. To learn more about Transperfect Connect go to www.transperfect.com.

4.1.1 Using Transperfect

1. Dial 855-886-2901
2. Enter on your telephone keypad or provide the representative with the DD Client ID: 8186159 Enter pin 6476
3. Select language by stating the language preference or entering the three-digit code from Appendix 3 in this handbook

   Provide the representative with:

- Organization Name: Delta Dental of Iowa
- Dentist's first initial
- Dentist's last name
- City (where the dental office is located)

{An interpreter will be connected to the call.}

4. Brief the Interpreter: Summarize what you wish to accomplish and provide any special instructions.

4.2 Life Interpretation, Inc.

Participating Dentists can receive free sign language interpreting services from Life Interpretation, Inc. This service helps communication with deaf and hard of hearing members. To learn more, www.lifeinterpreter.com.

4.2.1 Using Life Interpretation, Inc.

1. Contact Life Interpretation Inc. at 515-265-5433 or via email at schedule@lifeinterpreter.com to schedule an interpreter. Be sure to contact Life Interpretation, Inc. as possible to schedule an appointment.
2. Identify yourself as a DD Participating Dentist to schedule an interpreter at no cost.
3. Provide Life Interpretation with the following information:

- Date, time and duration of the member's appointment
- Address of dentist's office
- Name of the deaf or hard of hearing member
- Dentist's name, phone number and name of office contact

4. If you need to cancel, please contact Life Interpretation, Inc. at least 24 hours before the appointment.
5. You will receive confirmation from Life Interpretation, Inc. for the interpreter.

4.3 Business Associate Agreements

Please note: Offices filing claims or claim attachments electronically or who use the Internet to verify eligibility or claims status are considered a covered entity under HIPAA Privacy and Security Rules.

If you are a covered entity and are also using Transperfect Connect or Life Interpretation, Inc., DD recommends that you secure a Business Associate agreement with them due to the extent of possible protected Member Health Information (PHI) being exchanged. For more information regarding HIPAA, refer to the HIPAA section of this Manual.

Send Business Associate Agreements to:

- Transperfect Services, 8440 S. Hardy Drive, Suite 101, Tempe, AZ 85284
- Life Interpretation, Inc., P. 0. Box 5002, Des Moines, IA 50305

*This information is for instructional and educational purposes only. It does not constitute legal advice. Recipients are strongly urged to contact their legal counsel for advice with respect to the interpretation of HIPAA and its applicability and the facts and circumstances of the situation at hand.

5 HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and implementing regulations) is a federal law intended to provide better access to health insurance, limit fraud and abuse and reduce administrative costs. Since electronic transactions are significantly more cost effective than paper for providers, members and health plans, HIPAA includes a major provision (Administrative Simplification)

that is designed to encourage the use of electronic transactions, while safeguarding member privacy.

To do so, HIPAA created a universal language or standard for electronic transmissions used in the health care industry. It is also established standards governing the privacy/security of health information, which is an extremely important issue for consumers today. Specific requirements are detailed in rules issued by the federal Department of Health and Human Services (DHHS). Please refer to the end of this section for important HIPAA websites.

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

5.1 Health Information

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

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

5.2 Individually Identifiable Health Information (IIHI)

IIHI is information that is subset of Health Information, including demographic information collected from an individual, and;

- Is created or received by a health care provider, health plan, employer, or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for provision of health care to an individual;
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

5.3 Protected Health Information (PHI)

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

5.4 Business Associate

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

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

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

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

5.5 National Provider Identifier (NPI)

Dentists who are Covered Entities are required by law to obtain a NPI number and use a National Provider Identifier under 42 CFR part 435 (Medicaid Managed Care Regulations) which the Hawki provider must comply with. The NPI is a ten-digit unique identifier for health care providers and organizations. There are two basic types of NPIs available: individual and organizational. Individual NPIs, also known as Type 1 NPIs, are for health care providers, such as dentists. Organizational, or Type 2 NPIs are for use by incorporated businesses, such as group practices and clinics.

5.5.1 NPI Application Process

1. Visit https://nppes.cms.hhs.gov or call 800-465-3203 to request a paper copy.
2. Complete the application and follow instructions to submit either online or by mail. Faxes are not accepted.
3. After confirmation of the receipt of your application, you should receive your NPI via email within one to five business days if you submitted the application online. Mailed applications may require up to 20 days to process.

Be sure to notify DD of your NPI number(s) by contacting Professional Relations at 888-472-1205 or email provrelations@deltadentalia.com.

5.5.2 HITECH Act

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

5.5.3 HIPAA Questions and Answers

Frequently Asked Questions
1. Do dental offices need a Business Associate agreement with DD?

No. Business Associate agreements are not necessary between Covered Entities for the purpose of treatment, payment, and health care operations (TPO).
2. Is a fax transmission considered an electronic transmission under HIPAA standards?
No. DHHS has not adopted a transaction standard for fax transmissions. However, if you are a Covered Entity, you are subject to the Privacy and Security Standards. You need to take appropriate steps to ensure the fax machine is located in a private and secure location to protect PHI that may be on incoming or outgoing documents.
3. Can I give DD fees over the phone for procedures I have performed?
Yes. Fees are necessary for treatment, payment and health care operations (TPO) and are not considered PHI.
4. What can dental offices expect when calling DD for member eligibility, benefits, and claims status?
DD authenticates callers to ensure that customers' privacy rights are protected under HIPAA. It is necessary for the dental office to provide the following information when requesting disclosure of a member's Protected Health Information: • Caller name • Dentist or office name • Dentist tax identification number (TIN) • Member's identification number • Member name • Member date of birth This information becomes part of DD's call log and is necessary for tracking uses and disclosures of Protected Health Information (PHI) under HIPAA.
5. Do I need an NPI if I file paper claims?
Yes, the Hawki must comply with the Medicaid and Managed Care Regulations 42 CFR part 438. (Medicaid Managed Care Regulations)
6. Does it cost to apply for an NPI?
No. There is no cost to apply for an NPI.
7. Am I subject to HIPAA requirements if I access the Delta Dental website to check benefits, eligibility, and check status of claims?
Yes. If you use the Internet to check member's benefits, eligibility, and check status of claims, as a Covered Entity, you are required to follow HIPAA provisions, including obtaining an NPI. Be sure to notify DD of NPI so it can be added to the provider records. This information is for instructional and education purpose only. It does not constitute legal advice. Recipients are strongly encouraged to contact their legal counsel for advice with respect to the interpretation of HIPPA and its applicability to the recipient and the facts and circumstances of the situation at hand.

5.5.4 HIPAA Informational Website

- Visit the official HIPAA website at www.hrsa.gov/hipaa/index.html
- Access the Office for Civil Rights website at www.hhs.gov/ocr

6 Customer Service

The Delta Dental Hawki Customer Service is available from 7:30 a.m. to 6:00 p.m. Monday through Friday.

To contact a Customer Service Representative, use the following number:

- 888-472-1205

All calls disclosing Protected Health Information are authenticated. When calling the Hawki customer service center, please be prepared to provide the Customer Service Representative with your name, the dentist office name, the dentist office tax identification number, the member's identification number, name and date of birth. For more information regarding HIPAA, refer to the HIPAA Section of this Manual.

Contact Customer Service for information regarding:

- Filing status
- Claim status
- Eligibility
- Benefits
- Claim processing

6.1 Hawki Website

The Delta Dental website allows you to confirm member eligibility, benefits, claim status, submit claims, prior authorizations, benefit estimates, and real time claims. You can also view member limits for all Covered Services as well as send and inquiry 24 hours a day, 7 days a week on the secure Dentist Connection website at www.deltadentali.com. Dental offices can easily look up member's benefits, submit claims, access claims status, view payments, submit an inquiry, and much more.

Real-time claims submission is a feature on the Dentist Connection, which allows you to submit claims and see the result immediately, for claims that do not require review and attachment information. Please see the Dentist Connection User Manual for complete instructions for sending real time claims on the Dentist Connection and get started today!

To access the Dentist Connection, you will need a user id and password. DD has issued your user id and password upon your participation in the Hawki Program. An email with your user id and password has been sent to you if you provided an email address to us. Otherwise, we have sent the user id and password to you in the mail. The user id and password must be protected and is only used by the individual for whom it was assigned. It is the responsibility of the Participating Dentist to ensure activity on their behalf via the Dentist Connection are accurate and correct. It is the Participating Dentist's responsibility to inform Professional Relations Staff when your user id and password need to be inactivated, for example you no longer practice at the location the username and password were assigned.

6.1.1 Accessing the Website

Get started today! Go to www.deltadentalia.com

You must change your password from the default assigned to you by DD upon logging onto the Dentist Connection.

6.1.1.1 How to change your password:

1) Enter your user id
2) Enter your current password
3) Place a check mark in change password after validation
4) Select log in or press enter on your keyboard
5) You will be prompted to enter and confirm your new password
6) Enter new password
7) Re-enter password at confirm password
8) Select Submit

If you forget your password, call or email Professional Relations at 888-472-1205 or provrelations@deltadentalia.com and we will reset your password.

6.2 Professional Relations Staff

Certain questions or information should be directed to the Professional Relations staff. Please contact Professional Relations at 888-472-1205 or email provrelations@deltadentalia.com if you:

- Change your office address or phone number.
- Have a change in your credentialing information.
- Is a new dentist opening an office or have a new associate or locum tenens dentist joining your practice?
- Are leaving a practice due to retirement, relocation, etc.
- Change your tax identification number (TIN).
- Have questions about your Participating Dentist's Agreement(s), credentialing, processing policies.
- Would like to schedule an office visit with a DD's Professional Relations Representative regarding office training needs, network participation, claims processing guidelines, attachment requirements or any other are of concern.
- Need information regarding your participation with DD.
- Have questions about the Dentist Connection on website or have questions about registering for the Dentist Connection.
- Need to add additional staff access for the Dentist Connection.
- Forgot your password for the Dentist Corporation.
- Update website information to indicate your office is no longer seeing new Hawki Kids members.

7 Claim Filing

The DD Participating Dentist's Hawki Agreement requires Participating Dentists to file claims on behalf of members. In addition, Participating Dentists agree to follow DD's billing instructions, processing policies and submission requirements and recommendations for specific procedures. This section of the manual provides information on filing paper and electronic claims, services beneficial to your office, and claim filing tips. Refer to the Procedures and Processing Policies Section in this Manual for a list of procedure codes and processing policies.

7.1 Electronic Claims Submission

All Hawki Participating Dentist are required to submit claims electronically. There are many benefits to filing claims electronically. The following are some of the advantages:

- Improved accuracy because the claims enter directly into DD's claims system.
- Faster payment turnaround time which results in improved cash flow.
- Less paperwork and simpler claims filing.
- Reduced mail costs and mail time.
- More efficient and better for the environment.
- Minimal start-up investment and maximizes your computer's capability.

You are required to submit claims electronically. Electronic claims consist of claims received electronically via a clearinghouse or electronic claims submitted via the Dentist Connection at www.deltadentalia.com. Electronic claims submitted via the Dentist Connection are convenient and are at no cost to you. Electronic Claims can be submitted at no cost via the Dentist Connection. For more information about submitting claims electronically via the Dentist Connection please see the Dentist Connection User Manual in the Download Center on the Home page of the Dentist Connection at www.deltadentalia.com. DD has sent you an email with your username and password. If you did not supply an email, your username and password have been mailed to you. You may contact Professional Relations if you are unable to locate your username and password.

Please contact DD's Professional Relations staff at 888-472-1205 if you have questions.

7.1.1 Alternative to electronic submissions

In the event your office does not have the ability to file electronic claims, we are providing you with a mailing address for any claims, attachments, or inquiries.

DD address:

Delta Dental of Iowa-Hawki PO Box 9030, Johnston, IA 50131-9030

7.1.2 Claims Forms

DD accepts the American Dental Association claim form. Please refrain from using superbills. Superbills are easily detached from the claim and delay the claim preparation and processing.

Some practice management systems require a "payer identification number". The payer ID number for DD's Wellness Plan is CDIAM.

If your system requests a DD "provider number" use the dentist's state issued license number. DD does not issue provider numbers.

7.2 Radiograph Return Policy

DD will not return radiographs or other attachments unless accompanied with a self-addressed, stamped envelope. When radiographs are needed, please send duplicates only - no originals. Be sure to properly identify and date the copy of the image.

Please follow DD's attachment guidelines unless DD individually instructs you otherwise. You will find a current list of attachment requirements on the Dentist Connection at www.deltadentalia.com or you may contact Professional Relations at 888-472-1205 or email provrelations@deltadentalia.com for a copy.

DD retains the right to request radiographs and/or other documentations for any procedure when necessary to process a claim.

7.3 Electronic Attachments

Electronic attachments may be submitted at no cost directly to the secured Dentist Connection website along with your claim or inquiry. For more information about how to submit electronic attachments, claims and inquiries, see the Dentist Connection User Manual in the Download Center at www.deltadentalia.com.

If you would like information about National Electronic Attachment Inc.'s (NEA) FastAttachTM software, please contact NEA at 800-782-5150 ext.2 or visit www.welcometonea.com to learn more about how this software provides dental offices the capability of sending digitized radiographs and attachments in support of their electronic claims.

NEA's Payer ID number is 080001.

7.4 Direct Deposit

The Hawki Participating Dentist Agreement requires direct deposit of your claim payments directly into your designated bank account. Choosing Direct Deposit will avoid the hassle of paper check processing and mail time of paper checks.

There are two options available for receiving your Remittance Advice (RA) so you can post payments to your member accounts:

- You can choose to receive an email which prompts you to access the secure Dentist Connection on the Delta Dental website to retrieve your RAs; or
- You may opt to have your RAs mailed.

Sign up for Direct Deposit is quick and easy. You may download a Direct Deposit authorization form from the Dentist Connection at www.deltadentalia.com. You may also contact Professional Relations for additional information at 888-472-1205 or email provrelations@deltadentalia.com.

7.5 Claim Filing Procedures

File claims as soon as the service is completed. The requirement for timely filing is 180 days from the date of service. All documents and attachments necessary to review must be included with the claim. Documentation includes, but is not limited to, clinical rationale/narrative, radiographs, periodontal chart, member's treatment record, and coordination of benefits information as applicable. If the claim is not received within this time period, the claim will be the Participating Dentist's responsibility and not billable to the member.

7.5.1 Filing a Dental Claim

All sections of the claim must be completed to avoid a delay in processing. If you need assistance filing a claim, contact a Customer Service Representative at 888-472-1205. Below is a list of guidelines when completion sections of a claim.

7.5.2 Member / Subscriber Information

Please use the following guidelines when completing the member section of a claim:

- Use the member's full name. Do not submit nicknames.
- It is extremely important to enter the member's correct date of birth.
- Be sure to indicate the Member's name and identification number which is listed on the Hawki identification card. The identification number for Hawki member is the State assigned Medicaid number.
- Include the Member's address on the claim.
- If applicable, include information about the member's other dental insurance so that benefits are coordinated appropriately. Medicaid is always the payer of last resort.

7.5.3 Record of Services

Please use the following guidelines when completing the record of services section of a claim:

- Indicate if radiographs or other review documents are included with the claim.
- Indicate where the treatment was performed.
- DD uses the standard tooth numbering system. Use letters to identify primary teeth and numbers to identify permanent teeth. Supernumerary teeth in the permanent dentition are identified by the numbers 51-82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar. Supernumerary teeth in the primary dentition are identified by placing an "S" following the tooth letter adjacent to the supernumerary tooth. Refer to the Current Dental Terminology (CDT) Manual for a tooth chart.
- Tooth numbers are required on procedures involving specific teeth. Generalized procedures, such as prophylaxis, fluoride treatments, radiographs, evaluations are excluded from the tooth number requirement.

- The mouth is divided into four quadrants: upper right (UR), upper left (UL), lower right (LR), and lower left (LL). When filing periodontal services, note the tooth number(s) or the quadrant to identify the teeth/area being treated.
- Identify the tooth surfaces when submitting a restoration. The following single letter codes are used to identify surfaces: Surface Codes:
    - Buccal- B
    - Distal -D
    - Facial- F
    - Lingual-L
    - Mesial- M
    - Occlusal- O
- Give complete written description of the service performed.
- When submitting a claim for payment, record the date each procedure was completed. DD does not pay for incomplete procedures. Do not list a date of service if a benefit estimate or prior authorization is being submitted.
- When listing procedure codes, use the most recent version of the American Dental Association's (ADA) Current Dental Terminology (CDT) manual.
- Each CDT code (service) provided, and the billed charge must be entered on the claim form. The billed charge must be your billed charge amount.
- If a payment has been received from a third party, indicate the amount received in the area that indicates "less third-party payments". A copy of the primary carrier's claim payment is required to coordinate benefits.
- Hawki benefit plan is always the payer of last resort. Therefore, payments from any other dental insurance carrier must be sought after and/ or applied before Hawki benefits are considered. When submitting claims, identify the other insurance carrier as the primary payer to ensure proper coordination of benefits.
- The treating dentist who performed the services should be listed as the treating dentist in the designated areas; the billing dentist should be listed in the billing dentist area. Include the treating dentist's license number and National Provider Identifier (NPI) number.
- When services are completed via teledentistry the following must be completed on the ADA form: the Place of Treatment (Box 38) should always be coded as 02 (This is the Centers for Medicare and Medicaid Services (CMS) Health Information Portability and Accountability Act (HIPAA) standard code for telehealth). Additionally, the CDT code for synchronous or asynchronous teledentistry must be on the claim form.
- If a CDT code needs to be modified on the claim after filing to DD, you will need to submit a new claim with the updated CDT procedure that was completed.
- To adjust the original claim, please submit an inquiry.

7.5.4 Dentist Information

This section of the claim identifies the billing entity and treating dentist.

Please use the following guidelines when completing the dentist's information on a claim:

- Please list the billing entity or dentist's name, address and phone number.
- Include the billing entity or dentist's tax identifications number (TIN). The number entered should be the TIN recorded with the Internal Revenue Service (IRS). Please contact the dentist's accountant if you are unsure of the correct TIN.
- Enter the National Provider Identifier (NPI) number. (Please see HIPAA Section of this Manual for more information regarding the NPI number.)
- It is important to input the state issued license number of the dentist who performed services.
- The dentist who performed the treatment needs to sign and date the claim. Also, include the treating dentist's license number and National Provider Identifier (NPI) number.

7.5.5 Ancillary Claim Information

This area of the claim includes information about occupational injury, accident as well as prosthetic placements dates.

- Be sure to indicate if treatment is a result of occupational injury. If yes, provide a brief description of the injury and the injury date and include a copy of the medical carrier's claim payment report, if applicable.
- Indicate if treatment is the result of an accident and include a brief description of the accident and the accident date and include a copy of the medical carrier's claim payment report, if applicable.
- If services include placement of a prosthesis, please indicate if it is the initial placement or if it is a replacement. If it is a replacement, include the date of previous placement, if known, and the reason for the replacement.

7.5.6 Duplicate Claims

Each duplicate claim filed results in additional administrative costs for your office. To help control costs and avoid duplicate claims please be sure to access the claims status on the Dentist Connection at www.deltadentalia.com and check your electronic submissions to ensure you're not including claims sent previously. Duplicate filings occur in some dental office practice management systems when claims at the end of a transmission are not deleted and are subsequently resubmitted. If you are unsure whether the claim has been filed, please access the Dentist Connection on the website at www.deltadentaia.com. If your office has a high occurrence of duplicate claims filing, a member of DD's Professional Relations team may contact your office to assist in determining if there is a claim filing issue or training need.

7.5.7 Infection Control

DD understands that costs are incurred by the dentist to comply with Centers for the Disease Control (CDC) recommended infection control guidelines. However, infection control is not a unique element of a dental procedure but is a dentist's professional responsibility. These costs are part of the day-to-day operations and office overhead and should not be billed separately. Participating Dentists may not bill the member or DD separately for these charges.

7.5.8 Claim Filing Tips

Review the following filing tips to ensure quick and accurate claims processing:

- If you are approved to submit paper claims, verify the print quality and legibility of your claims.
- Prior Authorizations are required for certain services. For a list of services requiring Prior Authorization refer to the Prior Authorization Section.
- It is very important to submit claims with the member's correct date of birth.
- When sending photos or radiographs, indicate the date of the image and identify teeth by labeling "right" (R) or "left" (L). Do not send original photos or radiographs. DD will not return photos or radiographs unless the office includes a self-addressed, stamped envelope with the submission. Be sure to include sufficient postage.
- Submit crowns, onlays, and dentures with seat date, not the preparation date.
- File root canal therapy (RCT) with the completion or fill date.
- When you file periodontal services (i.e. root planning and scaling, osseous surgery, grafting, gingivectomy), include the tooth number or the quadrant (UR, UL, LL, LR) to identify the teeth/area being treated. Be sure to include the necessary submission requirements for these procedures. (Please refer to the Procedures and Processing Policies section of this Manual for additional details)
- Be sure to include the tooth number when filing a claim for re-cementing a restoration.
- List tooth numbers on claims for fillings, onlays, crowns.
- If you need to make a change to an already submitted prior authorization or claim (e.g. DOS, CDT code, tooth surface), please submit an inquiry and file a new claim. DD can not make changes to an already submitted prior authorization or claim.

7.5.9 Fraud

DD is dedicated to conducting business in an ethical and legal manner. DD maintains an Anti-Fraud Plan for continuous monitoring of potential fraud, waste, and abuse activity. We are committed to preventing, detecting, and reporting fraud, waste, and abuse and overpayments.

Definitions:

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

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

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

Disciplinary actions could result from these monitoring activities including, but not limited to, payment recoupment, education, corrective action plans, and/or contract termination.

If you suspect fraud or an overpayment was made, report it immediately to DD's Utilization Review Coordinator at 515-261-5638 or 888-472-1205.

Some common types of fraud and abuse include:

- Billing for services not performed
- Keeping over-payments
- Billing for a non-covered services as a covered services
- Misrepresenting dates of services, diagnosis, or procedures performed
- Misrepresenting location of a service
- Misrepresenting provider of a service
- Billing twice for the same service
- Billing for inappropriate or unnecessary services
- Reporting a higher level of dental service than was performed
- Falsifying a member name or their personally identifiable information to obtain payment for services
- Deliberately failing to report the existence of additional dental benefits coverage and billing two or more carries for the full amount
- Kickbacks or bribe
- Members who misrepresent themselves as another person to obtain dental services

- Lying about degrees and licenses

7.5.10 Recoupment of Overpayment

In the event DD makes payments and payments are later determined to have been:

- Made in error
- Were for dental services not covered because they were cosmetic, elective, not dentally necessary or dentally appropriate
- Were due to an office/dentist's error, or DD's error

DD will deduct the incorrect payment from future payments due to the dentist. DD directs network providers to disclose and return overpayments to DD within 60 calendar days after the date on which the overpayment was identified, and to notify DD in writing of the reason for the overpayment.

8 Prior Authorization and Benefit Estimates

8.1 Submit Prior Authorizations on the Dentist Connection

When submitting a prior authorization, be sure to include all required documentation. Filing a prior authorization will assist you in determining if you will be reimbursed for the service based upon the clinical criteria required, as well as the benefits available for a member. Prior authorization is not a guarantee of member eligibility. When a member loses Hawki eligibility, any prior authorizations for services become void.

All services submitted for prior authorization will be adjudicated like a claim with a date of service. The submitted services will be checked for frequency limitations, age limitations, processing policies, review requirements, etc. If a service requires a review of clinical documentations or radiographs, the prior authorization will be suspended for clinical review prior to a decision being determined.

Prior authorizations can be submitted via the Dentist Connection or through other methods of claim submission such as electronic/clearinghouse claims. When submitting a prior authorization via a clearinghouse do not enter a date of service.

The member will also receive a copy of the prior authorization notice in the case of a denial. The adverse benefit determination notice will include an explanation of denied benefits and advise the member of their appeal rights.

8.2 Existing Approved Prior Authorizations

DD will honor all existing authorizations for a minimum of 90 days from another carrier regardless of provider network status.

8.3 Void, Pay and Submit a Prior Authorization

Approved services, once completed, must be submitted for payment online. Retrieve the member's eligibility and click on Prior Authorizations. Select the Prior Authorization that you wish to utilize. You will be presented with four buttons:

Select one of the actions by clicking the appropriate button.

Button	Description
Pay on Authorization	This link will allow you to submit for payment on a previously approved prior authorization. This is the preferred method of claim submission on a previously approved prior authorization. If you are unable to submit through the Dentist Connection and are submitting for payment via a paper claim, you must include a copy of the prior authorization with the paper claim. Any claim submitted through a clearinghouse or by paper must include a comment referencing the prior authorization number. If the prior authorization number is not included, the claim will be rejected. To avoid rejection, submit through this Pay on Authorization option.
Submit Prior Authorization	This link will take you to the Claim Submission screen where you may request a prior authorization. To learn more about submitting prior authorizations on the Dentist Connection follow the steps page in the Dentist Connection User Manual, located on the Dentist Connection.

8.4 Benefit Estimate

A benefit estimate is different from a prior authorization. Dentists can use the Benefit Estimator tool on the Dentist Connection to quickly determine how a planned service may be adjudicated. Like a prior authorization, services submitted using the Benefit Estimator will be checked for frequency limitations, age limitations, and processing polices.

Unlike a prior authorization, services submitted using the Benefit Estimator tool assumes any clinical criteria required to be submitted and reviewed when submitting an actual claim for services is met. The Benefit Estimator tool provides immediate, real-time results and is not a guarantee for payment and does not satisfy the requirement for prior authorization.

To submit a benefit estimate you must use the Benefit Estimate tool on the Dentist Connection. If, you submit a benefit estimate via paper or electronic/clearinghouse method, the benefit estimate will become a prior authorization.

For detailed information on how to use the Benefit Estimator Tool, see the Dentist Connection User Manual available on the Dentist Connection at www.deltadentalia.com.

8.5 Urgent/Expedited Prior Authorization Request

For cases in which a provider or member indicates, or the DD determines, that following the standard time frame could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, DD must make an expedited authorization decision. DD must provide notice to the provider and member as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. If additional information is needed and it's in the best interest of the member or provider, DD may request an extension of an additional 14 calendar days to review the service authorization. The member and provider will be notified of this 14-calendar day extension in writing and by

phone. A Provider can request an urgent/expedited prior authorization by including Urgent or Expedited to box 35 Remarks section on the ADA claim form.

9 Communications

It is important to stay connected. DD provides the following ongoing communications:

9.1 Delta Dental- Dental Connection

Through Dentist Connection, dentists and dental office staff can easily look up member benefits, submit a claim, submit a prior authorization, pay on a prior authorization, benefit estimate, check claims status, submit inquiries, view payments and have access to much more valuable information. Login today at www.deltadentalia.com.

9.2 Dental Dash Newsletter

The Dental Dash newsletter is sent via email to Hawki provider offices. This publication includes important information and facts about the plan. Current and past issues are posted on the Dentist Connection at www.deltadentalia.com.

DD would like to communicate with you electronically and having your current email is key in the age of electronic communications. Contact Professional Relations at 888-472-1205 and provide your email address.

10 Miscellaneous

10.1 Iowa Smoking Quit Line

The Hawki dental Program do not cover smoking counseling or cessation programs. Any members requiring these programs can contact the Iowa Medicaid Smoking Quit Line at 800-QUITNOW (800-784-8669) or find information online at www.quitnow.net/iowa or www.betobaccofree.gov

10.2 Nutritional Counseling

Hawki members that require nutritional counseling should access these benefits through their Medical Benefits by seeing their Medical Home Physician.

10.3 Cultural Competency

DD encourages contracted providers to address the care and service provided to members with diverse values, beliefs, and backgrounds that vary according to their ethnicity, race, language and abilities. We strongly encourage all contracted providers to complete cultural competency training to meet the needs of all members. DD recommends completing the U.S. Department of Health & Human Services Cultural Competency Program for Oral Health Providers available free of cost. (https://www.thinkculturalhealth.hhs.gov/education/oral-health-providers). Providers can attest to the completion of cultural competency training through the credentialing and re-credentialing process.

11 Member Services

11.1 Care Coordination

DD is responsible for coordinating dental services for members to ensure ongoing dental care.

DD staffs Care Coordination Specialists to ensure Hawki members maintain or identify a dental provider. Members are able to find a dentist online at www.deltadentalia.com or calling Member Services at 1-888-472-2793. Care Coordinators may email or send a hard copy of dental providers to members at their request.

New Hawki members receive a Welcome Letter and Packet via mail within 7-10 days of enrollment from DD explaining the Hawki benefits and providing contact information vital to the program.

A toll-free number will be answered by customer services representatives (CSRs) specifically trained to provide enhanced education and referrals for the adult Medicaid population. These specially trained CSRs will:

- Provide information on the importance of routine dental care.
- Answer dental benefit questions.
- Assist in finding a general dentist or dental specialist.

DD sends postcards and text messages to enrollees to increase utilization for all members. These methods are used for newly eligible members, and for members who have not utilized services after being with the Hawki for six months. CSRs also follow up with outbound calls for members to help establish a dental home and answer questions about their benefits.

11.2 Hawki Outreach and Care Coordination I-Smile

I-Smile™ is a program that connects Iowa families with dental, medical, and community resources for a lifetime of health and wellness. The I-Smile program will continue to be an integral part of the Hawki Program. DD will be working closely with local I- Smile™ coordinators (dental hygienists), that are located statewide, to help low- income children get dental care and create strong partnerships within communities to promote the importance of oral health. The program services as the backbone for access to dental care and good oral health for Medicaid-enrolled children. The I-Smile structure aims to:

- Increase access to dental care by providing dental screenings, sealant, and fluoride in schools
- Help families find a dentist, make dental appointments, and link with community resources.
- Develop relationships with dentists and medical providers.
- Provide oral health education for children and parents.
- Provide training for medical offices on dental screenings and fluoride applications.
- Build partnerships with community organizations and businesses.

- Promote oral health by participating in local community events.
- For more information about the I-Smile program or to find a list of local coordinators, visit: https://hhs.iowa.gov/programs/programs-and-services/dental-and-oral-health/i-smile/find-i-smile-coordinator

11.3 Community Partnerships

DD partners with many state level programs and organizations, as well as local level partners, to assist with outreach and education efforts to low-income adults about the availability of oral health services and how to access those services.

11.4 Continuity of Care

DD will work with members who move out of a service area or choose to see another dentist in obtaining a copy of their dental records from their current dentist to provide to their new dentist. Participating Dentists must furnish members with copies of their records, including x-rays, free of charge.

The Hawki plan allows a member to continue care with an existing dental home provider for up to 90 days from their enrollment date. The provider must be enrolled with Iowa Medicaid and bill the dental carrier that the member is assigned to. After 90 days, DD is not obligated to pay for services provided by a non-participating network provider unless for emergency care.

11.5 "No Show" Members

We strongly encourage you to use reminder tools for members to keep their appointments. The population is transient, so obtaining members' cell phone numbers for texting reminders may be the best mechanism for communication.

11.6 Reading/Grade Level Consideration

All member materials produced by DD are written at a sixth-grade reading level to promote enhanced communication between the Medicaid population, providers, and DD. Our goal is to create plain and clearly understandable member communications.

11.7 Discrimination

Providers may choose whether to accept a member as a Hawki member. Providers are not required to accept every Hawki member requiring treatment; however, providers must be consistent in this practice and not discriminate against a Hawki member based on the member's race, religion, national origin, color, or impairment.

Providers must not differentiate or discriminate in the treatment of any member because of the member's race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.

DD may not discriminate in the participating, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under the applicable state law, solely based on that license or certification. If DD declines to include an individual or group of providers in the Hawki network, it must give the affected providers written notice of the reason for the decision

12 Procedures and Processing Policies

This section provides in depth details about DD's standardized processing policies used for Hawki.

12.1 Delta Dental of Iowa's Responsibility

It is DD's responsibility to the Iowa Department of Health and Human Services to oversee utilization and billing patterns of the Participating Dentist network. Utilization review is performed to determine if a dentist's practice patterns are beyond the Iowa norm of like dentists with similar education and practice experience. If, unusual patterns are detected, DD will review all factors that could establish reasons why a dentist would demonstrate differing results than peers.

12.2 In-Office Audit and Desk Audit

As indicated in the Hawki Uniform Regulations, DD and its representatives may make periodic examination of a Participating Dentist's office and records (including, without limitation, the records required to be maintained under Section 6 of the Uniform Regulations) during regular office hours to determine Participating Dentist's compliance with the agreement. Without limiting the generality of the foregoing, DD may request, and Participating Dentist shall provide at no cost, de-identified data regarding fees charged to other members not enrolled in Hawki. Participating Dentist understands and agrees that governmental agencies with regulatory authority over the Hawki product shall also have access to Participating Dentist's office and records as required or permitted under applicable law.

12.3 Dental Necessity

DD will provide a decision within 14 calendar days of the request. When service authorizations are received without the necessary clinical information and documentation, clinical staff will contact the dental office by phone, email, fax or the inquiry process in the DD claims management system to requesting missing information. If the additional information for the service authorization has not been received on the 14-calendar day, or the member or provider request additional time a written communication will be sent to the member and provider to extend the timeframe another 14-calendar days.

If a decision is not reached within applicable timeframes for standard or expedited service authorizations for any reason, DD will notify the provider and member.

Some examples would include waiting for additional information from the provider or if it is in the best interest of the member or due to lack of clinical staff to review services authorizations at DD.

As outlined in the Hawki Uniform Regulations section 12, and in addition to the further terms and conditions of the Agreement, including the incorporated documents, Participating Dentist shall furnish and will receive payment only for dental services that are Dentally Necessary. DD shall not be responsible to pay for dental services that are not Dentally Necessary. Prior to providing a member with dental services that are not Dentally Necessary, a Participating Dentist shall inform the member of DD's payment policies and obtain a written acknowledgement from the member that he/she has been informed that the dental services may not be paid

by a third party. In the event a payment is made to Participating Dentist by DD for dental services that are later determined not to be Dentally Necessary, DD (or the applicable regulatory agency) may recoup payment pursuant to Section 9 of the Hawki Uniform Regulations.

A procedure, service or supply shall be considered "Dentally Necessary" if and only if DD determines that each of the following statements is true with respect to such procedure, service or supply:

- The diagnosis is proper.
- The treatment is necessary to address disease or basic function of the teeth and the health of the gums, bone and other tissues, which support the teeth.
- It is the most appropriate procedure, service or supply for the member's individual circumstances.
- It is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by DD.

Notwithstanding the foregoing and in all events, Participating Dentist shall exercise his or her independent professional judgment in providing dental services. Nothing herein shall be construed to (a) interfere with or otherwise affect the rendering of dental services by Participating Dentist in accordance with Participating Dentist's independent professional judgment, or (b) prohibit or otherwise restrict Participating Dentist acting within the lawful scope of his or her profession, from discussing with a member the member's health status and dental care or treatment options.

12.4 Post Stabilization Care

Post stabilization care services are covered services, related to an emergent dental condition that are provided after a member is stabilized to maintain the stabilized condition. The provider treating the member for the emergent care is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

Follow guidelines identified by the American Academy of Pediatric dentist for emergent and post stabilization care:

- https://www.aapd.org/assets/1/7/P HospitalizationInfants.pdf
- https://www.aapd.org/globalassets/media/policies guidelines/bp monitoringsedation.pdf

12.5 Member Record Keeping

At times it may be necessary for DD to request a copy of a member's clinical record, tooth chart and/or ledge for further clarification of a claim. It is important that the member's records are complete and legible. The following lists member record keeping requirements, as outlined by the Iowa Dental Board (IDB):

- 650 -27.11 (153,272C) Record keeping. Dentists shall maintain member records in a manner consistent with the protection of the welfare of the member. Records shall be permanent, timely, accurate, legible, and easily understandable.

- 27.11 (1) Dental records. Dentists shall maintain dental records for each member. The records shall contain all of the following:

1. Personal data
   a. Name, date of birth, address and, if a minor, name of parent or guardian. Name and telephone number of person to contact in case of emergency.
2. Dental and medical history. Dental records shall include information from the member's parent or guardian regarding the member's dental and medical history. The information shall include sufficient data to support the recommended treatment plan. Dental records may contain documentation of advance directives, as appropriate.
3. Member's reason for visit. When a member presents with a chief complaint, dental records shall include the member's stated oral health care reasons for visiting the dentist.
4. Clinical examination progress notes. Dental records shall include chronological dates and descriptions of the following:
   a. Clinical examination findings, tests conducted, and a summary of all pertinent diagnoses.
   b. Plan of intended treatment and treatment sequence.
   c. Services rendered and any treatment complications.
   d. All radiographs, study models, and periodontal charting, if applicable.
   e. Name, quantity, and strength of all drugs dispensed, administered, or prescribed.
   f. Name of dentist, dental hygienist, or any other auxiliary, who performs any treatment or service or who may have contact with a member regarding the member's dental health.
   g. Informed consent. Dental records shall include, at a minimum, documentation of informed consent that includes discussion of procedure(s), treatment options, potential complications and known risks, and member's consent to proceed with treatment.

- 27.11 (2) Retention of records. A dentist shall maintain a member's dental record for a minimum of ten years after the date of last examination, prescription, or treatment. Records for minors shall be maintained for a minimum of either (a) one year after the member reaches the age of maturity (18), or (b) ten years, whichever is longer. Proper safeguards shall be maintained to ensure safety of records from destructive elements.
- 27.11 (3) Electronic record keeping. The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, a dentist shall keep either a duplicate hard copy record or use an unalterable electronic record.
- 27.11 (4) Correction of records. Notations shall be legible, written in ink, and contain no erasures or white outs. If incorrect information is placed in the record, it must be crossed out with a single, non-deleting line and be initialed by a dental health care worker.
- 27.11 (5) Confidentiality and transfer of records. Dentists shall preserve the confidentiality of member records in a manner consistent with the protection of

the welfare of the member. Upon request of the member or member's legal guardian, the dentist shall furnish the dental records or copies or summaries of the records, including dental radiographs or copies of the radiographs that are of diagnostic quality, as will be beneficial for the future treatment of that member. The dentist may charge a nominal fee for duplication of records but may not refuse to transfer records for nonpayment of any fees. (IDB Code 650, Chapter 27 - Standards of Practice and Principles of Professional Ethics)

12.6 Member Dismissal Policy

Sometimes it's best for a dentist and patient to part ways. In these cases, this is because there's some friction that can't be resolved or a difference in philosophies of care.

The dentist has the right to dismiss a patient in situations where it is impossible to resolve differences or if the dentist cannot abide the patient's behavior within the practice, as long as the dismissal is not for a legally impermissible discriminatory reason.

- Develop a patient dismissal policy. The dismissal policy should include your processes and policies for dismissing a patient.
- Develop a template for a dismissal letter. Fill in the details about the cause for the release objectively and advise the patient of the need to find another provider. Also detail the number of days you will be available to treat the patient in the event of an emergency.
- While you should document all communication with patients in their record, including phone calls, it's especially important that you do this when dismissing a patient. That type of information, while considered a best practice in any situation, can be especially helpful in dismissal cases that can become emotionally charged.

It is also recommended that you consult state laws and state dental practice act to determine any requirements about dismissing a patient, including how many days you need to be available to the patient in case of an emergency.

ADA has developed additional guidance and template member dismissal letter at:

https://www.ada.org/en/resources/practice/practice-management/managing-patients-dismissal

Request a Review/Reconsideration of a Denied or Claim Not Billable to the Member or Prior Authorization

If DD does not pay all or part of a member's claim; or a submitted prior authorization was Denied or not billable to the member, a Participating Dentist can ask for a review. A review, also called a reconsideration, can be requested when a Participating Dentist provides additional information. Providers have 60 days once the remittance advice has been received to file a reconsideration.

To request a Review of a claim or prior authorization a dentist must

- Send an inquiry requesting review or reconsideration of the Denied or claim not billable to the member or prior authorization. You may use the Inquiry feature on the Dentist Connection.
- Document the reasons why DD should reconsider the original decision and outline what new information is being submitted.
- Provide all appropriate review documentation (e.g. narrative, member treatment record, radiographs, etc.).
- Include your name, member's name and the member identification number on all documents.

This information will be reviewed, and a determination will be provided to the Participating Dentist.

Dentist Connection: Inquiry Feature (See the Dentist Connection User Manual in the Download center on the Dentist Connection at www.deltadentalia.com)

Email Address: Hawki Members@deltadentalia.com (Be sure to secure the email since Protected Health Information is included.) Please put "Reconsideration Request" in the email subject line.

Mailing Address: Delta Dental of Iowa, Attn: Hawki Reconsideration Request, PO Box 9030, Johnston, IA 50131

12.7 Peer to Peer Review

DD offers peer to peer consultations regarding claims and prior authorizations. The peer to peer will be with one of our dentist consultants or DD's Chief Dental Officer. To request a peer-to-peer discussion, please contact the DD Professional Relations Representative or call the Hawki Provider customer service center. We will do our best to accommodate the peer-to-peer meeting within seven business days depending on the availability of both parties.

13 Hawki Appeal and Grievance System

Members, Participating Dentists, or a representative acting on behalf of a member, have access to the Grievance process.

This system includes and Appeal and Complaint Process and access to the Iowa Department of Health and Human Service's state fair hearing system. DD is available to provide assistance to members when filing a complaint or an appeal.

13.1 Hawki Appeal Process

An Appeal is a request for review of an adverse benefit determination, which is defined as any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.

3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at §447.45(b) of this chapter is not an adverse benefit determination.
4. The failure to provide services in a timely manner, as defined by the State.
5. The failure of DD to act within the timeframes provided in §438.408(b)(l) and (2) regarding the standard resolution of grievances and appeals.
6. For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
7. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Any action outlined above can be appealed by a member, Participating Dentist or representative of the member. A Participating Dentist or a representative of the member must have the member's written authorization to act upon their behalf when submitting an appeal. A member may request an appeal orally at any time by calling Member Services at 1-888-472-2793.

To request an Appeal on behalf of a member, a dentist must

Obtain written consent from the member and discuss with the member the services that the appeal covers. The member must complete the Personal Representative Appointment and Authorization to Release Protected Health Information (PHI) Form. The completion of this form and signature from the member must be signed by a member during the time of prior authorization appointment.

- Submit a completed Appeal Request Form and Personal Representative Appointment and Authorization to Release PHI Form within 60 days of the adverse benefit determination.
- The appeal request must include the appeal reason. The appeal request must be signed by the Participating Dentist.
- Provide all appropriate documentation (narrative, member treatment record, radiograph, photo, etc.).
- Include the Participating Dentist's name, the member's name and identification number on all documents submitted.

Upon receipt of both the Appeal Form and Personal Representative Appointment and Authorization Release PHI Form (both forms can be found in the Forms section of the Download Center on the Dentist Connection), DD will:

- Respond in writing with an acknowledgment letter within five calendar days of the appeal receipt date.
- Respond in writing with the final disposition of the appeal within 30 calendar days of the appeal receipt date. If the member, provider or DD needs more time to collect and review the supporting documentation and it's in the best interest of the members, DD can extend the time by up to 14 calendar days. The member and

provider will receive written and oral communication of the 14-calendar day extension.

- The written response will include information about how to request a State Fair Hearing in the event the original decision is upheld in the appeal.
- All appeals will be reviewed by the Government Programs Appeals Committee.

13.2 How to Request an Appeal on Behalf of a Member

Your request may be sent via the following options:

- Fax Number: 888-264-0195
- Email Address: GPAppeals@deltadentalia.com (Be sure to secure the email since Protected Health Information is included.) (Please put " Hawki Appeal" in the email subject line)
- Mailing Address:
- Delta Dental of Iowa, Attn: Hawki Appeal PO Box 9040, Johnston, IA 50131

Punitive action will not be taken against a provider who requests an expedited appeal or supports a member's appeal.

13.3 Expedited Appeal

A Participating Dentist or a representative of the member must have the member's written authorization to act upon their behalf when submitting an expedited appeal. The member must complete the Personal Representative Appointment and Authorization to Release Protected Health Information (PHI) Form. An Expedited Appeal can be written or oral.

An Expedited Appeal can be requested if taking the time for the standard appeal could seriously jeopardize the member's life, health or ability to regain maximum function. This information should be included in the Expedited Appeal information. DD will provide a decision both written and orally to provider and member within 72 hours of the request.

DD may extend the time to process a standard or expedited appeal by up to 14 calendar days of the request, if the member or provider requests an extension or if DD shows there is a need for additional information, and a delay would be in the member's best interest. DD will communicate with the member and provider in written and oral formats for the extension request.

13.4 Continuation of Benefits

A member has a right to request continuation of benefits that the contractor seeks to reduce or terminate during an Appeal or State Fair Hearing, if filed within the allowable timeframes, although the member may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision is adverse to the member.

A Continuation of Benefits may be requested if all the following are true:

- The Appeal is filed timely, meaning on or before the later of the following:

- Within 60 days of the adverse benefit determination (Remittance Advice).

- The Appeal involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The authorization period has not expired, if applicable.
- The request of continuation of benefits is filed on or before the later of:
- Within 10 days of the adverse benefit determination, or
  - The intended effective date of the processed adverse benefit determination.
- The member can find more information about the continuation of benefits process in the Member Handbook.

13.5 Hawki Grievance Process

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. The grievance can be about the Hawki Program, DD, a provider, potential fraud, waste or abuse, or services received including the quality. Grievance can also be regarding the failure to respect a member's rights. A member may submit a grievance orally at any time by calling Member Services at 1- 888-472-2793. A Participating Dentist must have the member's written authorization to submit a grievance.

To submit a grievance on behalf of a member a dentist must

- Obtain a written consent from the member. The member must complete the Personal Representative Appointment and Authorization to Release PHI Form.
- Submit a completed Grievance Form and the Personal Representative Appointment and Authorization to Release PHI Form. The forms are available in the forms section of the Download Center on the Dentist Connection at www.deltadentalia.com.
- Provide all appropriate documentation.
- Include the Participating Dentist's name, the member's name and identification number on all documents submitted.

Upon receipt of both the Grievance Form and Personal Representative Appointment and Authorization to Release PHI Form, DD will respond in writing within 30 calendar days. This time may be extended by up to 14 additional days if the member requests the extension or DD needs more additional information, and the delay is in the best interest of the member.

The request may be sent via the following options:

- Fax Number: 888-264-0195
- Email Address: HawkiMembers@deltadentalia.com (be sure to secure the email since PHI is included.) Pleas put “Hawki Grievance” in the email subject line.

- Mailing Address: Delta Dental of Iowa, Attn: Hawki Grievance, PO Box 9040, Johnston, IA 50131

13.6 State Fair Hearing

If the member is not satisfied with our Appeal decision, they may have the right to request State Fair Hearing. A Participating Dentist may request the hearing if the State permits the Participating Dentist to act as the member's authorized representative.

The hearing must be requested within 120 days of the appeal resolution letter. The State will typically reach a decision within 90 days of the hearing request date or Appeal request date.

Participating Dentists do not have the right to a State Fair Hearing to address payment disputes between the provider and DD after the services have been rendered.

To request a State Fair Hearing, send the request to:

- Department of HHS, Attn: Iowa Medicaid/Appeal Liaison, 1305 E. Walnut Street, 5th floor, Des Moines, IA 50309
- Fax: 515-564-4044

13.7 Requesting Clinical Records from the Provider for Grievance or Appeal

Delta Dental may request clinical records from a provider for a grievance or appeal. Delta Dental will send a certified letter to the provider office requesting the member's clinical record. The members' clinical record must be sent to DDIA within the seven-business day requirement so all timelines can be met.

13.8 Member Rights

Getting dental health services is a private matter. We respect our members' right to access care and be treated with respect. Members are provided with these rights and can be found in the Hawki Member Handbooks and at www.deltadentalia.com. Hawki members have the following rights:

1. Be treated with dignity and respect. Member's privacy must be respected.
2. Receive care no matter the member's race, color, nationality, disability, sex, religion or age.
3. Get correct, easy to understand information from Delta Dental and their dentist.
4. File a grievance (complaint) about us, the dentist, or the care they receive. More information can be found starting on page 37 of this Manual.
5. File an appeal about an action or decision we made. More information can be found starting on page 35 of this Manual.
6. Ask for a State Fair Hearing if you are not happy with the results of your appeal. More information can be found starting on page 35 of this manual.
7. Members have a right to know:
    a. How Delta Dental decides whether a service is covered and/or dentally necessary.
    b. Who at Delta Dental makes those decisions.

8. Have the right to get information about dentists in the Hawki network. This includes the dentist's name, address, contact information, and accessibility information.
9. Pick from a list of dentists that is large enough that members can get the right kind of care when you need it.
10. Take part in all the choices about their dental care.
11. Speak for themselves in all treatment choices, including the right to refuse treatment.
12. Get a second opinion from another dentist about what kind of treatment they need at no cost to the member.
13. Be treated fairly by Dental Wellness Plan Network dentists and other dentists.
14. Have the right to:
    a. Talk to their dentist in private
    b. Have their dental records kept private
    c. Request a copy of their dental records
    d. Ask for changes to those records
15. The dentist who provides you with care can give your information about:
    a. Health status
    b. Dental care
    c. Dental treatment
16. Are not responsible for paying for covered services. Dental Wellness Plan Network Dentists cannot require a member to pay any other amount for covered services.
17. Receive information in other formats such as in another language, larger font, Braille, etc. Members can contact us toll-free at 1-888-472-2793 or email hawkimembers@deltadentalia.com to ask for this. Members can get a spoken translation for most languages at no cost.
18. Recommend changes to policies and services under the Dental Wellness Plan. Members can write us, or call toll-free 1-888-472-2793, or email hawkimembers@deltadentalia.com.
19. Receive services free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

Dentist Office Manual Preamble

The following provides the Hawki Kids processing policies for all CDT codes. These policies are standards of payment and should not be misconstrued as standards of care. Please refer to the covered services grid for covered procedures.

14 Processing Policies

These processing policies reflect data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. It is the policy of DD to comply with all such requirements as well as to require participating dentists to comply with such requirements. However, consistent with HIPAA, DD exercises its right to determine claims reimbursement procedures and requires the processing of such codes in accordance with the following policies, unless prohibited under applicable law. Dentists are required to utilize those procedure codes reflective of

services rendered and in accordance with HIPAA. Amounts charged under any procedure shall not be inflated or manipulated in light of the processing policies.

14.1 General Policies

All services provided to Hawki members are subject to the following general policies:

- Documentation of extraordinary, unusual, unique circumstances can be submitted for review by report.
- Fees for completion of claim forms and submission of documentation to DD to enable benefit determination are not benefits. They are collectable from the Enrollee by a Participating Dentist.
- Infection control and OSHA compliance are included in the fee for the dental services provided. Separate fees are not billable to the member and not collectable separately from the Enrollee by a Participating Dentist.
- Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable and fixed prosthetic appliances. The completion date for crowns and onlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.
- Charges for procedures determined not to be necessary or not meeting generally accepted standards of care will not be Billable to the Member. Many of the processing policies that follow detail payment procedures are based on the timing and sequence of interrelated procedures. However, the timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the Participating Dentist based on the member's needs.
- Processing Policies
- DD's processing policies reflect the data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations.
- However, consistent with HIPAA, DD exercises its right to determine claims reimbursement procedures and requires the processing of such codes in accordance with the following policies, unless prohibited under other applicable law or specific contract provisions.
- Notwithstanding treatment of procedures under DD's processing policies, dentists are required to utilize those procedure codes reflective of services rendered and in accordance with HIPAA. Amounts charged under any procedure shall not be inflated or manipulated in light of DD's processing policies. Please refer to the HIPAA section of this Manual for further information regarding HIPAA.
- DD will reimburse providers using the Iowa Medicaid approved Hawki fee schedule. All providers will be reimbursed on a fee-for-service basis except special provider types such as FQHC and IHCPs.

14.1.1 Federally Qualified Health Centers (FQHC) and Indian Health Programs (IHP)

- These entities will be reimbursed for dental services performed in the FQHC and the IHPs facilities using Hawki fee schedule.
- Each CDT code (service) provided, and the billed charge must be entered on the claim form. The billed charge must be your billed charge amount.
- If no restorative or other treatment services are necessary, all preventive and diagnostic services must be performed on a single date of service. If restorative or other treatment services are necessary, preventive and diagnostic services may be performed on the same date of service as the restorative or other treatment services. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the member's dental record.
- Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same data of service. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the member's dental record.
- Additionally, unless contraindicated, all extractions per quadrant and the contralateral quadrant must be performed on the same date of service. If there are circumstances that do not allow extractions in this manner, the contraindication(s) must be documented in the member's dental record.
- When a procedure is submitted by report and subject to coverage under medical, it should be submitted to the member's medical carrier first. When submitted to DD, a copy of the remittance advice or payment voucher from the medical carrier should be included with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information, the procedure or service will not be Billable to the member.
- When a radiograph is required, the most current radiograph must be provided. Please date and label radiographs. If you are sending radiographs via mail, do not send original radiographs. Send a copy. If you would like the radiograph returned, you must include a postage paid envelope. DD does not return radiographs unless a postage paid envelope is included.
- Frequency limitations apply for all procedures including care delivered under Iowa Medicaid and any additional Hawki Benefit Administrators.

Charges for procedures determined not to be necessary or not meeting generally accepted standards of care may be Denied or are not Billable to the Member. Many of the processing policies that follow detail payment procedures that are based on the timing and sequence of inter-related procedures. However, the timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the Participating Dentist based on the member's needs.

- When a procedure is by report and subject to coverage under medical, it should be submitted to the member's medical carrier first. When submitting to DD, a copy of the explanation of payment or payment voucher from the medical carrier

should be included with the claim, plus a narrative describes the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information, DD will not benefit the procedure.

- The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.
- Phased treatment planning involves using proper sequence to address a member's concerns. Complex treatment plans can be sequenced in phases, including an urgent phase, control phase, re-evaluation phase, definitive phase, and maintenance phase. Proposed treatment can be denied when a phased treatment plan is addressed.

14.1.2 Government Programs Clinical Practice Guidelines

The Government Programs Clinical Practice Guidelines serve as a resource for dental professionals to guide clinical decisions through the incorporation of evidence-based practices. The clinical practice guidelines help optimize the enrollee's care.

1. Guidelines for Oral Cancer from the American Dental Academy https://jada.ada.org/article/S0002-8177(14)60942-9/abstract
2. Guidelines for Periodontal Therapy from the American Academy of Pediatric Dentistry https://www.aapd.org/research/oral-health-policies--recommendations/guideline-for-periodontal-therapy/
3. Guidelines for the use of Fluoride from the American Academy of Pediatric Dentistry https://www.aapd.org/research/oral-health-policies--recommendations/fluoride-therapy/
4. Guidelines for the use of Sealants from the American Academy of Pediatric Dentistry https://www.aapd.org/research/oral-health-policies--recommendations/pit_and_fissure_sealants/
5. Management of Dental Patients With Special Healthcare Needs https://www.aapd.org/research/oral-health-policies--recommendations/management-of-dental-patients-with-special-health-care-needs/
6. Guidelines on Oral Health for People with Diabetes https://diabetes.org/health-wellness/keeping-your-mouth-healthy
7. Guidelines for caries management. https://www.ada.org/resources/research/science/evidence-based-dental-research/caries-management-clinical-practice-guidelines/
8. Guidelines for antibiotics related to dental pain and swelling. https://www.ada.org/resources/research/science/evidence-based-dental-research/antibiotics-for-dental-pain-and-swelling
9. Topical Fluoride for caries management https://www.ada.org/resources/research/science/evidence-based-dental-research/topical-fluoride-clinical-practice-guideline
10. Non Fluoride Caries Preventive Agents https://jada.ada.org/article/S0002-8177(14)62481-8/pdf
11. Guidelines for the Management of Traumatic Dental Injuries: Injuries in the Primary Dentition https://www.aapd.org/globalassets/media/policies_guidelines/e_injuries.pdf

12. Use of Anesthesia Providers in the Administration of Office-based Deep Sedation/General Anesthesia to the Pediatric Dental Patient https://www.aapd.org/globalassets/media/policies_guidelines/bp_anesthesiapersonnel.pdf
13. Guideline on Behavior Guidance for the Pediatric Dental Patient https://www.aapd.org/globalassets/media/policies_guidelines/bp_behavguide.pdf

15 Current Dental Terminology (CDT)

15.1 Exams

Code	Description	Benefit Limits
D0120	Periodic oral evaluation (established member)	Limited to 1 per 6 months. The fees for consultation, diagnosis,and routine treatment planning are considered components ofthe oral evaluation, by the same dentist/dental office.
D0140	Limited oral evaluation – problem focused	Exam code can be used for specific problems and/or urgent and emergent issues, trauma and acute infections.
D0145	Oral evaluation for patient under three years of age	Limited to 1 per 6 months. The fees for consultation, diagnosis,and routine treatment planning are considered components ofthe oral evaluation, by the same dentist/dental office.
D0150	Comprehensive oral evaluation (new or established member)	Limited to 1 per 3 years. The fees for consultation, diagnosis, and routine treatment planning are NOT BILLABLE TO THE PATIENT as components of the fee for the evaluation, by thesame dentist/dental office.
D0160	Detailed and extensive oral evaluation	The fees for re-evaluation are NOT BILLABLE TO THE PATIENT in conjunction with any other service or procedure by the same dentist/dental office.
D0170	Re-evaluation-limited, problem focused (Established member; not post-op visit)	The fees for re-evaluation are NOT BILLABLE TO THE PATIENT in conjunction with any other service or procedure by the same dentist/dental office.
D0171	Re-evaluation post operative office visit	The fees for re-evaluation are NOT BILLABLE TO THE PATIENT in conjunction with any other service or procedure by the same dentist/dental office.
D0180	Comprehensive periodontal evaluation (new or established member)	Limited to 1 per 3 years. The fees for consultation, diagnosis, and routine treatment planning are DENIED as components ofthe fee for the evaluation, by the same dentist/dental office. This evaluation code will be used primarily by a periodontist fora referred member from a general dentist and should not be reported in addition to a comprehensive oral evaluation (D0150) by the same dentist in the same treatment series. This procedure is not intended for use as a separate code for periodontal charting.
D0190	Screening of a patient	

15.1.1 Diagnostic Imaging

a) Fees for duplication (copying) of diagnostic images for insurance purposes are NOT BILLABLE TO THE PATIENT.

b) Images must be of diagnostic quality; properly oriented if submitted for document purposes, and with the date of exposure and a member identifier indicated on all images. Images not of diagnostic quality are NOT BILLABLE TO THE PATIENT.

c) A full mouth radiographic survey, consisting of a minimum of 14 periapical films and bite-wing films or panoramic radiograph with bitewings is a payable service once in a five year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A pantographic-type radiography with bitewings is consider the same as a full mouth radiography survey. When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will NOT BE BILLABLE TO THE PATIENT.

d) When interpretation of a diagnostic image procedure (D0391) is submitted with the capture and interpretation procedures, the fee for the interpretation of a diagnostic image (D0391) will NOT BE BILLABLE TO THE PATIENT.

e) Diagnostic imaging codes (D0210 - D0371) include image capture and interpretation. The fee for interpretation of a diagnostic image by a practitioner not associated with the capture of the image is processed according to contract. In all other instances, the fees for interpretation are NOT BILLABLE TO THE PATIENT.

f) The FDA/ADA 2012 document Selection of Members for Radiographic Examinations provides guidance for when the prescription of a full mouth series of radiographs is appropriate. These guidelines state that radiographs are to be prescribed by dentists only after reviewing the member's health history and completing a clinical examination. Once a decision to obtain radiographs is made, it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the member's exposure to radiation. For most new member encounters in dentate adults, and children or adolescents with transitional or permanent dentition, an individualized radiographic exam is appropriate, usually consisting of selected periapical images, posterior bitewings and a panoramic exam. A full mouth intraoral radiographic exam is usually performed when the member has clinical evidence of generalized dental disease or history of extensive dental

treatment. Table 1. from these guidelines is provided here: http://www.fda.gov/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/ucm116504.htm

Code	Description	Benefit Limits
D0210	Intraoral-complete series radiographic images	Limited to 1 in 5 years. The fee for any type of bitewings submitted with an intraoral- complete series are considered part of the full mouth series for payment and benefit purposes. Bitewings, of any type, are NOT BILLABLE TO THE PATIENT within 12 months of a full mouth series. A separate fee for a panoramic radiographic image (D0330) in conjunction with D0210 by the same dentist/dental office is NOT BILLABLE TO THE PATIENT as a component part of D0210. When bitewings are processed as part of an intraoral complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met within the benefit year. See full mouth series policies for frequency limitations.
D0220	Intraoral-periapical-first radiographic image	See full mouth series policies for frequency limitations.
D0230	Intraoral-periapical-each additional radiographic image	See full mouth series policies for frequency limitations. Routine working and final treatment radiographic images taken by the same dentist/dental office for endodontic therapy are considered a component of the complete treatment procedure. Separate fees for these images are NOT BILLABLE TO THE PATIENT.
D0240	Intraoral-occlusal radiographic image	See full mouth series policies for frequency limitations.
D0250	Extraoral- 2-D projection radiographic image created using a stationary radiation source and detector	See full mouth series policies for frequency limitations.
D0251	Extraoral posterior dental radiographic image	See full mouth series policies for frequency limitations.
D0270	Bitewing-single radiographic image	Limited to 1 per 12 months. See full mouth series policies for frequency limitations.
D0272	Bitewing-two radiographic image	Limited to 1 per 12 months. See full mouth series policies for frequency limitations.

Code	Description	Benefit Limits
D0273	Bitewings- three radiographic images	Limited to 1 per 12 months. See full mouth series policies for frequency limitations.
D0274	Bitewings-four radiographic images	Limited to 1 per 12 months. See full mouth series policies for frequency limitations.
D0330	Panoramic radiographic image	Limited to 1 in 5 years. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings, and/or occlusal radiographic images) is considered a complete series for time limitation purposes. Benefits for subsequent panoramic radiographic images taken within the contractual time limitation for an intraoral complete series are DENIED and the approved amount is collectable from the member.
D0340	2-D Cephalometric radiographic image – acquisition, measurement and analysis	Limited to 1 in 1 year and covered for orthodontics only. A cephalometric radiographic image is payable only in conjunction with orthodontic benefits. The fee for a cephalometric radiographic image taken in conjunction with services other than orthodontic treatment is DENIED.

15.1.2 Tests and Examinations

Code	Description	Benefit Limits
D0460	Pulp vitality tests	Pulp vitality tests are payable per visit, not per tooth, and only forthe diagnosis of emergency conditions. Fees for pulp tests are NOT BILLABLE TO THE PATIENT when performed on the same date by the same dentist/dental office as any other definitive procedure except: limited oral evaluation – problem focused (D0140), protective restoration (D2940), palliative treatment (D9110), radiographic images (D0210 - D0391), andconsultation (D9310).

15.2 Preventive (D1000-D1999)

a) A fee for a prophylaxis done during the same episode of treatment by the same dentist/dental office as a periodontal maintenance, scaling in the presence of generalized moderate or severe gingival inflammation, scaling and root planning or periodontal surgery is considered to be part of those procedures and is NOT BILLABLE TO THE PATIENT.

b) Periodontal maintenance (D4910) is counted toward the frequency limitation for prophylaxis (D1110).

c) Benefits for restorations placed within three months of interim caries arresting medicament applications are fee reduced.

15.2.1 Dental Prophylaxis

Code	Description	Benefit Limits
D1110	Prophylaxis-adult	Limited to 1 per 6 months. When submitted with D4346, the fees for D1110 are NOT BILLABLE TO THE PATIENT by the same dentist/dental office.
D1120	Prophylaxis-child	Limited to 1 per 6 months. When submitted with D4346, the fees forD1120 are NOT BILLABLE TO THE PATIENT by the same dentist/dental office.

15.2.2 Topical Fluoride Treatment (office procedure)

a) Using prophylaxis paste containing fluoride, a fluoride rinse, or fluoride swish in conjunction with a prophylaxis is considered a prophylaxis only and a separate fee for this type of topical fluoride application is NOT BILLABLE TO THE PATIENT.

b) Fluoride gels, rinses, tablets, or other preparations intended for home applications are DENIED and the approved amount is collectable from the member.

Code	Description	Benefit Limits
D1206	Topical fluoride varnish	Two times a year. (1206, 1208) The application of topical fluoride varnish must be delivered on a single visit and involve the entire oral cavity. Benefits for topical fluoride varnish when used for desensitization or as cavity liner are DENIED.
D1208	Topical application of fluoride -excluding varnish	Two times a year. (1206, 1208)

15.2.3 Other Preventive Services

Code	Description	Benefit Limits
D1351	Sealant-per tooth	Limited to 1 in 3 years. A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration and is NOT BILLABLE TO THE PATIENT.

Code	Description	Benefit Limits
		Benefits for repair or replacement of sealants requested after 24 months have elapsed since initial placement are DENIED and the approved amount is collectable from the member.
D1352	Preventive resin restoration in a moderate to high caries risk member	
D1353	Sealant repair – per tooth	Limited to 1 in 3 years and is allowed for at risk molars only. Fees for repairing sealants completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are NOT BILLABLE TO THE PATIENT as a component of the restoration. Benefits to repair sealants are DENIED when submitted documentation or the member's claims history indicates a restoration on the occlusal surface of the same tooth. Fees for repair or replacement of a sealant are NOT BILLABLE TO THE PATIENT if performed within 24 months of initial placement by the same dentist/dental office. Benefits for repairing sealants requested 24 months or more following the initial placement are DENIED.
D1354	Interim caries arresting medicament application – per tooth Allowed twice per tooth per year; processing policiesapply	Limit 2 times per year. Conservative treatment of an active, non-symptomatic carious lesionby topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure. Restorations placed within 90 days of D1354 are reduced by the amount of D1354 if completed by the same dentist/office.

15.3 Space Maintenance (passive appliances)

a) Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

b) The benefits for repair or replacement of a space maintainer are DENIED.

c) Only one space maintainer is provided for a space. Additional appliances are DENIED.

d) Space maintainer fees include all teeth, clasps and rests. Any fee charged more than the approved amount for the appliance by the same dentist/dental office is NOT BILLABLE TO THE PATIENT.

e) Re-cement/re-bond space maintainers- D1551, D1552, D1553 payment only to a provider who did not originally place the appliance. Services provided by the originating provider would include D1510, D1515, D1520, D1525, D1575.

f) Removal of space maintainers- D1556, D1557, D1558 payment only to a provider who did not originally place the appliance. Services provided by the originating provider would include D1510, D1515, D1520, D1525, D1575.

Code	Description	Benefit Limits
D1510	Space maintainer-fixed unilateral	Limited to 1 per quad, per lifetime.
D1516	Space maintainer-fixed-bilateral, maxillary	Limited to 1 per arch per lifetime.
D1517	Space maintainer- fixed-bilateral, mandibular	Limited to 1 per arch per lifetime.
D1520	Space maintainer-removable unilateral	Limited to 1 per quad per lifetime.
D1526	Space maintainer-removable-bilateral, maxillary	Limited to 1 per arch per lifetime.
D1527	Space maintainer-removable- bilateral, mandibular	Limited to 1 per arch per lifetime.
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	The fee for re-cementation or re-bonding by the same dentist/dentaloffice who placed the appliance is NOT BILLABLE TO THE PATIENT. Once per arch per lifetime
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	The fee for re-cementation or re-bonding by the same dentist/dentaloffice who placed the appliance is NOT BILLABLE TO THE PATIENT. Once per arch per lifetime
D1553	Re-cement or re-bond unilateral space maintainer	Limited to 1 per quad, per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.
D1556	Removal of fixed unilateral space maintainer	Limited to 1 per quad, per lifetime. The fee for removal by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.

Code	Description	Benefit Limits
D1557	Removal of fixed bilateral space maintainer – maxillary	The fee for removal by the same dentist/dental office who placedthe appliance is NOT BILLABLE TO THE PATIENT. Once per arch per lifetime
D1558	Removal of fixed bilateral space maintainer – mandibular	The fee for removal by the same dentist/dental office who placedthe appliance is NOT BILLABLE TO THE PATIENT. Once per arch per lifetime
D1999	Unspecified preventive procedure, by report.	A Prior Authorization is required for this procedure.

15.4 Restorative (D2000 – D2999)

a) The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal, and gingivectomy done on the same date of service as the restoration. A separate fee for any of these procedures by the same dentist/dental office is NOT BILLABLE TO THE PATIENT.

b) A fee for the replacement of amalgam or composite restorations, same tooth and same surface(s), is NOT BILLABLE TO THE PATIENT if done by the same dentist/dental office within 24 months of the initial restoration.

c) When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, the allowance is limited to that of a multi-surface restoration. Any fee charged in excess of the allowance for the multi-surface restoration by the same dentist/dental office is NOT BILLABLE TO THE PATIENT. A separate benefit may be allowed for a noncontiguous restoration on the buccal or lingual surface(s) of the same tooth.

d) Any restoration involving two or more contiguous surfaces should be reported using the appropriate multiple surface restoration code.

e) When restorations not involving the occlusal surface are requested or performed on posterior teeth, the allowance is limited to that of a one surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is NOT BILLABLE TO THE PATIENT.

f) Benefits are allowed only once per surface in a 24-month interval, irrespective of the number or combination of procedures requested or performed. A fee for restoration of a surface within 24 months of previous treatment is NOT BILLABLE TO THE PATIENT.

g) Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances.

The completion date for crowns is the cementation date regardless of the type of cement utilized.

h) If an indirectly fabricated restoration is performed by the same dentist/dental office within 24 months of the placement of an amalgam or composite restoration the Delta Dental of Iowa payment and member co-payment allowance for the amalgam or composite restorations will be deducted from the indirectly fabricated restoration benefit.

i) Tooth preparation, temporary restorations, cement bases, impressions, laboratory fees and material, occlusal adjustment, gingivectomies (on the same date of service), and local anesthesia are included in the fee for all restorations, and a separate fee for any of these procedures by the same dentist/dental office is NOT BILLABLE TO THE PATIENT. Fees for buildups, not required for retention are NOT BILLABLE TO THE PATIENT.

j) Benefits for restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic, or other splinting are DENIED.

15.4.1 Definitions

Term	Definition
Attrition	• The frictional wearing of the teeth over time. Severe attrition, due to bruxing may be evident. (Treatment Planning in Dentistry; Mosby 2006).
Abrasion	• Wearing away or notching of the teeth by a mechanical means, such as tooth brushing. (Treatment Planning in Dentistry; Mosby 2006). • The grinding or wearing away of tooth substance by mastication, incorrect brushing methods, bruxism or similar causes. (Mosby's Dental Dictionary). • The abnormal wearing away of a substance or tissue by a mechanical process. (Mosby's Dental Dictionary). • The loss of tooth structure from the mechanical rubbing of teeth by some object or objects (no source) • The act or result of the grinding or wearing away of a substance, such as a tooth worn by mastication, bruxing or tooth brushing. (The Glossary of Operative Dentistry Terms).
Erosion	• The wasting away or loss of substance of a tooth by a chemical process that does not involve known bacterial action. (Treatment Planning in Dentistry; Mosby 2006). • The process and the results of loss of dental hard tissue that is chemically etched away from the tooth surface, by acid and/or chelation, without bacterial involvement. (ten Cate & Imfeld, Eur J Oral Sci 1996; 104:241).
Abfraction	• Pathological loss of tooth structure owing to biomechanical forces (flexion, compression, or tension) or chemical degradation; it is most visible as V-

Term	Definition
	shaped notches in the cervical area of a tooth. (Mosby's Medical Dictionary, 9th edition; 2009 Elsevier)

15.4.2 Amalgam Restorations (including polishing)

Code	Description	Benefit Limits
D2140	Amalgam – one surface, primary orpermanent	Limited to 1 in 24 months.
D2150	Amalgam – two surfaces, primary orpermanent.	Limited to 1 in 24 months
D2160	Amalgam – three surfaces, primary orpermanent	Limited to 1 in 24 months.
D2161	Amalgam – four or more surfaces,primary or permanent	Limited to 1 in 24 months.

15.4.3 Resin-Based Composite Restorations – Direct

In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate.

Code	Description	Benefit Limits
D2330	Resin-based composite – one surface,anterior	Limited to 1 in 24 months.
D2331	Resin-based composite – two surfaces,anterior	Limited to 1 in 24 months.
D2332	Resin-based composite – three surfaces,anterior	Limited to 1 in 24 months.
D2335	Resin-based composite – four or moresurfaces or involving the incisal angle (anterior)	Limited to 1 in 24 months.
D2390	Resin-based composite crown, anterior	Limited to 1 in 24 months.
D2391	Resin – based composite – one surface,posterior	Limited to 1 in 24 months.
D2392	Resin – based composite – two surfaces,posterior	Limited to 1 in 24 months.
D2393	Resin – based composite – three or moresurfaces, posterior	Limited to 1 in 24 months.
D2394	Resin – based composite – four or moresurfaces, posterior	Limited to 1 in 24 months.

15.4.4 Inlay/Outlay Restorations

a) Inlay and Onlay restorations are not a Hawki Benefit.

b) Inlay: An intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusp tips.

c) Onlay: A dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.

15.4.5 Crowns – Single Restorations Only

a) Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point where it cannot be restored by an amalgam or resin restoration.

b) Crowns are payable when there is at least a fair prognosis for maintaining teeth and a more conservative procedure would not be serviceable.

c) A fee reduction will be taken on a permanent crown if a restoration has been paid within 24 months and completed by the same DDS/office. A fee reduction will not be taken if the restoration was completed by a different DDS/office.

d) A fee reduction will be taken on a permanent crown if a stainless steel crown has been paid within 24 months and completed by the same DDS/office. A fee reduction will not be taken if the restoration was completed by a different DDS/office.

15.4.6 Crowns / Veneer for Anterior Teeth

Requests for crowns are considered as stated below:

a) Moderate peripheral tooth structure loss with 1/2 or more of the incisal edge structure lost, (including at least one incisal angle).

b) Severe damage to the peripheral tooth structure where both the mesial and distal proximal area structure loss extends beyond 3mm from the outer tooth surface.

c) Severe damage affecting more than 50% of central tooth structure.

15.4.7 Crowns / Veneer for Anterior Teeth are not Benefited When

a) There is minimal damage to the peripheral tooth structure with small proximal or Class V lesions.

b) Moderate damage to peripheral tooth structure with one incisal angle involved and less than 1/2 of the incisal edge structure is lost.

c) The tooth is treated endodontically, and the access is conservative and there are small proximal lesions.

d) The primary purpose is: cosmetics, alteration of tooth color, alteration of tooth shape and size, or closure of diastema spacing.

15.4.8 Crowns / Onlays for Posterior Teeth

a) Moderate to severe damage to the central core tooth structure, peripheral tooth structure loss is greater than 50% of the tooth surface, with at least one cusp with either no supporting dentin, or the cusp is lost (fractured).

b) Severe damage where central destruction extends into core of tooth. The structure loss is either:

c) Both mesial and distal proximal area structure losses are greater than 3 mm from the outer tooth surface.

d) Either of the proximal areas structure loss is greater than 3 mm and the occlusal structure loss is 1/2 the distance from the occlusal surface to the pulp chamber.

e) Endodontically treated teeth.

f) Cracked tooth syndrome with documented duration of symptoms, differential diagnosis, identification of the cusp involved, and the diagnostic tool used to identify the cracked tooth.

15.4.9 Crowns / Onlays for Posterior Teeth are not Benefited When

a) Minimal damage with small occlusal, proximal and / or facial lesions, or combined occlusal and proximal lesions.

b) Moderate damage where occlusal or proximal lesions extend 1mm past the dentino-enamel junction.

c) Periodontally compromised teeth with poor prognosis or for molars with significant furcation involvement.

15.4.10 Crowns, Onlays, Veneers

a) Crowns / Onlays / Veneers are not benefited that are preventative in nature (i.e., to prevent unpredictable or possible anticipated future fractures or to eliminate crack or craze lines in the absence of pathology).

b) Crowns / Onlays / Veneers are not benefited for primarily cosmetic purposes.

c) Crowns /Onlays /Veneers are not benefited when the primary purpose is for splinting.

d) Crowns / Onlays /Veneers are not benefited to replace tooth structure lost due to wear, attrition, abfraction, abrasion, or erosion.

Code	Description	Benefit Limits
D2710	Crown – resin-based composite(indirect)	Limited to 1 per 5 years; by report only.
D2712	Crown – ¾ resin-based composite(indirect)	Limited to 1 per 5 years; by report only.
D2720	Crown – resin with high noble metal	Limited to 1 per 5 years; by report only.
D2721	Crown – resin with predominantly basemetal	Limited to 1 per 5 years; by report only.
D2740	Crown – porcelain/ceramic	Limited to 1 per 5 years.
D2750	Crown – porcelain fused to high noblemetal	Limited to 1 per 5 years. A Prior Authorization is required for this procedure.
D2751	Crown – porcelain fused to predominantly base metal	Limited to 1 per 5 years.
D2752	Crown – porcelain fused to noble metal	Limited to 1 per 5 years.
D2753	Crown -porcelain fused to titanium and titanium alloys	Limited to 1 per 5 years.
D2781	Crown - ¾ cast predominantly basemetal	Limited to 1 per 5 years; by report only.
D2790	Crown – full cast high noble metal	Limited to 1 per 5 years.
D2780	Crown – ¾ cast high noble metal	Limited to 1 per 5 years.
D2781	Crown - ¾ cast predominantly base metal	Limited to 1 per 5 years.
D2782	Crown – ¾ cast noble metal	Limited to 1 per 5 years.
D2783	Crown – ¾ porcelain/ceramic	Limited to 1 per 5 years.

Code	Description	Benefit Limits
D2790	Crown- full cast high noble metal	Limited to 1 per 5 years.
D2791	Crown – full cast predominantly basemetal	Limited to 1 per 5 years.
D2792	Crown – full cast noble metal	Limited to 1 per 5 years.

15.4.11 Other Restorative Services

a) Delta Dental of Iowa considers the cementation date to be that date upon which the completed or indirectly fabricated post, prefabricated post and core, inlay, onlay, crown, or fixed partial denture is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary).

b) Fees for recementation or rebonding of indirectly fabricated or prefabricated post and cores, inlays, onlays, crowns, and fixed partial dentures are NOT BILLABLE TO THE PATIENT if done within six months of the initial seating date by the same dentist or dental office.

c) Benefits may be paid for one recementation or rebonding after six months have elapsed since initial placement. Subsequent requests for recementation or rebonding by the same provider are DENIED and the approved amount is collectable from the member. Benefits may be paid when billed by a provider other than the one who seated the bridge or performed the previous recementation or rebonding.

d) Post recement or rebond (D2915) and crown recement or rebond (D2920) are not allowed on the same tooth on the same day by the same dentist/dental office. The allowance will be made only for D2920 when D2915 and D2920 are submitted together. The fee for D2915 will NOT BE BILLABLE TO THE PATIENT.

e) Fees for crown, inlay, onlay and veneer repairs are NOT BILLABLE TO THE PATIENT within 24 months of the original restoration.

f) A fee reduction will be taken on a stainless steel crown if a restoration has been paid within 6 months and completed by the same DDS/office. A fee reduction will not be taken if the restoration was completed by a different DDS/office

Code	Description	Benefit Limits
D2910	Recement or rebond inlay, onlay, veneeror partial coverage restoration	Limited to 1 per 24 months.

Code	Description	Benefit Limits
D2915	Recement or rebond indirectly fabricated or prefabricated post andcore	Limited to 1 per 24 months.
D2920	Recement or rebond crown	Limited to 1 per 24 months.
D2921	Reattachment of tooth fragment, incisaledge or cusp	Limited to 1 per 24 months. Fees for the replacement of amalgam or composite restorations or attachment of tooth fragment within 24 months are NOT BILLABLETO THE PATIENT if done by the same dentist/dental office. Benefits may be allowed if done by a different dentist.
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	Limited to 1 per 24 months. A fee for replacement of a prefabricated porcelain/ceramic crown by the same dentist/dental office within 24 months is included in the initial crown placement and is NOT BILLABLE TO THE PATIENT.
D2929	Prefabricated porcelain/ceramic crown – primary tooth	Limited to 1 per 24 months. A fee for replacement of a prefabricated porcelain/ceramic crown bythe same dentist/dental office within 24 months is included in the initial crown placement and is NOT BILLABLE TO THE PATIENT.
D2930	Prefabricated stainless steel crown –primary tooth	Limited to 1 per 24 months. A fee for replacement of a stainless steel crown by the same dentist/dental office within 24 months is included in theinitial crown placement and is NOT BILLABLE TO THE PATIENT.
D2931	Prefabricated stainless steel crown –permanent tooth	Limited to 1 per 24 months. A fee for replacement of a stainless steel crown by the same dentist/dental office within 24 months is included in theinitial crown placement and is NOT BILLABLE TO THE PATIENT.
D2932	Prefabricated resin crown	Limited to 1 per 24 months. A fee for replacement of a stainless steel crown by the same dentist/dental office within 24 months is included in theinitial crown placement and is NOT BILLABLE TO THE PATIENT.
D2933	Prefabricated stainless steel crown withresin window	Limited to 1 per 24 months. A fee for replacement of a stainless steel crown by the same dentist/dental office within 24 months is included in theinitial crown placement and is NOT BILLABLE TO THE PATIENT.

Code	Description	Benefit Limits
D2934	Prefabricated esthetic coated stainlesssteel crown – primary tooth	Limited to 1 per 24 months. A fee for replacement of a stainless steel crown by the same dentist/dental office within 24 months is included in theinitial crown placement and is NOT BILLABLE TO THE PATIENT.
D2940	Protective restoration	Limited to 1 per 24 months; by report only. Protective restorations are a benefit for emergency relief of pain. Afee for a replacement of a protective restoration by the same dentist/dental office within 24 months, same tooth, is NOT BILLABLE TO THE PATIENT. A separate fee for protective restoration is NOT BILLABLE TO THE PATIENT when performed in conjunction with a definitive restorationor endodontic access closure by the same dentist/dental office. This procedure is NOT BILLABLE TO THE PATIENT when submittedwith any restorative codes D2000-D2999, bridge codes D6200- D6699, or endodontic codes D3220-D3330, D3346-D3353, D3410- D3450 and extraction codes D7111-D7251.
D2950	Core buildup, including any pins whenrequired	Limited to 1 per 5 years. Substructures are a benefit only when necessary to retain an indirectly fabricated restoration due to extensive loss of toothstructure from caries or fracture. The procedure should not be reported when the procedure onlyinvolves a filler to eliminate any undercut, box form, or concave irregularity in the preparation. Fees for buildups not required for retention are NOT BILLABLE TO THE PATIENT. A separate fee for a buildup is NOT BILLABLE TO THE PATIENTwhen radiographs indicate sufficient tooth structure remains to support an indirectly fabricated restoration.
D2951	Pin retention-per tooth, in addition torestoration	Limited to 1 per tooth, per lifetime. Pin retention is a benefit once per tooth when necessary on a permanent tooth and when completed at the same appointment. Fees for additional pins on the same tooth by the same dentist/dental office are NOT BILLABLE TO THE PATIENT as acomponent of the initial pin placement.

Code	Description	Benefit Limits
		A fee for pin retention when billed in conjunction with a buildup by the same dentist/dental office is NOT BILLABLE TO THE PATIENT as a component of the buildup procedure.
D2952	Post and core in addition to crown,indirectly fabricated	Limited to 1 per 5 years. An indirectly fabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for an indirectly fabricated post and core is NOT BILLABLE TO THE PATIENT when radiographs indicate an absence of endodontic treatment and incompletely filled canal space. Unresolved radiolucencies may be a reason for the fee to be NOT BILLABLE TO THE PATIENT but will be evaluated based on the time since the completion of the endodontic service and co-joint signs and symptoms. An indirectly fabricated post and core in anterior teeth isa benefit only when there is insufficient tooth structure to support a cast restoration.
D2953	Each additional indirectly fabricated post; same tooth	Limited to 1 per 5 years. An indirectly fabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for an indirectly fabricated post and core is NOT BILLABLE TO THE PATIENT when radiographs indicate an absence of endodontic treatment and incompletely filled canal space.
D2954	Prefabricated post and core in addition to crown	Limited to 1 per 5 years. A prefabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for a prefabricated postand core is NOT BILLABLE TO THE PATIENT when radiographs indicate an absence of endodontic treatment and incompletely filledcanal space. A prefabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast restoration.
D2971	Additional procedures to construct new crown under existing partial dentureframework	A Prior Authorization is required for this procedure.
D2976	band stabilization	Once per tooth per lifetime.
D2980	Crown repair, necessitated byrestorative material failure	Fees for a crown repair completed on the same date of service as anew crown are NOT BILLABLE TO THE PATIENT.

Code	Description	Benefit Limits
D2999	Unspecified restorative procedure, byreport	A Prior Authorization is required for this procedure.

15.5 Endodontics

a) Most endodontic procedures require a pre and post obturation radiograph and narrative explaining the clinical need for the service.

b) Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are NOT BILLABLE TO THE PATIENT as included in the fees for the retreatment.

15.5.1 Pulpotomy

Code	Description	Benefit Limits
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal tothe dentinocemental junction and application of medicament.	Limited to 1 per tooth per lifetime.
D3221	Pulpal debridement, primary andpermanent teeth	Limited to 1 per tooth per lifetime. The fee for gross pulpal debridement is NOT BILLABLE TO THE PATIENT when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office. This willnot be paid as phase 1 of a 2 phase root canal process. When the final endo therapy (3310, 3320, 3330) is completed within 60 days (by the same DDS/clinic) of debridement (3221), and narrative supports the 3221 was the start of endo, a fee reduction will occur.
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete rootdevelopment	Limited to 1 per tooth per lifetime. The fee for D3222 when performed within 30 days/same tooth/samedentist/same dental office as root canal therapy or codes D3351- D3353 is NOT BILLABLE TO THE PATIENT. The fee for partial pulpotomy for apexogenesis is NOT BILLABLE TO

Code	Description	Benefit Limits
		THE PATIENT when endodontic treatment is completed on the sametooth on the same day by the same dentist/dental office.
D3310	Anterior root canal (excluding final restoration)	Limited to 1 per tooth per lifetime.
D3320	Bicuspid root canal (excluding final restoration)	Limited to 1 per tooth per lifetime.
D3330	Molar root canal (excluding final restoration)	Limited to 1 per tooth per lifetime. A separate fee for palliative treatment is NOT BILLABLE TO THE PATIENT when done in conjunction with root canal therapy by the same dentist/dental office on the same date of service. Incompletely filled root canals are not a benefit and the fee for the endodontic therapy is NOT BILLABLE TO THE PATIENT.
D3331	Treatment of root canal obstruction; non-surgical access	Limited to 1 per tooth per lifetime.
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Limited to 1 per tooth per lifetime.
D3333	Internal root repair of perforation defects	Limited to 1 per tooth per lifetime.

15.5.2 Endodontic Therapy

Including treatment plan, clinical procedures, and follow-up care.

a) The fee for a root canal includes all radiographic images during treatment and temporary restorations. Any additional fee charged by the same dentist/dental office is NOT BILLABLE TO THE PATIENT.

b) When a radiographic image indicates obturation of an endodontically treated tooth has been performed without the use of a biologically acceptable nonresorbable semisolid or solid core material, fees for the endodontic therapy and/or restoration of the tooth are NOT BILLABLE TO THE PATIENT.

c) The completion date for endodontic therapy is the date that the canals are permanently filled.

d) Difficult removal of broken instrument or posts by a different dentist/dental office is subject to individual consideration.

15.5.3 Endodontic Retreatment

a) Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are NOT BILLABLE TO THE PATIENT as included in the fees for the retreatment.

b) The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within 24 months of initial treatment is NOT BILLABLE TO THE PATIENT as a component of the fee for the original procedure.

Code	Description	Benefit Limits
D3346	Retreatment of previous root canaltherapy – anterior	Limited to 1 per lifetime per tooth.
D3347	Retreatment of previous root canaltherapy - premolar	Limited to 1 per lifetime per tooth.
D3348	Retreatment of previous root canaltherapy – molar	Limited to 1 per lifetime per tooth.

15.5.4 Apexification/Recalcification

Code	Description	Benefit Limits
D3351	Apexification / recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Limited to 1 per lifetime per tooth. Apexification is eligible for benefits on permanent teeth withincomplete root development or for repair of a perforation.
D3352	Apexification / recalcification - interim medication replacement	Limited to 1 per lifetime per tooth.
D3353	Apexification / recalcification - final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)	Limited to 1 per lifetime per tooth. Apexification / recalcification - final visit benefits are administered asthe same processing policies as D3310, D3320, or D3330 (dependingon tooth type) and any fee charged in excess of the approved amount for the D3310, D3320, or D3330 (depending on the tooth type) is NOT BILLABLE TO THE PATIENT.

15.5.5 Apicoectomy/Periradicular Services

a) The fee for biopsy of oral tissue is NOT BILLABLE TO THE PATIENT as included in the fee for a surgical procedure (e.g. apicoectomy) when performed in the

same location and on the same date of service by the same dentist/dental office.

Code	Description	Benefit Limits
D3410	Apicoectomy – anterior	Limited to 1 per lifetime per tooth.
D3421	Apicoectomy - premolar (first root)	Limited to 1 per lifetime per tooth.
D3425	Apicoectomy - molar (first root)	Limited to 1 per lifetime per tooth.
D3426	Apicoectomy (each additional root)	Limited to 1 per lifetime per tooth.
D3430	Retrograde filling- per root	Limited to 1 per lifetime per tooth.
D3450	Root amputation - per root	Limited to 1 per lifetime per tooth. A separate fee for root amputation is NOT BILLABLE TO THE PATIENT when performed in conjunction with an apicoectomy bythe same dentist/dental office.
D3470	Intentional Reimplantation	Limited to 1 per lifetime per tooth.
D3471	Surgical repair of root resorption-anterior	Limited to 1 per lifetime per tooth. NOT BILLABLE TO THE PATIENT when performed on the same toothby the same dentist/dental office on the same date as apicoectomy (D3410-D3426), retrograde filling (D3430), and root amputation (D3450).
D3472	Surgical repair of root resorption-premolar	Limited to 1 per lifetime per tooth. NOT BILLABLE TO THE PATIENT when performed on the same toothby the same dentist/dental office on the same date as apicoectomy (D3410-D3426), retrograde filling (D3430), and root amputation (D3450).
D3473	Surgical repair of root resorption-molar	Limited to 1 per lifetime per tooth. NOT BILLABLE TO THE PATIENT when performed on the same toothby the same dentist/dental office on the same date as apicoectomy (D3410-D3426), retrograde filling (D3430), and root amputation (D3450).
D3501	Surgical exposure of root surface without apicoectomy or repair of rootresorption-anterior	Limited to 1 per lifetime per tooth

Code	Description	Benefit Limits
D3502	Surgical exposure of root surface without apicoectomy or repair of rootresorption-premolar	Limited to 1 per lifetime per tooth
D3503	Surgical exposure of root surface without apicoectomy or repair of rootresorption – molar	Limited to 1 per lifetime per tooth
D3910	Surgical procedure for isolation of tooth with rubber dam	Limited to 1 per lifetime per tooth
D3921	Decoronation or submergence of an erupted white	Limited to 1 per lifetime per tooth

15.5.6 Other Endodontic Procedures

Code	Description	Benefit Limits
D3999	Unspecified endodontic procedure, byreport	A Prior Authorization is required for this procedure.

15.6 Periodontics (D4000 – D4999)

a) When more than one surgical procedure is provided on the same teeth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

b) The fee for the following services: D1110, D1120, D4346, D4355, and/or D4910 may NOT BE BILLABLE TO THE PATIENT if the services are rendered by the same dentist/dental office within 30 days to the most recent scaling and root planing (D4341, D4342) or other periodontal therapy.

c) Fees for the included procedures are NOT BILLABLE TO THE PATIENT by a participating dentist/dental office. These inter-related services include but are not limited to the following hierarchy: D4260 (most inclusive), D4261, D4249, D4245, D4268, D4240, D4241, D4274, 4210, D4211, D4341, D4342, D4346, D4910, D1110, D4355 (least inclusive)

d) The fee for biopsy (D7285, D7286), frenulectomy (D7960) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are NOT BILLABLE TO THE PATIENT when the procedures are by the same dentist/dental office performed on the same date, same surgical site/area, and any other surgical procedure.

e) Laser disinfection is a technique, not a procedure. Fees for laser disinfection are NOT BILLABLE TO THE PATIENT.

f) Periodontal charting is considered as part of the oral evaluation (D0120, D0150, D0160, D0180). If periodontal evaluation and oral evaluation are billed on the same date of service the fee for the oral evaluation (D0120, D0150, D0160) is a benefit and the fee for the periodontal evaluation is NOT BILLABLE TO THE PATIENT.

g) The following categorizes procedures for reporting and adjudicating by quadrant, site or individual tooth in order to enhance standard benefits determination and expedite claims processing.

h) Radiographs must show loss of alveolar crest height beyond the normal 1-1.5 millimeter distance to the cement-enamel junction (CEJ). Note: panoramic radiographs per American Academy of Periodontology have limited value in the diagnosis of periodontal disease.

i) Prior to periodontal surgery, a waiting period of a minimum of four weeks should typically follow periodontal scaling and root planing to allow for healing and re-evaluating and to assess tissue response.

15.6.1 Surgical Services

Including Usual Postoperative Care.

a) A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4346, D4355, D4910), evaluations, or other surgical procedures (except soft tissue grafts) on the same date of service or for three months following the initial periodontal surgery in relation to both natural teeth and implants by the same dentist/dental office is NOT BILLABLE TO THE PATIENT. In the absence of documentation of extraordinary circumstances, the fee for additional surgery or for any surgical re-entry (except soft tissue grafts) by the same dentist/dental office for three years is NOT BILLABLE TO THE PATIENT. If extraordinary circumstances are present the benefits could be considered for coverage.

b) If periodontal surgery is performed less than four weeks after scaling and root planing, the fee for the surgical procedure or the scaling and root planing may NOT BE BILLABLE TO THE PATIENT, pending consultant review.

c) Periodontally involved teeth which would qualify for surgical pocket reduction benefits under these procedure codes (D4210, D4211, D4240, D4241, D4260, D4261) must be documented to have at least 5 mm pocket depths. If pocket depths are under 5 mm, then benefits are DENIED.

d) Benefits for periodontal surgical services are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc. are DENIED as a specialized or elective procedure.

e) Providing more than two D4245, D4265, D4266, D4267, D4268, D4270, D4273, D4275, D4276, D4277, D4278, D6101,D6102, or osseous grafts (D4263,D4264, D6103) within any given quadrant should be highly unusual and additional submissions will only be considered on a by report basis. Requested fees for more than two sites in a quadrant may NOT BE BILLABLE TO THE PATIENT. When documentation of exceptional circumstances is submitted, benefits may be considered.

Code	Description	Benefit Limits
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 per quadrant per 24 months. A Prior Authorization is required for this procedure.
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 per quadrant per 24 months. A separate fee for gingivectomy or gingivoplasty - per tooth - is NOTBILLABLE TO THE PATIENT when performed in conjunction with thepreparation of a crown or other restoration by the same dentist/dental office. Only diseased teeth/periodontium are eligible for benefit consideration. Bounded tooth spaces are not counted as the procedure does not require a flap extension. A Prior Authorization is required for this procedure.
D4212	Gingivectomy or gingivoplasty – to allow access for restorative procedures – per tooth	Limited to 1 per quadrant per 24 months. A separate fee for any gingivectomy or gingivoplasty procedure - per tooth is NOT BILLABLE TO THE PATIENT when performed in conjunction with the preparation of a crown or other restoration bythe same dentist/dental office. A Prior Authorization is required for this procedure to beconsidered.
D4240	Gingival flap procedure, including root planing – four or more contiguous teethor tooth bounded spaces per quadrant	Limited to 1 per quadrant per 24 months. A Prior Authorization is required for this procedure.
D4241	Gingival flap procedure, including root planing -	Limited to 1 per quadrant per 24 months.

Code	Description	Benefit Limits
	one to three contiguous teeth,or tooth bounded spaces per quadrant	Benefits are based upon, but not limited to, the most inclusive procedure. A tooth bounded space counts as one space irrespectiveof the number of teeth that would normally exist in the space. Only diseased teeth/periodontium are eligible for benefit consideration. A Prior Authorization is required for this procedure.
D4245	Apically positioned flap	Limited to 1 per quadrant per 24 months. Benefits are based upon, but not limited to, the most inclusiveprocedure. A Prior Authorization is required for this procedure.
D4249	Clinical crown lengthening - hard tissue	Limited to 1 per quadrant per 24 months. A separate fee for crown lengthening is NOT BILLABLE TO THE PATIENT when performed in conjunction with osseous surgery onthe same teeth by the same dentist/dental office. Crown lengthening is a benefit per site, not per tooth, when adjacentteeth are included. This procedure is carried out to expose sound tooth structure by removal of bone before restorative or prosthodontic procedures. It is not generally provided in the presence of periodontal disease. This is only a benefit when bone is removed and sufficient time is allowed for healing. The fees for crown lengthening are NOT BILLABLE TO THE PATIENT when performed on the same date asthe final restoration placement. A Prior Authorization is required for this procedure.
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four ormore contiguous teeth or tooth bounded spaces per quadrant.	Limited to 1 per quadrant per 24 months. A Prior Authorization is required for this procedure.
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one tothree contiguous teeth, or tooth bounded spaces per quadrant.	Limited to 1 per quadrant per 24 months. No more than two quadrants of osseous surgery on the same date ofservice are benefitted. For benefit purposes, the fee for osseous surgery includes crown lengthening, osseous contouring, distal or proximal wedge surgery,scaling and root planing, gingivectomy, frenectomy, frenuloplasty, debridements, periodontal maintenance,

Code	Description	Benefit Limits
		prophylaxis, anatomical crown exposure, surgical drainage and flap procedures. A separate fee for any of these procedures done on the same date, in the samesurgical area by the same dentist/dental office as D4260, is NOT BILLABLE TO THE PATIENT. A separate benefit may be available for soft tissue grafts, bone replacement grafts, guided tissue regeneration, biologic materials with demonstrated efficacy in aiding periodontal tissue regeneration, exostosis removal, hemisection, extraction, apicoectomy, root amputations. A Prior Authorization is required for this procedure.
D4263	Bone replacement graft – retainednatural tooth first site in quadrant	Limited to 1 per quadrant per 24 months. Bone replacement grafts are DENIED when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisectionsor with extractions. A Prior Authorization is required for this procedure.
D4264	Bone replacement graft – retained natural tooth, each additional site in quadrant	Limited to 1 per quadrant per 24 months. Bone replacement grafts are DENIED when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisectionsor with extractions. A Prior Authorization is required for this procedure.
D4265	Biologic materials to aid in soft andosseous tissue regeneration	Limited to 1 per quadrant per 24 months. Biologic materials may be eligible for stand-alone benefits whenreported with periodontal flap surgery and only when billed for natural teeth and performed for periodontal purposes. Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery,etc. are DENIED as a specialized or elective procedure. When submitted with a D4263, D4264, D4267, D4270, D4273, D4275, D4276, or D6103 in the same surgical site, the fee for the D4265 isDENIED. When a D4265 is submitted with an extraction or

Code	Description	Benefit Limits
		periradicular surgery, the D4265 is DENIED and the approved amount is collectable from the member. A Prior Authorization is required for this procedure.
D4268	Surgical revision procedure, per tooth	Limited to 1 per lifetime.
D4270	Pedicle soft tissue graft procedure	Limited to 1 per quadrant per 24 months. When multiple grafts are provided within a single quadrant, a maximum of two natural teeth are benefitted unless extraordinary circumstances are documented. A Prior Authorization is required for this procedure.
D4273	Autogenous connective tissue graft procedures, (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Limited to 2 per quadrant per 24 months. Benefits for GTR, in conjunction with soft tissue grafts in the same surgical area, are NOT BILLABLE TO THE PATIENT. A Prior Authorization is required for this procedure.
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Limited to 2 per quadrant per 24 months. D4275 may be eligible for benefit consideration in lieu of D4265, D4266, D4267, D4270, D4273, D4276, D4277 and D4278. Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are NOT BILLABLE TO THE PATIENT when performed in conjunction with D4275 or D4276. A Prior Authorization is required for this procedure.
D4276	Combined connective tissue and double pedicle graft per tooth	Limited to 1 per quadrant per 24 months. This procedure may be eligible for consideration in lieu of D4265, D4266, D4267, D4270, D4273, D4275, D4277 or D4278 under dentist consultant review based upon documentation of clinical conditions (Miller Class III). When multiple teeth are grafted within a single quadrant, a maximum of two natural teeth are benefitted unless extraordinary circumstances are documented. Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are NOT BILLABLE TO THE PATIENT when performed in conjunction with D4275 or D4276. A Prior Authorization is required for this procedure.

Code	Description	Benefit Limits
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) - first tooth, implant or edentulous tooth site in graft	Limited to 2 per quadrant per 24 months. When multiple grafts are provided within a single quadrant, amaximum of two teeth are benefitted unless extraordinary circumstances are documented. Benefits for GTR and or bone grafts, in conjunction with soft tissuegrafts in the same surgical area, are DENIED. Fees for a frenulectomy D7960 or frenuplasty D7963 are NOT BILLABLE TO THE PATIENT when performed in conjunction withsoft tissue grafts contiguous tooth position in same graft site). A Prior Authorization is required for this procedure.
D4278	Free soft tissue graft procedure (including recipient and donor sites) –each additional contiguous tooth position in same graft site	Limited to 2 per quadrant per 24 months. When multiple grafts are provided within a single quadrant, amaximum of two teeth are benefitted unless extraordinary circumstances are documented. Benefits for GTR and or bone grafts, in conjunction with soft tissuegrafts in the same surgical area, are DENIED. Fees for a frenulectomy D7960 or frenuplasty D7963 are NOT BILLABLE TO THE PATIENT when performed in conjunction withsoft tissue grafts contiguous tooth position in same graft site. A Prior Authorization is required for this procedure.
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additionalcontiguous tooth, implant or edentuloustooth position in same graft site	Limited to 2 per quadrant per 24 months. Benefits for GTR and or bone grafts, in conjunction with soft tissuegrafts in the same surgical area, are NOT BILLABLE TO THE PATIENT. Fees for a frenulectomy D7960 or frenuplasty D7963 are NOT BILLABLE TO THE PATIENT when performed in conjunction withsoft tissue grafts contiguous tooth position in same graft site. A Prior Authorization is required for this procedure.
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position	Limited to 2 per quadrant per 24 months. Benefits for GTR and or bone grafts, in conjunction with soft tissuegrafts in the same surgical area, are NOT BILLABLE TO THE PATIENT. Fees for a frenulectomy D7960 or frenuplasty D7963 are NOT BILLABLE TO THE PATIENT when performed in conjunction withsoft tissue grafts

Code	Description	Benefit Limits
	in same graft site	contiguous tooth position in same graft site). A Prior Authorization is required for this procedure.
D4286	Removal of non-resorbable barrier	A Prior Authorization is required for this procedure.
D4341	Periodontal scaling and root planing -four or more teeth or spaces per quadrant	Limited to 1 per quadrant per 24 months. There must be documentation of alveolar bone and clinical attachment loss and at least 4mm pocket depths on the diseasedteeth/periodontium involved. In the absence of bone loss, clinical attachment and 4mm pockets, D4341 is processed as prophylaxis(D1110) and any fee in excess of the approved amount for D1110 isNOT BILLABLE TO THE PATIENT. Adult prophylaxis procedures (D1110, D4910), full mouth scaling (D4346) or debridement (D4355) are considered a component whensubmitted on the same date of service as D4341. Fees for the prophylaxis procedure by the same dentist/dental office are NOT BILLABLE TO THE PATIENT. The fee for retreatment within 24 months of initial therapy is NOTBILLABLE TO THE PATIENT. A fee reduction will apply to D4341 when performed within 24 months in the same quadrant, by the same dentist/office as D4342. If performed by a different dentist/office, the once in 24 month frequency will apply. A separate fee for D4341 billed in conjunction with (30 days prior or90 days following) periodontal surgery procedures by the same dentist/dental office is NOT BILLABLE TO THE PATIENT as a component of the surgical procedure. A Prior Authorization is required for this procedure.
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant Move this over to under the benefit limits	Limited to 1 per quadrant per 24 months. There must be documentation of alveolar bone and clinical attachment loss and at least 4mm pocket depths on the diseased teeth/periodontium involved. In the absence of 4mm pocket and alveolar bone and clinical attachment loss, D4342 is processed as prophylaxis (D1110) and any fee in excess of the approved amountfor D1110 is NOT BILLABLE TO THE PATIENT.

Code	Description	Benefit Limits
		Adult prophylaxis procedures (D1110, D4910), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4342. Fees for the prophylaxis procedure by the same dentist/dental office are NOT BILLABLE TO THE PATIENT.
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	Limited to 1 per 6 months. Benefits for D4346 include prophylaxis, fees for D1110, D1120 or D4355 are NOT BILLABLE TO THE PATIENT when submitted with D4346 by the same dentist/dental office. Fees for D4346 are NOT BILLABLE TO THE PATIENT when submitted with D4910 by the same dentist/dental office.
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	The procedure can be benefitted once every 24 months if there are no D1110, D4341, D4342, D4346, D4910 during the previous 24 months. A D4355 may be benefitted in order to do a proper evaluation and diagnosis if the member has not been to the dentist in several years and the dentist is unable to accomplish an effective prophylaxis under normal conditions. D4355 is NOT BILLABLE TO THE PATIENT in conjunction with a prophylaxis or any periodontal treatment.

15.6.2 Other Periodontal Services

Code	Description	Benefit Limits
D4910	Periodontal maintenance	Limited to once every 3 months following qualifying definitive periodontal procedure. A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations, or other surgical procedures (except soft tissue grafts) on the same date of service or for three months following the initial periodontal surgery by the same dentist/dental office is NOT BILLABLE TO THE PATIENT.
D4920	Unscheduled dressing change (by someone other than the treating dentist)	The definition of the same dentist includes dentists and staff in the same dental office. A fee for dressing change performed by the same dentist or staff in the same dental office is NOT BILLABLE TO THE PATIENT within 30 days following the surgical procedure.

Code	Description	Benefit Limits
D4921	Gingival irrigation with medicinal agent, per quadrant	
D4999	Unspecified periodontal procedure, by report	A Prior Authorization is required for this procedure.

15.7 Prosthodontics (D5000 – D5899)

a) Characterizations, staining, overdentures, or metal bases are considered specialized techniques or procedures and are NOT BILLABLE TO THE PATIENT.

b) The fees for full or partial dentures include any reline/rebase, adjustment or repair required within six months of delivery are NOT BILLABLE TO THE PATIENT when done by the same dentist/office.

c) Benefits may be DENIED and the approved amount is collectable from the member if repair or replacement within contractual time limitations is the member's fault.

d) The benefits for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED.

e) The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures by the same dentist/dental office are NOT BILLABLE TO THE PATIENT.

f) Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

g) If replacement is required, please include narrative.

h) One replacement for removable dentures (only) in the five (5) year period can be requested.

i) Partial denture benefits are available for the replacement of anterior teeth.

j) Partial denture benefits are also available for the replacement of posterior teeth when there are fewer than eight posterior teeth in occlusion or when required to balance the posterior occlusion.

15.7.1 Complete Dentures

Including routine post-delivery care.

a) When a member meets criteria for both an anterior fixed partial denture (bridge) and a removable partial denture in the same arch, both will not be allowed. In these cases, the removable partial denture will be benefitted, and the bridge denied.

Code	Description	Benefit Limits
D5110	Complete denture, maxillary	Limited to 1 per 5 years.
D5120	Complete denture, mandibular	Limited to 1 per 5 years.
D5130	Immediate denture, maxillary	Limited to 1 per 5 years.
D5140	Immediate denture, mandibular	Limited to 1 per 5 years.

15.7.2 Partial Dentures

Including routine post-delivery care.

Code	Description	Benefit Limits
D5211	Maxillary partial denture-resin base (including retentive/clasping materials,rests, and teeth)	Limited to 1 per 5 years per arch.
D5212	Mandibular partial denture-resin base (including retentive/ clasping materials,rests, and teeth)	Limited to 1 per 5 years per arch.
D5213	Maxillary partial denture-cast metal framework with resin denture bases (including retentive/clasping materials,rests, and teeth)	Limited to 1 per 5 years per arch.
D5214	Mandibular partial denture- cast metal framework with resin denture bases (including	Limited to 1 per 5 years per arch.

Code	Description	Benefit Limits
	retentive/clasping materials,rests, and teeth)	
D5225	Maxillary partial denture – flexible base(including any clasps, rests, and teeth)	Limited to 1 per 5 years per arch.
D5226	Mandibular partial denture – flexible base (including any clasps, rests, and teeth)	Limited to 1 per 5 years per arch.

15.7.3 Adjustments to Dentures

a) The fees for full or partial dentures include any adjustments or repairs required within six months of delivery. If performed by the same dentist/dental office within six months of initial placement, fees for adjustments or repairs are NOT BILLABLE TO THE PATIENT. If performed by a different office, fees for adjustments or repairs are DENIED.

b) The fees for adjustments to partials/dentures are limited to two adjustments, repairs, tissue conditioning, or rebase, per denture per twelve months (after six months has elapsed since initial placement).

Code	Description	Benefit Limits
D5410	Adjust complete denture – maxillary	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery
D5411	Adjust complete denture - mandibular	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery
D5421	Adjust partial denture – maxillary	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery
D5422	Adjust partial denture - mandibular	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery

15.7.4 Repairs to Complete Dentures

a) The fees for full or partial dentures include any adjustments or repairs required within six months of delivery.

Code	Description	Benefit Limits
D5511	Repair broken complete denture base,mandibular	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. Fees of complete dentures, if performed within six months of initial placement by the same dentist/dental office are NOT BILLABLE TOTHE PATIENT.

Code	Description	Benefit Limits
D5512	Repair broken complete denture base,maxillary	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. If performed within six months of initial placement by the same dentist/dental office are NOT BILLABLE TOTHE PATIENT.
D5520	Replace missing or broken teeth-complete denture (each tooth)	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery

15.7.5 Repairs to Partial Dentures

a) The fees for full or partial dentures include any adjustments or repairs required within six months of delivery.

Code	Description	Benefit Limits
D5611	Repair resin partial denture base,mandibular	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office areNOT BILLABLE TO THE PATIENT.
D5612	Repair resin partial denture base,maxillary	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office areNOT BILLABLE TO THE PATIENT.
D5621	Repair cast framework, mandibular	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office areNOT BILLABLE TO THE PATIENT.
D5622	Repair cast partial framework, maxillary	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office areNOT BILLABLE TO THE PATIENT.
D5630	Repair or replace broken retentiveclasping materials- per tooth	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery
D5640	Replace broken teeth-per tooth	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery

Code	Description	Benefit Limits
D5650	Add tooth to existing partial denture	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery
D5660	Add clasp to existing partial denture –per tooth	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	

15.7.6 Denture Rebase Procedures

a) The fee for the rebase includes the fee for relining. When the fee for a reline performed in conjunction with rebase (within six months of) by the same dentist/dental office the fee for the reline is NOT BILLABLE TO THE PATIENT.

b) The fee for a rebase includes adjustments required within six months of delivery. A fee for an adjustment performed within six months of a reline or rebase by the same dentist/dental office is NOT BILLABLE TO THE PATIENT.

Code	Description	Benefit Limits
D5710	Rebase complete maxillary denture	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. A Prior Authorization is required for this procedure.
D5711	Rebase complete mandibular denture	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. A Prior Authorization is required for this procedure.
D5720	Rebase maxillary partial denture	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. A Prior Authorization is required for this procedure.
D5721	Rebase mandibular partial denture	Limited to 2 repairs/adjustments per arch, per year; after 6 monthsof denture delivery. A Prior Authorization is required for this procedure.

15.7.7 Denture Reline Procedures

a) The fee for a reline includes adjustments required within six months of delivery. A fee for an adjustment billed within six months of a reline by the same dentist/dental office is NOT BILLABLE TO THE PATIENT.

b) The fee for the rebase includes the fee for relining. The fee for a reline performed in conjunction with (within six months of) a rebase by the same dentist/dental office is NOT BILLABLE TO THE PATIENT.

Code	Description	Benefit Limits
D5730	Reline complete maxillary denture (chairside)	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.
D5731	Reline complete mandibular denture (chairside)	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.
D5740	Reline maxillary partial denture (chairside)	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.
D5741	Reline mandibular partial denture (chairside)	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.
D5750	Reline complete maxillary denture (laboratory)	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.
D5751	Reline complete mandibular denture (laboratory)	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.
D5760	Reline maxillary partial denture (laboratory)	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.
D5761	Reline mandibular partial denture (laboratory)	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.
D5765	Soft liner for complete or partial removable denture-indirect	Limited to 1 reline per arch every 12 months, starting 6 months after denture delivery.

15.7.8 Other Removable Prosthetic Services

Code	Description	Benefit Limits
D5850	Tissue conditioning, maxillary	Limited to 2 repairs per arch, per 12 months, starting 6 months after denture delivery. A separate fee for tissue conditioning is NOT BILLABLE TO THE PATIENT if performed by the same dentist/dental office on the same day the denture is delivered or a reline/rebase is provided. Tissue conditioning/denture adjustments/repair are allowed twice per denture unit per year. Additional tissue conditioning/denture adjustments/repair is DENIED.
D5851	Tissue conditioning, mandibular	Limited to 2 repairs per arch, per 12 months, starting 6 months after denture delivery. A separate fee for tissue conditioning is NOT BILLABLE TO THE PATIENT if performed by the

Code	Description	Benefit Limits
		same dentist/dental office on the same day the denture is delivered or a reline/rebase is provided. Tissue conditioning/denture adjustments/repair are allowed twice per denture unit per year. Additional tissue conditioning/denture adjustments/repair is DENIED.
D5862	Precision attachment, by report	A Prior Authorization is required for this procedure.

15.7.9 Implant Supported Prosthetics

a) Benefits for the placement of an implant to natural tooth bridge are DENIED. Special consideration may be given by report particularly where there is documentation of semi-ridged fixation between the tooth and implant and where other risk factors are not present.

b) Prior authorization dental implants and related services, when prior authorization has been received, shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

c) Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

Code	Description	Benefit Limits
D6065	Implant supported porcelain/ceramic crown	A Prior Authorization is required for this procedure.

15.8 Prosthodontics, Fixed (D6200 – D6999)

a) A fixed partial denture replacing posterior teeth requires prior approval. Approval shall be granted for members who meet the criteria for a removable denture and have a physical or mental condition that precludes the use of a removable partial denture or have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

b) Benefits will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth.

c) The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries, laboratory charges and materials, and other associated procedures. Any fees charged for these procedures by the same dentist/dental office in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures are NOT BILLABLE TO THE PATIENT.

d) Cementation date is the delivery date. The type of cement used is not a determining factor (whether permanent or temporary).

e) The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED and the approved amount is collectable from the member.

f) Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

g) Fixed partial denture prosthetic procedures include the routine use of temporary prosthetics during the time for normal laboratory fabrication of the completed prosthesis. Interim or provisional appliances are NOT BILLABLE TO THE PATIENT when reported less than six months.

h) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who: have a physical or mental condition that precludes the use of a removable partial denture or have a bridge that needs replacement due to breakage or extensive, recurrent decay.

i) High noble metals shall be approved only when the member is allergic to all other restorative materials.

15.8.1 Fixed Partial Denture Pontics

Code	Description	Benefit Limits
D6241	Pontic-porcelain fused to predominantlybase metal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.

Code	Description	Benefit Limits
D6242	Pontic-porcelain fused to noble metal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6243	Pontic-porcelain fused to titanium andtitanium alloys .	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6245	Pontic-porcelain/ceramic	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure..

15.8.2 Fixed Partial Denture Retainers – Inlays/Onlays

Code	Description	Benefit Limits
D6545	Retainer-cast metal for resin bondedfixed prosthesis	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.

15.8.3 Fixed Partial Denture Retainers Crown

Code	Description	Benefit Limits
D6740	Retainer crown-porcelain/ceramic	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6750	Retainer crown-porcelain fused to highnoble metal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6751	Retainer crown-porcelain fused topredominantly base metal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6752	Retainer crown-porcelain fused to noblemetal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure..
D6753	Retainer crown-porcelain fused totitanium and titanium alloys	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6780	Retainer crown-¾- cast high noble metal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6781	Retainer crown-¾- predominantly base metal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6782	Retainer crown-¾- noble metal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.

Code	Description	Benefit Limits
D6783	Retainer crown-¾-porcelain/ceramic	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6784	Retainer crown- ¾-titanium andtitanium alloys	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6790	Retainer crown-full cast high noblemetal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6791	Retainer crown-full cast predominantlybase metal	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.
D6792	Retainer crown-full cast noble metal.	Limited to 1 fixed or removable denture per 5 years, per arch. A prior authorization is required for this procedure.

15.8.4 Other Fixed Partial Denture Services

Code	Description	Benefit Limits
D6920	Connector bar	Limited to 1 per arch per 5 years. A Prior Authorization is required for this procedure.
D6930	Recement or rebond fixed partialdenture	Limited to 1 per tooth per 24 months. Delta Dental of Iowa considers the cementation date to be that dateupon which the completed bridge is first delivered to the mouth. The type of cement used is not a determining factor. Fees for recementation or rebonding of inlays, onlays, crowns, and fixed partial dentures are NOT BILLABLE TO THE PATIENT if done within six months of the initial seating date by the same dentist/dental office. Benefits may be paid for one recementation orrebonding after six months have elapsed since initial placement. Subsequent requests for recementation or rebond by the same dentist/dental office are DENIED and the approved amount is collectable from the member. Benefits may be paid when billed by aprovider other than the one who seated the bridge or performed the previous recementation or rebonding.
D6940	Stress breaker	Limited to 1 fixed or removable denture per 5 years, per arch.A Prior Authorization is required for this procedure.

Code	Description	Benefit Limits
D6950	Precision attachment	Limited to 1 fixed or removable denture per 5 years, per arch.A Prior Authorization is required for this procedure.
D6980	Fixed partial denture repair necessitated by restorative material failure	Limit 1 per 24 months. The fee for the repair of a fixed partial denture cannot exceed one- half of the fee for a new appliance, and any fee charged in excess of the allowance by the same dentist/dental office is NOT BILLABLETO THE PATIENT.

15.9 Oral and Maxiollfacial Surgery (D7000 – D7999)

a) The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine postoperative care, including treatment of dry sockets. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are NOT BILLABLE TO THE PATIENT.

b) Fees for exploratory surgery or unsuccessful attempts at extractions are NOT BILLABLE TO THE PATIENT

c) Impaction codes are based on the anatomical position of the tooth, rather than the surgical procedure necessary for removal.

d) The fees for biopsy (D7285, D7286), frenulectomy (D7960), frenuloplasty (D7963) and excision of hard and soft tissue lesions (D7411, D7450, D7451) are NOT BILLABLE TO THE PATIENT when the procedure is performed on the same day, same surgical site/area, by the same dentist/dental office and any other surgical procedure. Requests for individual consideration can always be submitted by report for dental consultant review.

15.9.1 Extractions

Includes local anesthesia, suturing if needed, and routine postoperative care.

Code	Description	Benefit Limits
D7111	Extraction, coronal remnants - primarytooth	Limit 1 per tooth per lifetime. D7111 is considered part of any other primary surgery in the same surgical area on the same date and the fee is NOT BILLABLE TO THE PATIENT if performed by the same dentist/dental office.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Limit 1 per tooth per lifetime

15.9.2 Surgical Extractions

Includes local anesthesia, suturing if needed, and routine postoperative care.

Code	Description	Benefit Limits
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated.	Limit 1 per tooth per lifetime
D7220	Removal of impacted tooth - soft tissue	Limit 1 per tooth per lifetime
D7230	Removal of impacted tooth - partially bony	Limit 1 per tooth per lifetime
D7240	Removal of impacted tooth - completely bony	Limit 1 per tooth per lifetime
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Limit 1 per tooth per lifetime
D7250	Removal of residual tooth roots (cutting procedure)	Limit 1 per tooth per lifetime. Includes cutting of soft tissue and bone, removal of tooth structure and closure. The fee for root recovery is NOT BILLABLE TO THE PATIENT if submitted in conjunction with a surgical extraction (in the same surgical area) by the same dentist/dental office.

15.9.3 Other Surgical Procedures

Code	Description	Benefit Limits
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	D7270 includes anesthesia, suturing, postoperative care and removal of the splint by the same dentist/dental office.
D7280	Exposure of an unerupted tooth	D7280 may be considered under orthodontic benefits by dental consultant review. A Prior Authorization is required for this procedure.
D7282	Mobilization of erupted or malpositioned teeth to aid eruption	The fee for D7282 is NOT BILLABLE TO THE PATIENT when performed by the same dentist/dental office in conjunction with other surgery in immediate area.

Code	Description	Benefit Limits
D7283	Placement of device to facilitateeruption of impacted tooth	A Prior Authorization is required for this procedure.
D7284	Excisional biopsy of minor salivary glands	By report.
D7285	Incisional biopsy of oral tissue - hard(bone, tooth)	A fee for biopsy of oral tissue is NOT BILLABLE TO THE PATIENT if not submitted with a pathology report. Biopsy of oral tissue is only benefitted for oral structures.
D7286	Incisional biopsy of oral tissue - soft (allothers)	A fee for biopsy of oral tissue is NOT BILLABLE TO THE PATIENT ifnot submitted with a pathology report. Biopsy of oral tissue is only benefitted for oral structures.
D7287	Exfoliative cytological sample collection	By report.
D7288	Brush biopsy - transepithelial sample collection	By report.
D7291	Transeptal fiberotomy/supra crestal fiberotomy, by report	By report.

15.9.4 Alveoloplasty-Preparation of Ridge for Dentures

a) A quadrant for oral surgery purposes is defined as four or more continuous teeth and/or teeth spaces distal to the midline.

b) Extractions, by CDT definition, include smoothing of bone.

c) The reimbursement for surgical extraction includes alveoloplasty. Claim Submission Requirement: Include a panoramic radiograph and a narrative explaining why the alveoloplasty is required and why it is more than normal bone smoothing as part of an extraction.

Code	Description	Benefit Limits
D7310	Alveoloplasty in conjunction with extractions- four or more teeth or toothspaces per quadrant	Limit 1 per quadrant per lifetime.
D7311	Alveoloplasty in conjunction with extractions – one to three	Limit 1 per quadrant per lifetime.

Code	Description	Benefit Limits
	teeth or toothspaces per quadrant	A tooth bounded space counts as one space irrespective of thenumber of teeth that would normally exist in the space.
D7320	Alveoloplasty not in conjunction with extractions- four or more teeth or toothspaces per quadrant	Limit 1 per quadrant per lifetime. A Prior Authorization is required for this procedure.
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or toothspaces per quadrant	Limit 1 per quadrant per lifetime. Count tooth bounded spaces for D7321 partial quadrant code. A tooth bounded space counts as onespace irrespective of the number of teeth that would normally existin the space. A Prior Authorization is required for this procedure.

15.9.5 Excision of Intra-Osseous Lesions

a) Pathology laboratory report is required. If no report is submitted, the fee for the procedure is NOT BILLABLE TO THE PATIENT.

b) The fee for D7450 and D7451 is NOT BILLABLE TO THE PATIENT as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/dental office.

Code	Description	Benefit Limits
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Pathology laboratory report is required. If not, report is submitted,the fee for this procedure is not billable to the patient. A Prior Authorization is required for this procedure.
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	Pathology laboratory report is required. If not, report is submitted,the fee for this procedure is not billable to the patient. A Prior Authorization is required for this procedure.

15.9.6 Excision of Bone Tissue

Code	Description	Benefit Limits
D7471	Removal of lateral exostosis (maxilla or mandible) This needs to be under the benefit limits	Pathology laboratory report is required. If not, report is submitted,the fee for this procedure is not billable to the patient. A Prior Authorization is required for this procedure.

Code	Description	Benefit Limits
D7472	Removal of torus palatinus	Pathology laboratory report is required. If not, report is submitted,the fee for this procedure is not billable to the patient. A Prior Authorization is required for this procedure.
D7473	Removal of torus mandibularis L this needs to be under the benefit limits	Pathology laboratory report is required. If not, report is submitted,the fee for this procedure is not billable to the patient. A Prior Authorization is required for this procedure.
D7485	Reduction of osseous tuberosity this needs to be under the limits	Pathology laboratory report is required. If not, report is submitted,the fee for this procedure is not billable to the patient. A Prior Authorization is required for this procedure.

15.9.7 Surgical Incision

a) Procedures D7530-D7560 require a pathology report.

Code	Description	Benefit Limits
D7509	Marsupialization of odontogenic cyst	By report. Prior Authorization required.
D7510	Incision and drainage of abscess -intraoral soft tissue	By report.
D7511	Incision and drainage of abscess- intraoral soft tissue – complicated (includes drainage of multiple fascialspaces)	By report.
D7530	Removal of foreign body from mucosa,skin, or subcutaneous alveolar tissue	By report.

15.9.8 Repair of Traumatic Wounds

a) Repair of traumatic wounds is limited to oral structures.

Code	Description	Benefit Limits
D7910	Suture of recent small wounds up to 5cm	By report.

15.9.9 Complicated Suturing

Reconstruction requiring delicate handling of tissues and wideundermining for meticulous closure

a) Complicated suturing is limited to oral structures.

Code	Description	Benefit Limits
D7911	Complicated suture - up to 5 cm	By report.
D7912	Complicated suture - greater than 5 cm	By report.
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	By report.
D7961	Buccal/labial frenectomy (frenulectomy)	Limit 1 per arch, per lifetime. A separate fee for frenulectomy is NOT BILLABLE TO THE PATIENTwhen billed in conjunction with any other surgical procedure(s) in the same surgical area, by the same dentist/dental office.
D7962	Lingual frenectomy (frenulectomy)	Limit 1 per arch, per lifetime. A separate fee for frenulectomy is NOT BILLABLE TO THE PATIENTwhen billed in conjunction with any other surgical procedure(s) in the same surgical area, by the same dentist/dental office.
D7963	Frenuloplasty	Limit 1 per arch, per lifetime. A separate fee for frenuloplasty is NOT BILLABLE TO THE PATIENTwhen billed in conjunction with any other surgical procedure(s) in the same surgical area by the same dentist/dental office. A Prior Authorization is required for this procedure to be considered.
D7970	Excision of hyperplastic tissue - per arch	Limit 1 per arch, per lifetime. The fee for excision of hyperplastic tissue is NOT BILLABLE TO THE PATIENT when billed in conjunction with other surgical procedure(s)in the same surgical area by the same dentist/dental office. A Prior Authorization is required for this procedure to be considered.
D7971	Excision of pericoronal gingiva	Limit 1 per quad, per lifetime. The fee for excision of pericoronal gingiva is NOT BILLABLE TO THEPATIENT when billed in conjunction with other surgical procedure(s)in

Code	Description	Benefit Limits
		the same surgical area by the same dentist/dental office. A Prior Authorization is required for this procedure to be considered.
D7999	Unspecified oral surgery procedure, by report	A Prior Authorization is required for this procedure to be considered.

15.10 Orthodontics (D8000 – D8999)

a) Surgical procedures should be reported separately under the appropriate procedure codes.

b) Orthodontic services are a medically necessary service for members 0 through 20 years old and requires a prior authorization.

c) A request for prior approval must be accompanied by:

d) An interpreted cephalometric radiograph and either a full series of radiographs or panoramic film.

e) Study models trimmed so that the models simulate centric occlusion of the member when the models are placed on their heels.

f) Limited orthodontic treatment should be used with:

g) Orthodontic treatment with a limited objective, not necessarily involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

h) Interceptive orthodontic treatment should be used with:

i) Interceptive orthodontics is an extension of preventive orthodontics including localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of dental crossbite, or recovery of space loss where overall space is adequate. When initiated during the incipient stages of a developing problem interceptive orthodontics may reduce the severity of the malformation and mitigate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require subsequent comprehensive therapy.

j) Comprehensive orthodontic treatment should be used with:

k) Comprehensive orthodontic care includes a coordinated diagnosis and treatment leading to the improvement of the member's craniofacial dysfunction and/or dentofacial deformity which may include anatomical,

functional and/or aesthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing members. Adjunctive procedures, to facilitate care may be required. Comprehensive orthodontics may incorporate several phases focusing on specific objectives at various stages of dentofacial development.

15.10.1 Limited Orthodontic Treatment

Code	Description	Benefit Limits
D8020	Limited orthodontic treatment of transitional dentition	A Prior Authorization is required for this procedure.

15.10.2 Comprehensive Orthodontic Treatment

Code	Description	Benefit Limits
D8070	Comprehensive orthodontic treatment of the transitional dentition	A Prior Authorization is required for this procedure.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	A Prior Authorization is required for this procedure.

15.10.3 Minor Treatment to Control Harmful Habits

Code	Description	Benefit Limits
D8210	Removable appliance therapy	A Prior Authorization is required for this procedure.
D8220	Fixed appliance therapy	A Prior Authorization is required for this procedure.

15.10.4 Other Orthodontic Services

Code	Description	Benefit Limits
D8660	Pre-orthodontic treatment examination to monitor growth and development.	This procedure code is used for diagnostic procedures (radiographs, films, photographs, casts, etc.)
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)	A Prior Authorization is required for this procedure.
D8701	Repair of fixed retainer, includes reattachments-maxillary	Limited to one per lifetime per arch.

Code	Description	Benefit Limits
D8702	Repair of fixed retainer, includes reattachments-mandibular	Limited to one per lifetime per arch.
D8703	Replacement of lost or broken retainer – maxillary	Limited to one per lifetime per arch.
D8704	Replacement of lost or broken retainer – mandibular	Limited to one per lifetime per arch.
D8999	Unspecified Orthodontic procedure, by report	This code is used for transfer cases. A Prior Authorization is required for this procedure.

15.11 Adjunctive General Services (D9000 – D999)

Unclassified Treatment

Code	Description	Benefit Limits
D9110	Palliative (emergency) treatment of dental pain-minor procedures	The fee for palliative treatment is NOT BILLABLE TO THE PATIENT when any other definitive treatment is performed on the same date by the same dentist/dental office. Limited radiographic images (D0210-D0391) and tests necessary to diagnose emergency conditions are considered separately. Palliative treatment is a benefit on a per visit basis, once on the same date, and includes all procedures necessary for the relief of pain. Evaluation is not considered as the relief of pain. A separate fee for palliative treatment is NOT BILLABLE TO THE PATIENT when billed on the same date as root canal therapy by the same dentist/dental office.

15.11.1 Anesthesia

Code	Description	Benefit Limits
D9222	Deep sedation/general anesthesia – first 15 minutes	Deep sedation/general anesthesia is a benefit only when administered; 1. With appropriate monitoring by a properly licensed provider who is acting in compliance with applicable State rules and regulations. 2. In conjunction with oral surgical procedures (D7000- D7999) when covered, or when necessary, due to concurrent medical conditions.

Code	Description	Benefit Limits
		A maximum of 1 hour of anesthesia (CDT D9223, D9243) will bebenefited on one date of service. Providers shall round 1 to 7 minutes down to zero units and round 8 to 14 minutes up to 1 unit. Otherwise, the benefit for deep sedation/general anesthesia isDENIED.
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	A maximum of 1 hour of anesthesia (CDT D9223, D9243) will bebenefited on one date of service. Additional increments beyond 1 hour will only be considered on a “byreport” basis with documentation of exceptional circumstances. Deep sedation/general anesthesia is a benefit only when administered; 1. With appropriate monitoring by a properly licensed provider who is acting in compliance with applicable State rules and regulations. 2. In conjunction with oral surgical procedures (D7000- D7999) when covered, or when necessary, due to concurrent medicalconditions. Providers shall round 1 to 7 minutes down to zero units and round 8 to 14 minutes up to 1 unit. Otherwise, the benefit for deep sedation/general anesthesia is DENIED. The benefit for deep sedation/general anesthesia is DENIED when billed by anyone other than an appropriately licensed and qualified provider.
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered; 1. In a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who isacting in compliance with applicable rules and regulations, and 2. In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary, due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious)sedation/analgesia is DENIED.

Code	Description	Benefit Limits
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	A maximum of 1 hour anesthesia (CDT 9223, D9243) will be benefited on one date of service. Additional increments beyond 1 hour will only be considered on a "by report" basis with documentation of exceptional circumstances. Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered; 1. In a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who is acting in compliance with applicable rules and regulations, and 2. In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious) sedation/analgesia is DENIED. The benefit for intravenous moderate (conscious) sedation/analgesia is DENIED when billed by anyone other than an appropriately licensed and qualified dentist.

15.11.2 Professional Consultation

Code	Description	Benefit Limits
D9310	Consultation (diagnostic service provided by dentist or physician otherthan requesting dentist or physician.)	Limit 1 per 12 months per dentist/office. A separate fee for a consultation is NOT BILLABLE TO THE PATIENTwhen billed in conjunction with an examination/evaluation by the same dentist/dental office. The benefit for a consultation in connection with non-coveredservices is DENIED. Consultation (D9310) may benefit when the service is provided by a dentist whose opinion or advice regarding an evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic ortherapeutic services.

15.11.3 Miscellaneous Services

Code	Description	Benefit Limits
D9995	Teledentistry – synchronous; real-time encounter	Covered code that is non-reimbursable that is used to identify location of services and/or special circumstances.
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review.	Covered code that is non-reimbursable that is used to identify location of services and/or special circumstances.
D9999	Unspecified adjunctive procedure, by report	A Prior Authorization is required for this procedure.