PROVIDER OFFICE REFERENCE MANUAL

CALIFORNIA DENTAL MANAGED CARE

Effective July 1, 2025

DentaQuest, Benefits Provided by California Dental Network
PO Box 2906
Milwaukee, WI 53201-2906

www.dentaquest.com/en/providers/california

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SECTION 1. INTRODUCTION

DENTAQUEST INFORMATION

Welcome to the DentaQuest network of Participating Providers. We take great pride in our extensive network of qualified dental professionals, who provide both general and specialized treatments, ensuring comprehensive access for our members.

The purpose of this Office Reference Manual (ORM) is to be a resource to assist each Participating Provider and their staff in understanding the administration of DentaQuest benefit plans as well as information regarding DentaQuest's standard policies. Please be advised that this manual serves as a summary of certain terms from the Provider Agreement between you (or the contracting dental office/facility) and DentaQuest; additional terms and conditions of the Provider Agreement are also applicable. In the event of any conflict between the provisions of this manual and those of the Provider Agreement, the terms of the Provider Agreement shall take precedence. In all cases, specific group contract provisions, limitations and exclusions take precedence. A fully executed copy of your Provider Agreement will be provided to you upon activation in DentaQuest's network; however, you may also request a copy at any time by contacting us at CAproviders@dentaquest.com.

DentaQuest will not deny contracting with, or payment to, any eligible dental office for covered services solely based on that office's good faith communication or advocacy on behalf of prospective, current, or former patients regarding the provisions, terms, or requirements of the member's DentaQuest benefit plan. Primary Care Providers (PCPs) include general dentists and pediatric dentists. Specialty providers include endodontists, oral surgeons, orthodontists, periodontists and prosthodontists.

To ensure you have the most up-to-date information, please access updates to the Office Reference Manual by logging into the Provider Portal at: Provider.dentaquest.com

Note: DentaQuest Reserves the right to add, delete or change the policies and procedures described in this reference guide at any time.

OUR MISSION

DentaQuest is dedicated to improving the oral health of all through purpose-driven, outcomes-based solutions.

CALIFORNIA PROVIDER CONTACT AND INFORMATION GUIDE

DentaQuest provides 24/7 real-time access to important information and tools through our secure online Provider Portal Providers.dentaquest.com.

Please visit Providers.dentaquest.com to create your account.

Other important phone numbers and contact information can be found on the next page.

Important Phone Number and Contact Information

DentaQuest California Office Address:

23291 Mill Creek Dr Ste 100, Laguna Hills, CA 92653

California Provider & Member Services:

DentaQuest:

Los Angeles County: 855-388-6257

Sacramento County: 833-479-1984

HealthNet:

Los Angeles County: 844-233-4522

Sacramento County: 833-493-0428

General TTY/TDD Number:

800-466-7566 (711)

Fraud Hotline:

800-237-9139

Compliance Hotline:

866-737-3559

Medi-Cal Dental's Fraud Hotline:

(800) 822-6222

Credentialing:

California Dental Network

PO Box 2182

Milwaukee, WI 53201-2182

Fax: 262-241-7401

Credentialing Hotline:

800-233-1468

Authorizations (Paper) Requests:

DentaQuest – UM Department

PO Box 2182

Milwaukee, WI 53201-2182

Electronic Authorizations:

Direct entry on the web – Providers.dentaquest.com

Non-Emergent Review Fax:

262-834-3589

ER Review Fax Line:

262-834-3589

Claims (Paper) Requests:

DentaQuest – Claims

PO Box 2182

Milwaukee, WI 53201-2182

Electronic Claims should be sent:

Direct entry on the web – Providers.dentaquest.com

Or

Via Clearinghouse – Payor ID CX014

Include address on electronic claims –

California Dental Network

PO Box 2182

Milwaukee, WI 53201-2182

Short Procedure Unit (SPU) for review of Operating Room (OR) cases:

DentaQuest - SPU Department

PO Box 2182

Milwaukee, WI 53201-2182

Fax line: 262-834-3589

Provider Appeals:

DentaQuest – Provider Appeals

PO Box 2182

Milwaukee, WI 53201-2182

GENERAL INFORMATION

This Office Reference Manual serves as an addendum to the Provider Agreement. Providers, upon entering into the full credentialing process, are provided direction on obtaining the Office Reference Manual (ORM) via print (free of charge) and also through our portal. During the onboarding process providers are coached on where to find the clinical information, claims submission process, recredentialing process, benefit information and all other critical needs as described here in the manual. In addition, DentaQuest has multiple on the ground representatives that are in the field weekly to assist them in the usage of this distribution. Providers - if you are in need of a new ORM or education, please utilize one of the below forums:

1. Contact their local Provider Engagement Representative
2. Email CAproviders@dentaquest.com
3. Contact the DentaQuest Provider & Member Services Center at
   DentaQuest:
   Los Angeles County: 855-388-6257

Sacramento County: 833-479-1984

HealthNet:
Los Angeles County: 844-233-4522
Sacramento County: 833-493-0428

4. Visit the Provider Portal at Providers.dentaquest.com
   This manual requires all providers to adhere to DentaQuest's Quality Improvement Oral Health Access Transformation (QIOHAT) Program Policies and Procedures.

DentaQuest maintains two separate and distinct files for each provider. The first is the provider's quality improvement file, which is maintained with restricted access by the Quality Management Department. This file includes confidential credentialing information. The second file is the provider's facility file which is maintained by the Provider Engagement Department and also includes audit results. The latter contains copies of signed agreements, addenda, and related business correspondence.

DentaQuest's team of Provider Partners are responsible for recruiting, contracting, servicing, and maintaining our network of Providers. We encourage our Providers to communicate directly with their designated Provider Partner to assist with the following:

- DentaQuest Plan Contracting
- Claim Payment Issues
- Education on DentaQuest Members and Benefits
- Opening, Changing, or Closing a Location
- Adding or Terminating Associates
- Credentialing Inquiries
- Change in Name or Ownership
- Federal ID/Taxpayer Identification Number (TIN) Change

Keeping your contact information updated is essential for ensuring appropriate access to care for our members. DentaQuest is committed to monitor impact on our network dental practices and member's ability to access care.

DentaQuest conducts surveys each quarter to ensure you are providing timely access to appointments and that your demographic information is up to date in our system. Remember, most up-to-date information is important to us, but more significantly it impacts our members.

It is essential that DentaQuest maintains an accurate provider database in order to ensure proper payment of claims, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members.

Any limitations to or changes in daily operations, including scheduling and available services; and the extent to which the office may be available for services, should be reported to DentaQuest immediately. Optimum patient care, especially during periods of crisis, requires accurate and prompt communication from our partners.

Any changes should be reported to DentaQuest by completing our Provider Update Form, found on Dentaquest.com and sending by fax to 262-241-4077 or via e-mail to Standardupdates@greatdentalplans.com. To ensure that your information is displayed accurately, please submit all changes within thirty (30) calendar days. See Section 6 for more information on how to access forms within the provider portal.

SECTION 2: PROGRAM OVERVIEW

CALIFORNIA MEDI-CAL DENTAL MANAGED CARE

DentaQuest serves as the dental benefits administrator for the Sacramento Geographic Managed Care (GMC) and Los Angeles Pre-Paid Health Plan (PHP) Medi-Cal Dental Managed Care (DMC). Additionally, DentaQuest administers the dental benefits for HealthNet Dental GMC and PHP Medi-Cal Dental plans. Your office can gain immediate access to the Department of Health Care Services (DHCS) Medi-Cal DMC Provider Handbook, specifically Section 5 – Manual of Criteria (MOC), at: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

MEDI-CAL (Medicaid) DENTAL BENEFITS

Reference the sections below for additional guidance on Provider Billing Practice and Non-Covered Services.

Medi-Cal members cannot be charged for covered services, broken appointments, and canceled appointments. Medi-Cal members cannot be charged for non-covered services, unless the member has been properly informed of all non-covered services, and your office has obtained an adequate informed consent form signed by the member consenting to treatment and accepting financial responsibility.

An adequate informed consent form must state that the services are not covered, include the procedure code and description, the cost of the services, and the member's signature, indicating they understand that the services are not covered and agree to be financially responsible for the costs.

Your office may use your own informed consent forms, that meet the criteria above, or you can use the DentaQuest forms that are available on our provider portal. See Section 6 for more information.

PROVIDER BILLING PRACTICE

Medi-Cal dental providers and dental offices must verify Medi-Cal eligibility before providing any covered or non-covered services. California law prohibits dental providers and offices from billing Medi-Cal members as private pay patients to circumvent claim submissions, prior authorization, or other program requirements once eligibility has been confirmed.

Once a member's Medi-Cal eligibility is verified, they cannot be billed or charged for any portion of a Medi-Cal covered service. Additionally, dental providers and offices are not permitted to bill members for private insurance cost-sharing amounts, such as

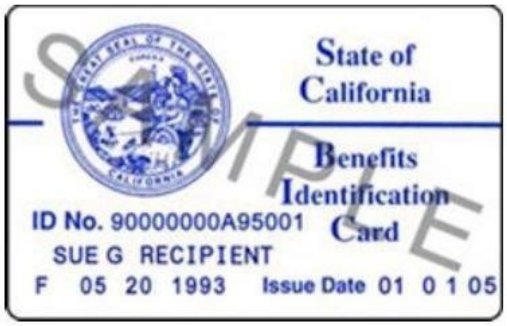
deductibles, coinsurance, or copayments.

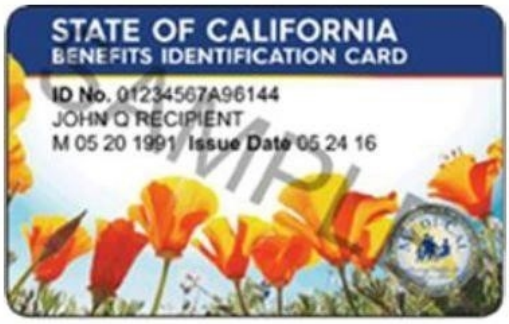
Medi-Cal dental providers and offices may enter into a private payment agreement with a member only under the following conditions:

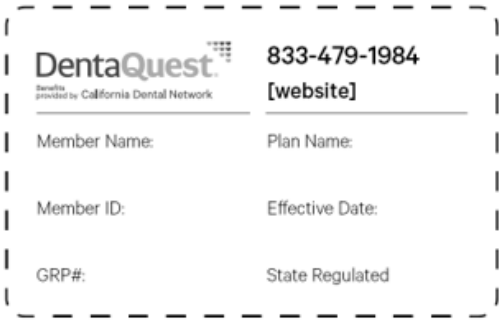
1. The provider and member agree that the specific dental treatment falls outside the benefits provided by Medi-Cal DMC. In this case, the provider has not verified the member's eligibility or submitted any requests for a pre-estimate or claim payment for this phase of treatment.
2. The provider has submitted a request for a pre-estimate or claim payment for a specific dental procedure that was denied because it was either not covered under Medi-Cal DMC or did not meet the medical necessity criteria or time and frequency limitations for the procedure.

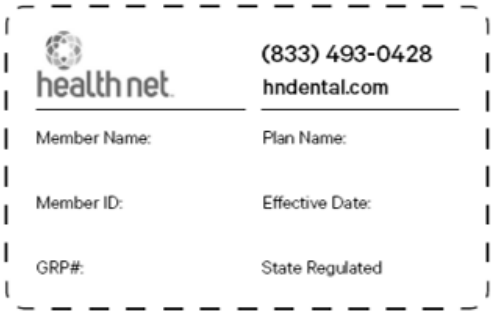
MEMBER IDENTIFICATION CARD

Members will receive a dental plan ID card. They are required to show their dental plan ID card and their Medi-Cal Benefits Identification Card (BIC) when they arrive at your office for services. Here are sample BIC and dental plan ID cards so that you know what they will look like:









DentaQuest recommends that each dental office make a photocopy of the member's identification card each time treatment is provided. An identification card in itself does not guarantee that a person is currently enrolled and active in the health plan.

Participating providers may access member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Provider portal. The eligibility information received from either system will be the same information you

would receive by calling DentaQuest's provider services department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Provider Services Representative.

To access the IVR, simply call DentaQuest's Provider Services number and press 2 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Provider Services Representative to answer any additional questions, i.e. Member history, which you may have.

Directions for using DentaQuest's IVR to verify eligibility:
Entering system with Tax and Location ID's

1. Call DentaQuest Provider Services Department.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the member's ID have numbers and letters in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have only numbers? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history, or get fax confirmation of your call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 for each Member.

If you are having difficulty accessing either the IVR or website, please contact the Provider Services Department at 1 (877) 468-5581. They will be able to assist you in utilizing either system.

NON-COVERED SERVICES

Before recommending or providing any non-covered services, members must receive a comprehensive explanation of the treatment plan options available as covered benefits under Medi-Cal DMC.

Dental providers and offices may not use administrative or quality-of-care denials to determine that a procedure is not a covered benefit or service. Any services denied for technical or administrative reasons cannot be billed to, or charged to, Medi-Cal members under any circumstances.

Dental providers and offices cannot require Medi-Cal members to pay out of pocket for non-covered benefits or services as a condition for receiving covered benefits or

services.

Participating Providers shall hold members, DentaQuest, Plan and Agency harmless for the payment of non-covered services except as provided in this paragraph. Provider may bill a member for non-covered services if the provider obtains a written waiver from the member prior to rendering such service that indicates:

- The service to be provided
- DentaQuest, Plan and Agency will not pay for or be liable for said services; and
- Member will be financially liable for such services

A recommend member consent form can be found on the DentaQuest Provider Web Portal.

CALIFORNIA ADVANCE AND INNOVATING MEDI-CAL (CALAIM) ORAL HEALTH INITIATIVES

There are three oral health initiatives for Medi-Cal providers.

1. Pay-for-Performance (P4P): To improve oral health through increasing the utilization of preventive dental care services. Under this initiative, Medi-Cal providers will continue to qualify for bonuses as a P4P initiative and be able to offer additional covered services to their patients. Select eligible preventive procedure codes for P4P payments at an enhanced rate can be found on the DHCS bulletin. DHCS Bulletin – Volume 37, Number 24: Special Provider Bulletin November 2021 (ca.gov)
2. Additional Benefits: The initiative adds two statewide oral health benefits.
    - The Caries Risk Assessment (CRA) bundle (D0601/D0602/D0603/D1310) and Silver Diamine Fluoride (SDF) (D1354) are two new benefits added to promote a risk-based utilization of preventive services.
    - Treating Young Kids Everyday (TYKE) training:
    - All rending dental providers must complete the training to be eligible for reimbursement for the CRA Bundle. To complete training register via the link: https://www.cda.org/Home/Education/Learning/TYKE- Program.
    - Upon completion of the training please submit the certificate to the email address: CAproviders@dentaquest.com
    - Any provider who has previously taken the TYKE training will need to submit certificates issued to the following email address: CAproviders@dentaquest.com
3. The CalAIM initiative is to establish a dental home for all members by scheduling and providing follow-up on recall exams to increase patients' return to your office year after year for continuity of care and improved dental outcomes.

SECTION 3: ENROLLMENT REQUIREMENTS

CREDENTIALING/RE-CREDENTIALING

Every plan requires that DentaQuest credential providers. DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines and plan requirements.

DentaQuest has the sole right to determine which dentists (DDS or DMD) it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of Participating Providers. DentaQuest considers each Provider's potential contribution to the objective of providing effective and efficient dental services to Members of the Plan.

Nothing in this Credentialing Plan limits DentaQuest's sole discretion to accept and discipline Participating Providers. No portion of this Credentialing Plan limits DentaQuest's right to permit restricted participation by a dental office or DentaQuest's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement, instead of this Credentialing Plan. The Plan has the final decision-making power regarding network participation. DentaQuest will notify the Plan of all disciplinary actions enacted upon Participating Providers.

Appeal of Credentialing Committee Recommendations (Policy CA_QM.050.01)

If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

The applicant must request a reconsideration/appeal in writing and the request must be received by DentaQuest within 30 days of the date the Committee gave notice of its decision to the applicant.

Discipline of Providers (Policy CA_QM.050.01)

Procedures for Discipline and Termination (Policy CA_QM.050.01)

Recredentialing

Network Providers are re-credentialed at least every 36 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Provider Services Department at Los Angeles County: 855-388-6257 and Sacramento County: 833-479-1984 or via e-mail at CAproviders@dentaquest.com. All provider credentials are continually monitored and updated on an ongoing basis.

ANESTHESIA PERMITS

California law mandates that all general dentists, specialists, and anesthesiologists must be contracted as Medi-Cal providers and maintain active permits and endorsements for the type of sedation administered, which must be on file with the Dental Board of California.

General Anesthesia/Deep Sedation:

1. General Anesthesia permit for dental patients aged seven (7) years and older.
2. General Anesthesia permit, Pediatric Endorsement, and Documentation of Deep Sedation and General Anesthesia or Moderate Sedation Cases for Pediatric Endorsement form for pediatric patients under the age of seven (7).

Moderate Sedation (Replaced "Conscious Sedation")

1. Oral Conscious Sedation permit for adult dental patients.
2. Oral Conscious Sedation permit and Pediatric Endorsement for dental patients under thirteen (13).

Pediatric Minimal Sedation (Replaced "Oral Conscious Sedation")

1. Pediatric Minimal Sedation permit for dental patients under the age of thirteen (13).

Requests for pre-estimates and requests for claims payment submitted without active sedation permits on file will be denied until the rendering provider submits the required sedation permits and supporting documentation through the PAVE Portal.

To update your permit information, submit a Supplemental Change Form in the PAVE Portal or contact Medi-Cal Dental at 800-423-0507 Monday through Friday 8:00 a.m. to 5:00 p.m. PST.

PROVIDER TRAINING

DentaQuest California Medi-Cal dental providers will receive initial orientation and training for all new offices, dentists, and associates prior to or within ten (10) days of activation.

DentaQuest offers initial orientation and training for all new providers and their offices. All California Medi-Cal providers will receive their initial orientation prior to or within ten (10) calendar days of activation. Additional training is available for new staff, when program changes occur, or in response to changes in provider utilization or other activities. DentaQuest also provides training through webinars, as well as telephonic and in-person meetings.

Providers and their dental office staff are required to complete annual compliance training modules. This training covers all requirements, including any contract amendments and the special needs of members. Additionally, providers receive instruction on identifying adverse incidents and the obligation to report such incidents to DentaQuest within forty-eight (48) hours.

DentaQuest offers a range of free training modules that are mandatory for all office staff, dentists, and associates to complete, along with an attestation of completion. These training modules can be accessed online through our Provider Portal at Providers.dentaquest.com

Mandatory annual training modules include but are not limited to:

- Affordable Care Act Section 1557
- Code of Conduct
- Compliance Plan
- Critical Incident
- Cultural and Linguistic Competency
- Cultural Competency Training
- Fraud, Waste, and Abuse (CMS)
- Fraud, Waste, and Abuse
- General Compliance (CMS)
- HIPAA (Privacy and Security)
- Early and Periodic Screening, Diagnostic and Treatment - EPSDT

Providers must maintain supporting documentation of all completed training for ten (10) years for all office personnel supporting DentaQuest's government business and can furnish the documentation upon request.

CLAIMS

Providers have 180 days from the date of service to submit claims to DentaQuest for all Medi-Cal plans.

Providers cannot demand payment from a Medi-Cal Member or representative of a Medi-Cal Member, for any services provided included in Medi-Cal scope of benefits. California law mandates that Medi-Cal dental providers and dental offices must reimburse a member for a claim if the member can provide proof of eligibility for the period during which medically necessary covered benefits or services were provided and paid for by the member.

DentaQuest receives dental claims in four possible formats. These formats include:

1. Electronic ADA claims via DentaQuest's website Providers.dentaquest.com
2. Electronic submission via clearinghouses
3. HIPAA Compliant 837D File
4. Paper ADA claims form

DentaQuest utilizes claims submissions and information to collect encounter data.

Electronic Attachments

DentaQuest accepts dental radiographs electronically via FastAttach™ for review requests. DentaQuest, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs. FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach, go to https://nea-fast.com/ or call

NEA at: 1(800) 782-5150.

Submitting X-Rays for Prior Authorization or Claims that Require Prepayment Review

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit https://nea-fast.com/ and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately, and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs be mounted when there are 5 or more radiographs submitted at one time. If 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2012 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.
- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

1. Cut out radiographs taped or stapled together.
2. Cut out radiographs placed in a coin envelope.
3. Multiple radiographs placed in the same slot of a radiograph holder or mount.

All radiographs should include member's name, identification number and office name to ensure proper handling.

ELECTRONIC CLAIM SUBMISSION VIA CLEARINGHOUSE

For claim submission via Clearinghouse, DentaQuest works directly with:

DentalXChange - 877-932-2567
Vyne Dental - 866-712-9584
Claim Remedi - 800-763-8484
TriZetto - 800-969-3666
Waystar - 888-989-5468

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that

submitted claims are forwarded to DentaQuest. DentaQuest's Payor ID is CX014.

HIPAA COMPLIANT 837D FILE

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

NPI REQUIREMENTS FOR SUBMISSION OF ELECTRONIC CLAIMS

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest Dental.

1. Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest Dental in its entirety.
2. All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
3. When submitting claims to DentaQuest Dental you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
4. If you are presently submitting claims to DentaQuest Dental through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

Paper Claim Submission

- Claims must be submitted on ADA approved claim forms (2012 or newer ADA claim form) or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable provider signature.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification,

the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.

- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.
- Claims should be mailed to the following address:

  DentaQuest
  PO Box 2182
  Milwaukee, WI 53201-2182

FRADS, RADS, OBRA, Exempt Dental Services, & Emergency Exempt Dental Services

If you believe that a member Qualifies for FRADS, RADS, OBRA, Exempt Dental Services, or Emergency Exempt Dental Services, please note this on the claim submission for proper and prompt claims adjudication.

COORDINATION OF BENEFITS (COB)

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

FILING LIMITS

Each provider contract specifies a specific timeframe after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the

timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing", the provider cannot bill the member. If DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

VOIDING, CANCELING OR DELETING CLAIMS

DentaQuest is required by CMS to maintain an audit trail for voided, canceled and deleted claims. As a result, DentaQuest may only cancel, void, or delete claims that are not able to be processed for acceptable reasons. Below are the only acceptable reasons in which a provider could contact DentaQuest to void, cancel or delete a claim:

- A breakdown of charges is not provided, i.e., an itemized receipt is missing.
- The patient's address is missing.

DentaQuest must deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons. Below are unacceptable reasons in which a provider could NOT contact DentaQuest to void, cancel or delete a claim.

- A provider notifies DentaQuest that claim(s) were billed in error and requests the claim be deleted.
- The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (Type of Bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review.
- The patient's name does not match any Health Insurance Claim Number (HICN).
- A claim meets the criteria to be returned as not able to be processed under the incomplete or invalid claims instructions in the Medicare Claims Processing Manual, Chapter 1, Section 80.3.2.ff, which is available on the CMS website - http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/clm104c01.pdf

If a provider realizes that any of the unacceptable scenarios above are applicable, the provider must submit a formal grievance to DentaQuest so that DentaQuest can recoup funds from the provider. Once funds have been recouped, the provider must submit the corrected claim to DentaQuest for proper processing and payment.

RECEIPT AND AUDIT OF CLAIMS

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Provider Services Department with any questions you may have regarding claim submission or your remittance.

Each DentaQuest Provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

DIRECT DEPOSIT

As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider's banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Authorization Form that can be found on the website Dentaquest.com.
- Attach a voided check to the form. The authorization cannot be processed without a voided check.
- Return the Direct Deposit Authorization Form and voided check to DentaQuest.

  Via Email: StandardUpdates@dentaquest.com

  Via Mail:

  Attn: PDA Department
  PO Box 2182
  Milwaukee, WI 53201-2906

  Via Fax: (262)241-4077

The Direct Deposit Authorization Form must be legible to prevent delays in processing. Providers should allow up to six weeks for the Direct Deposit Program to be implemented after the receipt of completed paperwork. Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 2 -3 weeks. DentaQuest is not responsible for delays in funding if Providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

Steps:

1. Login to the PWP at Providers.dentaquest.com
2. Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go.
3. Log in using your password and ID

4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".
5. The remittance will display on the screen.

OVERPAYMENT

Participating Practice, in compliance with 42 CFR 438.608(d)(2), agrees to promptly notify DentaQuest in writing if Participating Practice receives an overpayment and the reason for such overpayment. Further, Participating Practice shall return to DentaQuest the full amount of such overpayment within sixty (60) days after the date on which an overpayment is identified.

MISSED APPOINTMENTS

Broken appointments are a concern for DentaQuest. We recognize that broken appointments are a costly and unnecessary expense for Providers. Medi-Cal members may not be charged for missed or canceled appointments. Such instances should be documented in the member's record and reported to DentaQuest through the claims submission process using the appropriate codes for missed (D9986) and canceled (D9987) patient appointments. Missed and broken appointments will be paid at $0.00.

It is important to continue outreach efforts to these members to emphasize the significance of keeping their appointments and rescheduling when necessary to avoid interruptions in dental care. As a result of feedback, we have received from dentists in the community, we have developed several Broken Appointment Best Practice guidelines. We encourage you to implement these practices in your office.

The following list contains office policies which have helped to reduce broken appointments and the effects of broken appointments in other dental practices.

- Confirm appointments after hours when the patient is likely to be home to answer the call.
- Confirm all appointments, including recall and hygiene appointments, the day before the appointment.
- Consider telling Members they must confirm their own appointment the day before the visit, or their appointment slot will be lost.
- Continuing care appointments made for three (3) to six (6) months ahead should be reserved for Members of record with no history of broken appointments.
- Members with a history of broken appointments or Members that did not schedule a continuing care appointment, should receive a postcard asking them to call to schedule an appointment.
- Many emergency Members will not keep future appointments if scheduled on the day of emergency treatment. These Members should be called later during the week to schedule follow-up treatment.
- When a procedure needs to be completed at a subsequent appointment, send information home with Members about that next appointment. The information should stress the importance of such a procedure and indicate possible outcomes if it is not completed within the designated timeframe.

- Maintain a list of Members that can be contacted to come in on short notice; this will allow you to fill gaps when late notice cancellations occur.
- Many Members cite daytime obligations such as work or childcare as significant contributing factors to missing appointments. Having extended hours on selected days of the week or occasional weekend hours can alleviate this barrier to accessing dental care.

PRIOR AUTHORIZATION AND PREPAYMENT REVIEW

Plans that DentaQuest administers, may require review of certain procedures to ensure that procedures meet the requirements of federal and state laws and regulations and medical necessity criteria. DentaQuest performs the review using one of two processes – "prior authorization" or "prepayment review". The requirements to obtain an authorization for dental services may include one or more of the following processes:

"Prior Authorization" requires that the provider obtain permission to perform the procedure prior to performing the service. "Prior Authorization" requires specific documentation to establish medical necessity or justification for the procedure.

"Prepayment Review" is the review of claims prior to determination and payment. "Prepayment Review" requires documentation to establish medical necessity or justification for the procedure. For procedures that require "Prepayment Review", providers may opt to submit a "Prior Authorization" request prior to performing the procedure. If DentaQuest approves the "Prior Authorization" request, it will satisfy the "Prepayment Review" process.

To have the services reviewed for a determination, please follow these steps:

1. Verify the patient's eligibility and coverage with DentaQuest.
2. Determine if the proposed treatment or procedure requires Prepayment Review or Prior Authorization based on DentaQuest's policies.
3. Complete a Dental ADA Claim Form
4. Include the type of transaction, relevant patient and provider information, procedure codes, and clinical criteria. Attach any supporting clinical documentation (e.g., x-rays, photos, treatment plans).
5. Submit the completed form and documentation to DentaQuest, through our online portal, fax, or mail.

Providers can access and acquire both electronic and printable forms via our provider portal website at Providers.dentaquest.com.

The Clinical Criteria Guidelines in the Office Reference Manual (ORM) indicate which procedures require Review, which type of Review, and the documentation that the provider will need to submit to support his or her request. Utilization management decision making is based on appropriate care and service, does NOT reward for issuing denials, and does NOT offer incentives to encourage inappropriate utilization. DentaQuest does not make decisions about hiring, promoting, or terminating

practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff member supports, or tends to support, denial of benefits.

Electronic Prior Authorization or Claim Submission Including Claims Requiring Prepayment Review Utilizing DentaQuest's Website

Participating Providers may submit Prior Authorizations or Claims including claims requiring Prepayment Review directly to DentaQuest by utilizing the "Providers" section of our website. Submitting Prior Authorizations or Claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit prior authorizations or claims via the Portal, simply log on to Providers.dentaquest.com. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's TIN, Business ID and Zip Code. If you have not received instructions on how to complete Provider Self Registration, contact DentaQuest's Provider Services Department at Los Angeles County: 855-388-6257 or Sacramento County: 833-479-1984.

Once logged in, search for the member, and submit a pre-authorization or claim by clicking the three dots to the right of the menu or from the member details page. The Dentist Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the request.

If you have questions on submitting prior authorizations or claims or accessing the website, please contact our Systems Operations Department at Los Angeles County: 855-388-6257 or Sacramento County: 833-479-1984.

Health Insurance Portability and Accountability Act (HIPAA)

Use of Your Information

As a Participating Provider or a Participating Practice, you authorize DentaQuest, its affiliates, and its Plans to include Participating Provider and Participating Practice name(s) and practice information in provider directories, in marketing, administrative and other materials, and for legal and regulatory purposes. DentaQuest and Plans may be obligated to include name and practice information in their provider directories if required by applicable law. Additionally, Participating Provider's or Participating Practices' information (which may include sensitive personal information) may be used by DentaQuest, its affiliates, and Plans (as applicable) for the purposes described in your Dental Service Agreement(s) or this dental ORM, including but not limited to credentialing, recredentialing, and claims adjudication. DentaQuest and its affiliates may also disclose Participating Practice's and Participating Provider's information to third parties, including brokers and service providers, that help us conduct our business, including the provision of services, or as allowed by law. If we disclose such personal information to third parties, we require them to protect the privacy and security of this information.

As a healthcare provider, your office is required to comply with all aspects of the

HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA, as well as any other applicable federal and state requirements. One aspect of our compliance plan is working cooperatively with our participating providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its Participating Provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards recognized by the American Dental Association's (ADA) Current Dental Terminology (CDT) codes. Effective the date of this manual, DentaQuest will require participating providers to submit all claims with the current ADA/CDT codes listed in this manual. In addition, all paper claims must be submitted on the current claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Provider Services Department at Los Angeles: 855-388-6257 and Sacramento: 833-479-1984 or via e-mail at CAproviders@dentaquest.com

NATIONAL PROVIDER IDENTIFIER ("NPI")

Under the Health Insurance Portability and Accountability Act ("HIPAA"), DentaQuest requires National Provider Identifiers ("NPI") for all HIPAA-related transactions, including claims, claim payment, coordination of benefits, eligibility, referrals, and claim status.

The NPI is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used instead of legacy provider identifiers in the HIPAA standards transactions.

As outlined in Federal Regulations, and HIPAA, covered providers must also share their NPIs with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

HOW TO APPLY FOR AN NPI

Providers can apply for an NPI in one of three ways:

- Web-based application: http://nppes.cms.hhs.gov
- Dental providers can agree to have an Electronic File Interchange (EFI) Organization submit the application data on their behalf
- Providers can obtain a copy of the paper NPI application/update form (CMS-10114) by visiting: www.cms.gov and mail the completed, signed application to the NPI Enumerator.

VOLUNTARY PROVIDER CONTRACT TERMINATION

Providers must give DentaQuest at least ninety (90) days advance notice of intent to terminate a contract. Providers must continue to treat members until the last day of the month following the date of termination.

Affected members are given advance written notification informing them of their transitional rights. Providers are also responsible for assisting DentaQuest with the transfer of care.

DentaQuest at any time may termination a provider for cause or at will for no cause.

MATERIAL MODIFICATIONS

DentaQuest is committed to providing Providers with a forty-five (45) day written notification before any material modifications as required by applicable law.

SECTION 4: TREATING MEMBERS

MEMBER RIGHTS AND RESPONSIBILITIES

Federal law provides all Medicaid members with specific rights that must be adhered to by DentaQuest, our contracted dental providers, and dental office staff.

All members are entitled to the following rights:

1. All members have the right to:
    - Be treated with respect and dignity.

- Have access to, and where legally appropriate, receive copies of, amend or correct their dental record;
- Have dental records kept confidential. Dental care information will not be shared without written approval or unless it is required by law.
- Receive information about DentaQuest, our services, and our providers.
- Choose a Primary Care Dentist from the applicable program Provider Directory.
- Have access to Federally Qualified Health Centers, Indian Health Service Facilities, and emergency dental services outside the Plan's network pursuant to the federal law;
- Get services from providers outside of the network in an emergency.
- Get appointments within a reasonable amount of time.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;
- Participate in candid discussions and decisions about dental care needs, including appropriate or Dentally Necessary treatment options for the condition(s), regardless of cost or regardless of whether the treatment is covered by the Plan.
- Voice concerns, verbally or in writing, about the Plan, or about dental services received, to DentaQuest.
- Make recommendations about rights and responsibilities.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Freedom to exercise these rights without adversely affecting how members are treated by the Plan, provider, or the applicable program;
- Disenroll upon request
- Request an interpreter at no charge.
- Use interpreters who are not family members or friends.
- Receive Member materials translated into individual preferred languages.
- Receive written Member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested;
- File a complaint if linguistic needs are not met.
- Have access to Plan health education programs and outreach services in order to improve dental health.
- To request a second opinion, including from a Specialist at no cost.
- Request a State fair hearing, including information on the circumstances under which an expedited fair hearing is possible

2. Member responsibilities are to:
    - Give providers and DentaQuest correct information.
    - Understand dental problems(s) and participate in developing treatment goals, as much as possible, with provider.
    - Always present Member Identification Card when getting services.

- Ask questions about any dental condition and make certain that the explanations and instructions are understandable.
- Make and keep dental appointments, including informing the provider at least 24 hours in advance when an appointment must be cancelled.
- Help DentaQuest maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
- Notify DentaQuest as soon as possible if a provider bills inappropriately or if the Member has a complaint.
- Treat all DentaQuest personnel and providers respectfully and courteously.

3. These member rights and responsibilities are communicated to and reinforced with the members through multiple processes, including written materials, our Customer Service Representatives, our website, and through educational materials and programs.

MONTHLY ELIGIBILITY ROSTERS

Your office will receive an updated eligibility roster (eligibility list), at the beginning of each month. The eligibility list will include a record of DentaQuest members who have chosen and are assigned to your office for their general dental care.

PRIMARY CARE DENTIST (PCD)

Member's must choose a PCD within 30 days of enrolling in DentaQuest. They can choose any in-network general dentist or pediatric dentist as their PCD.
They can also choose a Federally Qualified Health Center (FQHC), community clinic, American Indian Health Center or other primary care facility that has dental services as their PCD if they are in the DentaQuest network.
A member may choose the same or different PCD for everyone in their family, although we do encourage them to all use the same office.
If a member does not choose a PCD within 30 days, a dentist who works with member care in DentaQuest will choose and assign a PCD on their behalf.
Provider support is essential to effectively employing the PCD program for Medi-Cal members. With assistance and support from dental professionals, a system for improving the overall health of children in the Medi-Cal program can be achieved. Having a PCD program builds a strong relationship between the primary care dental office and the patient. This relationship plays an important role in delivering necessary preventive and restorative care in an accessible, patient-centered way and improving oral health.

Do members need to be assigned to my office for me to treat them?
No. Members are not required to be assigned to your office for you to treat them. You may treat any eligible member.

The member is in my office now, his/her regular provider is not here today, can we see the member still?
The member is assigned to your location. They can see any participating DentaQuest provider.

Will I be paid if I treat a member that is not assigned to my office?
If the member is eligible for benefits and the services are covered, you will be paid.

How do I know who is assigned to my office?
There are a couple of ways to verify member assignment:

By signing on to the secure provider portal at Providers.dentaquest.com with your office specific ID and password, you may:

- Access patient eligibility and assignment information by clicking on the Patient Menu and Member Eligibility Search on the left side of the screen.
- View/download a roster of your assigned members.

How do members know our office is their assigned PCD?
Members receive a post card that identifies their PCD and ways they can change it if desired. They can also see their assigned PCD on the member portal or in the member app.

How can members change their assigned PCD?
Members may change their PCD anytime by calling DentaQuest Customer Care at 1-855-388-6257 (TTY 1-800-466-7566) or be going to https://www.dentaquest.com/en/change-your-dentist.

Our office has Specialists, how does PCD assignment affect them?
Members are only assigned to general dentists and pediatric dentists. Members are not assigned to specialists so this will not affect them.

MEMBER TRANSITION OF CARE NOTIFICATION TO DENTAQUEST PROVIDERS

DentaQuest maintains a DHCS-approved transition of care policy for individuals transitioning to managed care from FFS, from one DMC to another, or from Covered California to Medi-Cal when a member without continued services would experience serious detriment to their health or put them at risk of hospitalization or institutionalization. Transition policies is consistent with the requirements in 42 CFR § 438.62(b)(1)

DentaQuest's Medi-Cal Dental members who are transferring from a Medi-Cal Dental fee-for-service plan to DentaQuest may request benefits for transition of care. Members may request that a current treatment plan be completed by an out-of-network provider with whom DentaQuest can establish that the member has been a patient of record in the past twelve (12) months.

Members, at any time, have the option to elect the continuation of care with a DentaQuest network provider. To make a formal request for Transition of Care benefits, a member or provider may contact DentaQuest's Member Services Department. Upon receipt of the request DentaQuest will:

- Begin the process within five (5) business days following the receipt of the request Verify member's patient of record status at an out-of-network dental office (if necessary).
- Develop a treatment plan with the treating provider and negotiate fees (if DentaQuest and an out-of-network provider cannot agree on fees, DentaQuest may recommend an in-network provider option).
- Complete non-urgent requests within thirty (30) calendar days, fifteen (15) calendar days for more serious dental conditions, and three (3) calendar days for members with imminent risk of harm.
- Upon completion, notify the member and provider of the determination, and for approvals, provide the timeframe (no longer than twelve (12) months from the date of DentaQuest enrollment) for the transition of care.
- Notify the member thirty (30) calendar days before the end of the Transition of Care period.
- Retroactive requests for Transition of Care benefits may also be made through Member Services so long as treatment occurred after February 1, 2017, and the request is made within thirty (30) days from the first date of service.

If you have any questions regarding DentaQuest's Medi-Cal Dental Members Transition of Care policy, please contact DentaQuest's Provider Engagement Department.

COVERED CALIFORNIA TO MEDI-CAL TRANSITION

DentaQuest will honor any active pre-estimate for up to sixty (60) days or until a new treatment plan is completed by a provider within the DentaQuest network. The new treatment plan must address the services specified in the pre-transition authorized treatment. DentaQuest will recognize all pre-transition treatment authorizations without requiring requests from the provider or member.

DentaQuest will also provide up to twelve (12) months of continuity of care with an out-of-network provider, provided that the continuity of services requirements outlined above are met. Continuity of care benefits will be available for covered services under the following conditions: acute illnesses, serious chronic conditions, pregnancy, terminal illnesses, care for newborns between birth and thirty-six (36) months, and surgeries or other procedures that were previously authorized as part of a documented course of treatment recommended by the provider to take place within one hundred eighty (180) days of the contract's transition date or within one hundred eighty (180) days of the effective date of coverage for newly enrolled members.

MEDICAID AND MEDICARE (DUALS) PRIOR-ESTIMATE OUTREACH

DentaQuest adheres to all applicable laws and contractual obligations, including the guidelines set forth by the Centers for Medicare and Medicaid Services (CMS), as well as state and federal regulations and accreditation standards.

DentaQuest processes all written or verbal requests for Expedited/Urgent ("Expedited") Utilization Management (UM) pre-estimate decisions within the required timeframes. When DentaQuest receives a pre-estimate request from a Medicaid or Duals member

that lacks the necessary information for a medical necessity determination, we will make reasonable outreach attempts to the provider to obtain the required information as early as possible in the decision-making process. Reasonable outreach attempts may include contacting the provider via telephone, fax, email, and mail, as appropriate, within timelines that align with whether the initial request is classified as standard or expedited.

Each outreach attempt will clearly specify the information and/or documents needed for DentaQuest to make a medical necessity pre-estimate decision and will include our contact information for the provider's response.

If DentaQuest does not receive a response to the request for additional information, a decision will be made based on the information available. Pre-estimate denials may be appealed through the member appeal process. For further details on the member grievance and appeals process, please refer to Section 8 Quality Management.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) BENEFITS

As mandated by federal law, DentaQuest provides comprehensive, diagnostic, and preventive dental services to eligible recipients under the age of twenty-one (21) if such services are medically necessary to correct or improve a defect, condition, or physical or mental illness that exceeds the state's Medicaid benefits. This encompasses emergency, preventive, diagnostic, and therapeutic services for dental diseases that, if left untreated, could lead to acute dental issues or irreversible damage to the teeth and supporting structures.

Members are entitled to EPSDT benefits, ensuring that children and adolescents receive the appropriate preventive and specialty dental care. For further details, please refer to your relevant state Medicaid Periodicity Schedule.

- American Academy of Pediatrics Periodicity Schedule https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

1. Contracted providers shall inform members that EPSDT services are available for members under 21 years of age, provide comprehensive dental screening and prevention services, and provide treatment for all medically necessary dental covered services.
2. DentaQuest has adopted the American Academy of Pediatric Dentistry periodicity schedule for dental services for children, including first visit by first birthday (See ***Policy CA_QM.004.01, Dental Periodicity***).
3. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additional medically necessary services. These additional services are known as EPSDT Supplemental Services and include: private duty nursing services from a Registered Nurse (RN) or a Licensed Vocational Nurse (LVN), Case Management, Pediatric Day Health Care, and Nutritional and Mental Health Evaluations and Services. For dental services, EPSDT Supplemental Services include any medically necessary dental service that is not covered under the

Medi-Cal Manual of Criteria (MOC), and include frequency or periodicity recommended beyond coverage limits and/or services that are not covered.

4. DentaQuest shall:
    a) Include relevant language on EPSDT supplemental service from the Medi-Cal Dental provider handbook in the plan's provider manual; and
    b) Provide specific training on EPSDT supplemental services to the contracted dental providers;
5. EPSDT Supplemental Services apply in any of the following situations and the dental provider would request prior authorization for an EPSDT Supplemental Service under any one of the following conditions:
    a) To perform a medically necessary dental procedure that is not listed in the current Manual of Criteria.
    b) To perform a medically necessary dental procedure that is listed in the current Manual of Criteria when the child does not meet the published criteria.
    c) The child needs a dental service more frequently than is currently allowed under Program criteria.
6. DentaQuest will coordinate any identified requests for EPSDT Supplemental Services through the Preauthorization Department.
7. The dental provider should submit the following information for preauthorization review of EPSDT supplemental service requests:
    a) The provider must submit a preauthorization request to DentaQuest;
    b) In addition, the provider must also submit the following medical documentation, as applicable:
    c) Diagnosis of the dental condition;
    d) Any medical information, which supports the medical necessity for the requested services, including any overall health issues and/or medical conditions;
    e) Prognosis with and without the requested treatment; and
    f) Clinical rationale for why a covered benefit or lower cost service will not suffice.
        A. Providers are encouraged to include copies of published clinical studies or articles from peer-reviewed, professional dental journals to support rationale.
        B. *Note:* Documentation can be narrative, radiographic, photographic, or copies of any relevant documents (including diagnostic imaging).

C. In some cases, the dental services are necessary to resolve or improve an associated medical condition. For example, a child's speech therapist determines that a diagnosed speech pathosis cannot be resolved without dental treatment. A consultation letter from the speech therapist should be included with the EPSDT Supplemental Services TAR/Claim.

8. Upon receipt of a preauthorization request for EPSDT Supplemental Services, DentaQuest will coordinate with the DHCS for review by a DHCS Dental Program Consultant, in accordance with the procedures identified by DHCS to ensure timely review and determination.

PRE-ESTIMATE OF EPSDT DENTAL SERVICES

For all EPSDT service(s), a pre-estimate is required for any dental service that is not listed on the state Medicaid benefit schedule, and any service(s) that are listed on the Medicaid benefit schedule that is subject to frequency limitations, or periodicity schedule guidelines. Any EPSDT service(s) that were not submitted for a pre- estimate described above will be denied and the members cannot be held financially responsible for the denied services. For all pre-estimate requests, medical necessity will be determined based on radiographic and/or other documented rationale.

You can learn more about EPSDT benefits through the Medi-Cal Provider Publications here: DHCS EPSDT Manual

Providers requesting a pre-estimate of billing for EPSDT services should select the "EPSDT" box in section 1 of the American Dental Association (ADA) dental claim form.

Pre-estimate requests will be clinically reviewed for medical necessity; and approved pre-estimates will be reimbursed based on your current fee schedule.

PREGNANCY or POSTPARTUM RELATED BENEFITS

Pregnancy-related services are services required to assure the health of the pregnant woman and the fetus, or that have become necessary as a result of the woman having been pregnant. Effective April 1, 2022 Medi-Cal Members will be covered for all medically necessary services during pregnancy and 12 months past the end of their pregnancy as part of the American Rescue Act Plan (ARPA). Thus, postpartum benefits are applicable for the 12-month period after pregnancy ends and until the end of the month in which the 12-month period ends. If pregnancy is appropriately identified, all services delineated in the Medi-Cal Dental Manual of Criteria (MOC), may be provided to pregnant Members, regardless of age, aid code, and/or scope of benefits (e.g., limited scope or pregnant/emergency services only), subject to their compliance with the Medi-Cal Dental MOC procedure requirements and criteria are met.

Make sure to write "pregnant" or "postpartum" for any applicable member that does not have full scope Medi-Cal in the Comments / Remarks section on the ADA claim form, plus any additional documentation and radiographs pertinent to the procedure for reconsideration, the applicable services may be rendered to a pregnant beneficiary and

reimbursed accordingly. Provider must document "pregnancy" or "postpartum" status on each document submitted.

Some documentation standards are different for pregnant/postpartum members, such as:

- Prior Authorization for Scaling and Root Planing (procedure codes D4341 or D4342) is waived for members with pregnant/postpartum status
    - Member must still meet medical necessity criteria for this procedure
- Reduced Radiographic Requirements:
    - For procedures that would usually require them, arch integrity radiographs are not required to be submitted by the provider
    - When requesting payment for scaling and root planning for members with pregnant/postpartum status, the provider may choose not to submit bitewing radiographs
- Scaling and Root Planing procedure codes may be submitted on a claim without prior authorization so long as medical necessity criteria are met for members with pregnant/postpartum status.
  The provider must document "pregnancy" or "postpartum" status on each document submitted

Additional information regarding dental care during pregnancy can be found at the CDA Foundation website: https://www.medi-cal.ca.gov/

CASE/CARE MANAGEMENT

DentaQuest offers Case/Care Management services for Medi-Cal dental members, including those enrolled in HealthNet Dental. The Case Management team at DentaQuest will coordinate dental services for Medi-Cal members, both children and adults, who are identified with complex dental conditions or special health care needs.

Case management involves the timely coordination of dental and health care services to meet an individual's specific needs in a cost-effective manner that ensures continuity and quality of care and promotes positive outcomes. The case manager serves as a patient advocate, while at the same time assuring appropriate use of resources. Case management is a collaborative process between the member, DentaQuest, Health Net as applicable, and providers, and requires the cooperation of all parties to achieve success.

DEFINITIONS

"Complex cases" are those cases where the dental condition is compromised by a medical condition, and either the care needs to be coordinated between medical and dental providers, or between the PCD and a specialty dental provider.

"Special needs cases" are those members with physical and/or mental disabilities in need of dental care from providers who have special experience working with these patients.

PROCEDURE

1. DentaQuest arranges for dental care management for all enrolled members through the primary care dental home. DentaQuest has adopted a standardized caries risk assessment tool and urges all participating Primary Care Dentists to complete initial caries risk assessments and ongoing reevaluation during recall and periodic dental visits.
2. All complex and special needs cases will be referred to the Referral/Case Management Coordinator for case management.
3. Children with Special Health Care Needs (CSHCN) are identified through Primary Care Dentists (PCDs), specialist referral, care coordination points, OHIF form and/or upon contact from the family. Identification of Members with Special Health Care Needs (SHCN) can occur through member contact with the Customer Service Department, on the OHIF form, or through dental provider contact with the Care Coordination or Utilization Management processes. Upon identification, Case Management Coordinators work with the family to ensure appropriate specialist referrals.
4. The Referral/Case Management Coordinator will conduct the following case management activities for complex and special needs cases:
    - In conjunction with the Dental Director, PCD, and primary care medical provider, develop a dental treatment plan.
    - In conjunction with the Dental Director, PCD, and primary care medical provider, assist with coordinating delivery of dental care with the most appropriate general or specialty dentist.
    - Assist with coordinating communication between medical providers and dental providers to ensure that dental treatments do not interfere with medical treatments.
    - Monitor and reevaluate the progress of the dental treatment plan to ensure effectiveness.
    - In conjunction with the Dental Director, PCD, and primary care medical provider, modify the dental treatment plan, as indicated by updated information.
    - Report any issues affecting access, availability, and coordination of care to the Dental Director for referral to the QM committee.
    - Following the member access of any emergency room services involving oral health, DentaQuest shall contact the member within two (2) days of receipt of information (by data transmittal from DHCS) to confirm that the member has a follow up visit with a dentist. DentaQuest shall be required to receive the data transmittals at least on a monthly basis.

5. Case Management and Care Coordination activities include contact and coordination with medical plans for complex dental services delivered in a hospital or ambulatory surgical center setting and/or to ensure collaboration in medical plan care coordination planning. Care coordination services will also include coordination with medical care providers and oral health care providers to ensure that appropriate dental care is included within the overall treatment planning, including increased frequency of medically necessary/ risk appropriate preventive dental services.
    a. The Referral/Case Management Department will identify a designated liaison for member health plans, which will be made available to programs to facilitate coordination activities between the dental and health plan.
6. Documentation is maintained through the specialty referral processes. Written authorizations or referrals are provided to the member, Primary Care Dentist, and specialist dental provider. DentaQuest's confidentiality guidelines govern all communications between the Case Management Coordinator, Member, and Providers, as necessary to coordinate the care. All HIPAA and document security policies are followed to ensure privacy and confidentiality. Disclosures of member specific information is made only to authorized persons and DentaQuest staff must follow release of information guidelines.
7. Case management activities are to be reported quarterly to the Utilization Management subcommittee and QIOHE committee and must be included in quarterly and annual reports of QM program activities to the Board of Directors.
8. Quality issues identified through case management activities will be reported to the Dental Director and QIOHE committee.
9. Dental services for children with special health care needs that can be delivered in the dental office are coordinated for referral to a contracted dental specialist with the primary care dentist through the Specialty Referral Department. Ongoing treatment needs can be facilitated through standing authorizations to specialists based on the treatment needs of the patient.
10. DentaQuest recruits and contracts with specialty dentists that treat children with special health care needs in their offices, including necessary anesthesia services when medically indicated.
11. When hospital dentistry is required, DentaQuest has access to contracted specialty dentists and general dentists that maintain hospital privileges and care can be readily coordinated with the Medical Plan to be delivered at local hospitals or surgi-centers.
12. DentaQuest facilitates non-contracted dental services as needed to schedule and coordinate care at other facilities based on dental operatory scheduling

and/or Medical Plan facility limitations. When the dental provider determines that the treatment plan must be delivered in a hospital setting, the Case Management Coordinator engages in the process.

a. Dental care coordination primarily occurs when hospital dentistry is part of the necessary treatment plan. The Case Management Coordinator facilitates the coordination of the services through the applicable medical plan, the hospital, and the dental provider. Hospital dentistry can be complex to coordinate:
    1. all medical facilities (hospitals and ambulatory surgical centers) do not offer hospital dentistry services,
    2. those that do frequently have few operatory days devoted to dentistry;
    3. medical plan coverage generally limits the member to the use of a medical plan contracted/network hospital or ambulatory surgical center; and
    4. The treating dental provider must have practice privileges at the hospital or ambulatory surgical center.

13. In the event that medical plan/hospital scheduling cannot be achieved within timelines necessary to meet the treatment needs of the patient, the Case Management Coordinator escalates the case to the Dental Director and Plan Administrator to initiate intervention with the medical plan and program, as needed.
14. The Referral/Case Management Department ensures that oral health care/dental services are consistent with the Member's dental care needs and the Medi-Cal benefits, or, if no benefits are available through the dental plan, referrals are made to the EPSDT supplemental program and/or other community programs.
    a. Referrals are made to contracted providers, including specialists
    b. If contracted providers are not available for necessary, covered services, off-panel/noncontracted provider care is coordinated. Network management and recruitment efforts are maintained to ensure that an adequate number of dental specialists treating children with special health care needs and maintaining hospital privileges with the facilities of the Medi-Cal contracted medical plans
    c. Referrals are made to other community resources, including California Children's Services (CCS) or other programs that may be able to assist the Member with noncovered services
    d. DentaQuest can initiate standing referrals to specialists to provide primary care services to children with special health care needs. The process is

currently a manual process and is coordinated through the Referral/Case Management Department, in accordance with Policy CL.003.02, Referrals for Specialist Dental Care.

e. When it is identified that an enrolled member has a diagnosis that may be covered by the California Children's Services (CCS) program, the member is referred to the local CCS office for a benefit eligibility determination.

15. The number of care coordination activities and the status of the cases are monitored through the Referral/Case Management Department under the oversight of the Dental Director. Key performance metrics are monitored by the Quality Management Committee.

HIPAA COMPANION GUIDE

To view a copy of the most recent Companion Guide please visit our website at Dentaquest.com. Once you have entered the website, click "LOGIN" in the top right corner. You will then be able to log in using your ID and password. Once you have logged in, click on the link named "Related Documents" where you will find the HIPAA Companion Guide (located under the picture on the right-hand side of the screen).

APPOINTMENT ACCESSIBILITY STANDARDS

DentaQuest is committed to our members receiving timely access to care. Providers are required to schedule appointments for eligible members per the standards set by the state of California for Medi-Cal.

COMPLIANCE WITH THE STANDARDS OF ACCESSIBILITY AND AVAILABILITY

DentaQuest monitors compliance with the standards set above through dental facility audits, provider/member surveys, and other Quality Management processes. DentaQuest may seek corrective action for providers that are not meeting accessibility standards.

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

The provider's after-hours response system must allow members to contact an on-call dentist 24 hours a day, 7 days a week. If the primary care provider is unavailable to see an emergency patient within twenty-four (24) hours, it is their responsibility to ensure that emergency services are accessible.

In providing for emergency services and care as a covered services, DentaQuest shall not:

1. Require a referral or prior authorization for emergency services and care
2. Indicate that emergencies are covered only if care is secured within a certain period of time
3. Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered
4. Deny payment based on the member's failure to notify DentaQuest in

advance or within a certain period of time after the care is given

Members requiring after-hours emergency dental services must receive a telephone assessment from the provider within one (1) hour of contacting the provider's "after-hours" telephone service. Members should be scheduled for an appointment within twenty-four (24) hours and informed that only the emergency issue will be addressed at that time.

If a member cannot access emergency care within these guidelines and must seek services outside your facility, you may be held financially responsible for the total cost of those services. Furthermore, if your office is unable to comply with DentaQuest guidelines, DentaQuest reserves the right to transfer some or all capitation program enrollments or to close your office to new enrollments.

DentaQuest is committed to our members receiving timely access to care. Providers are required to schedule appointments for eligible members per the standards set by the state of California for Medi-Cal.

"Appointment wait time" is defined as the time from the initial request for dental services by a member or the member's treating provider, to the earliest date offered for the appointment for services. This includes the time for obtaining authorization from DentaQuest, pending any other requirements of the Plan, or our contracting providers.

California Medi-Cal Dental Appointment Accessibility Standards	
Type of Appointment	**Appointment Scheduling/Wait Time**
Initial (exams and x-rays)	**Within 4 weeks**
Routine Care, Non-Emergency (restorative care)	**Within 4 weeks**
Preventive Care (prophylaxis or periodontal care)	**Within 4 weeks**
Emergency (acute pain/swelling/bleeding)	**As quickly as the member's condition requires but no later than 24 hours**
Urgent Care (Lost crown, broken filling)	**As quickly as the member's condition requires but no later than 72 hours**
After-Hours/Emergency Availability **All providers must have at least one of the following:** • **Answering service that will contact the provider on behalf of the member.** • **Call forwarding system that automatically directs member's calls to the Provider.**	**Must be available 24 hours a day, 7 days a week.**

• **Answering system with explicit instructions on how to reach the provider and emergency instructions**	
Specialists	**Within 30 days from approved authorization**
In-Office Wait Time (scheduled appointments)	**Not to exceed 30 minutes. Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by a provider.**
Telephone Wait Time to Answer	**Within 30 seconds**
Return Telephone Call	**Within 30 minutes**
Office Hours	**Minimum of 3 days/30 hours per week**

If a patient presents with an emergency condition that requires immediate treatment or intervention, you should always take necessary clinical steps to mitigate pain, swelling, or other symptoms that might put the members overall health at risk and completely document your findings.

DentaQuest shall compensate the dental provider for emergency dental services and care as long as member was eligible for services at time of treatment and services provided were medically necessary. If a determination is made that an emergency dental condition does not exist, DentaQuest is not responsible for payment for services rendered subsequent to that determination.

DentaQuest shall not deny payment for emergency services and care.

APPOINTMENT RESCHEDULING

When a provider or member needs to reschedule an appointment, it must be promptly rearranged in a way that meets the member's health care needs and maintains continuity of care in accordance with professional standards. Follow-up care appointments must be scheduled with the same criteria as initial appointments.

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to maintain and document a formal and active recall system for established patients who miss or cancel appointments. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointment for any health plan member that has sought dental treatment.

If a written process is utilized, the following language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that Medicaid patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the "no show" rate.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

PEER-TO-PEER

Network providers have the right to contact a DentaQuest dental director for a peer-to- peer discussion. To request a peer-to-peer please call Provider Services at Los Angeles: 855-388-6257 and Sacramento: 833-479-1984 DentaQuest encourages our network of dental providers to, when necessary; refer members with signs of behavioral health issues and/or substance abuse issues, to their medical plans for appropriate treatment.

PROVIDER RESPONSIBILITIES AND RIGHTS

- Provide and/or coordinate all dental care for members.
- Perform an initial dental assessment.
- Work closely with specialty care providers to promote continuity of care.
- Maintain adherence to DentaQuest's Quality Management and Improvement Program.
- Identify dependent children members with special health care needs, and adult members with special health care needs and notify DentaQuest of these needs.
- Notify DentaQuest of a member's death.
- Arrange coverage by another provider when away from the dental facility.
- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a week through primary care dentists.
- Maintain scheduled office hours.
- Maintain complete and accurate dental records for no less than ten (10) years.
- Document the member's preferred language and request/refusal of interpreting services in the dental chart.

- Post the availability of language assistance services signage in the provider office.
- Provide updated credentialing information upon renewal dates.
- Provide requested information upon receipt of member grievance/complaint within three (3) business days of the notice letter from DentaQuest.
- Provide encounter data on standard ADA claim forms on time (for capitation plans).
- Notify DentaQuest immediately of any changes regarding practice, including location name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc.
- Providers may not close, or otherwise limit, their acceptance of members as patients unless the same limitations apply to all commercially insured members.
- Provider understands and agrees that assignment or delegation by Provider of services under its agreement with DentaQuest is null and void unless prior written approval is obtained from DentaQuest and, to the extent required, by DentaQuest from relevant Health Plan clients.
- Report any suspected fraud, waste, and abuse.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES & RIGHTS

- In addition to the above provider rights and responsibilities, specialty care providers must:
- Provide specialty care to members.
- Work closely with primary care dentists to ensure continuity of care.
- Bill DentaQuest for all dental services that were authorized.

ANTI-DISCRIMINATION

As a DentaQuest contracted provider, you agree to comply with all non-discrimination laws and contractual requirements. Federal laws, under Section 1557 of the Patient Protection and Affordable Care Action prohibit discrimination against individuals participating in certain health programs or activities based on race, color, national origin, sex, age, or disability. This anti-discrimination clause extends to:

- Any health program or activity any part of which receives funding from HHS.
- Any health program or activity that HHS administers.
- Health Insurance Marketplace and all plans offered by issuers that participate in those Marketplaces.

ANTI-DISCRIMINATION AGAINST GENDER IDENTITY AND SEXUAL ORIENTATION

Provider will ensure their practices are non-discriminatory regarding race, color, national origin, sex, sexual orientation, gender identity, or disability. Any policy or practice that has the effect of discriminating based on race, color, national origin, sex, sexual orientation, gender identity, or disability is federally prohibited.

Providers and dental office staff will not discriminate against individuals eligible to enroll based on race, color, national origin, sex, sexual orientation, gender identity, or

disability and shall not use any policy or practice that has the effect of discriminating based on race, color, or national origin, sex, sexual orientation, gender identity, or disability according to 42 CFR § 438.3(d).

FACILITY PHYSICAL ACCESS FOR THE DISABLED – AMERICANS WITH DISABILITIES ACT

Under The Americans with Disabilities Act of 1990 ("ADA") and Section 504 of the Rehabilitation Act of 1973 (Section 504), providers may not discriminate against individuals with disabilities and are required to make their services available in an accessible manner by:

- Offering full and equal access to their health care services and facilities; and
- Making reasonable modifications to policies, practices, and procedures, when necessary, to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e., alter the essential nature of the services).

The ADA sets requirements for new construction and alterations of buildings and facilities, including healthcare facilities. In addition, all buildings, including those built before the ADA went into effect, are subject to accessibility requirements for existing facilities. Detailed service and facility requirements for disabled individuals can be found by visiting www.ada.gov.

SECOND OPINIONS

Members and providers may request a consultation with another network dentist for a second opinion to confirm the diagnosis and/or treatment plan, at no cost. Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest. Please call DentaQuest's Member Services Department at Los Angeles County: 855-388-6257 or Sacramento County: 833-479-1984, TTY: 800-466-7566 Monday through Friday, 8:00 a.m. to 5:00 p.m. PST.

CONTINUITY AND COORDINATION OF CARE

DentaQuest ensures appropriate and timely continuity and coordination of care for all plan members. A panel of network dentists shall be available in currently assigned counties from which members may select a provider to coordinate all their dental care. All care rendered to DentaQuest members must be properly documented in the patient's dental charts according to established documentation standards.

Communication between the Primary Care Dentist (PCD) and dental specialist occurs when members are referred for specialty dental care. DentaQuest enforces Quality Management Improvement Program policies and procedures that will ensure:

An enrollment packet contains a list of Providers that is given to all members upon enrollment.

A current list of Providers is maintained on DentaQuest's website at Dentaquest.com.

Members who do not select a Provider will be assigned one, based on the DentaQuest assignment algorithm.

Dental chart documentation standards are included in this provider guide. Dental chart audits will verify compliance with documentation standards.

Guidelines for adequate communications between the referring and receiving providers, when members are referred for specialty dental care, are included in this provider guide.

During facility on-site audits, DentaQuest monitors compliance with continuity and coordination of care standards.

When a referral to a specialist is authorized, the Provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and scheduling the member for any appropriate follow-up care.

When a specialty care referral is denied, the Provider is responsible for the evaluation of the need to perform the services directly and schedule the member for appropriate treatment.

The results of site audits shall be reported to the Quality Oversight Committee, and corrective action shall be implemented when deficiencies are identified.

CULTURALLY COMPETENT CARE

Per state and federal regulations, DentaQuest provides culturally competent care and services in a nondiscriminatory manner that ensures all members including those with Limited English Proficiency (LEP) and members with disabilities, receive effective and respectful care promptly and compatible with their culture, health beliefs, practices, and preferred language. DentaQuest collaborates and participates with applicable state and regulatory agencies to promote the delivery of care in a culturally competent manner.

Cultural considerations for appropriate care include but are not limited to ethnicity, race, gender, age, preferred language, English proficiency, sexual orientation, immigration status, acculturation factors, spiritual beliefs and practices, physical abilities and limitations, family roles, community networks, literacy, employment, and socioeconomic factors.

DentaQuest incorporates measures to promote cultural sensitivity/awareness in the delivery of Member services as well as healthcare services. Services to Members are delivered in a manner sensitive to the Member's cultural background and his/her religious beliefs, values and traditions. It is the policy of DentaQuest to provide Medicare, Medicaid, Commercial and DentaQuest employee information in a culturally competent manner that assists all individuals, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds or physical or mental disabilities issues in obtaining health care services. DentaQuest incorporates measures to track bias/discrimination issues that hinder or prevent to be administered in accordance with the American with Disabilities Act, and other applicable Federal and State laws, to its Members and DentaQuest employees and report appropriate occurrences to the Complaint and Grievance Department or the Human Resources Department.

DentaQuest ensures that its staff is trained in cultural awareness to provide a competent system of service, which acknowledges and incorporates the importance of culture, language, and the values and traditions of Members.

DentaQuest ensures that its staff is trained in cultural awareness to provide a competent system of service, which acknowledges and incorporates the importance of culture, language, and the values and traditions of all DentaQuest's employees.

DentaQuest supports Providers in efforts to work in a cross-cultural environment and to ensure the adaptation of services to meet Members cultural and linguistic needs.

A copy of DentaQuest's Cultural Competency Plan is available at no charge upon request by contacting DentaQuest's Provider Services Department.

LANGUAGE ASSISTANCE SERVICES

Language Assistance services are available to ensure LEP members have appropriate access to language assistance including special format for hearing and visually impaired members, while accessing dental care.

Interpretation services for LEP members (when and where required by state law or group/client arrangement are available at no cost):

Interpretation services, including American Sign Language, are available at no cost to members, 24 hours a day, 7 days a week by contacting DentaQuest's Member Services Department at Los Angeles County: 855-388-6257 or Sacramento County: 833-479-1984, TTY: 800-466-7566.

You will need the member's DentaQuest Dental ID number, date of birth, and the member's full name to confirm eligibility and access to interpretation services. It is not necessary to arrange for these services in advance.

A Provider covered by HIPAA, is not required to collect an individual's authorization to disclose PHI when using an interpreter to communicate with a member, as defined in federal regulation 45 CFR 160.103 and 164.506.

DentaQuest discourages the use of family or friends as interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical.

Providers must also fully inform the member that he or she has the right not to use family, friends, or minors as interpreters.

If a member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting.

Language preferences of members will be available to directly contracted dentists upon request through telephone inquiries, and only for those members entitled to receive such services by virtue of state requirements or client group requirements.

Written Member Informing Materials in threshold languages and alternative formats (including Braille and large font) are available to members at no cost and can be requested by contacting DentaQuest's Member Services Department.

Assistance in working effectively with members using in-person, telephonic interpreters, other media such as TTY/TDD, and remote interpreting services can be obtained by contacting DentaQuest's Member Services Department.

CONFIDENTIAL COMMUNICATIONS FOR SENSITIVE SERVICES

California law states that members can request confidential communications regarding the receipt of sensitive services. These types of services can include:

- Bills and attempts to collect payment
- A Notice of Adverse Benefit Determination(s)
- An Explanation of Benefits notice(s)
- A Plan's request for additional information regarding a claim
- A notice of a contested claim
- The name and address of a provider, description of services received, and other information related to a visit.
- Any verbal, written, or electronic communications from the Plan that contain protected health information.

  To request confidential communications from DentaQuest for any of the services listed above, please call Member Services or you can submit a request in writing by mail the following:

- By mail to: California Member Services, DentaQuest, PO Box 2906, Milwaukee, WI 53201-2906
- By telephone to: DentaQuest's Member Services at Los Angeles County: 855-388-6257 or Sacramento County: 833-479-1984, TTY: 800-466-7566

NEW PATIENT INFORMATION

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

INFECTION CONTROL

All contracted dentists must comply with the Centers for Disease Control (CDC) guidelines as well as other related federal and state agencies including the Dental Board of California for sterilization and infection control protocols in their offices. Offices are not allowed to pass an infection control fee of any kind, including a "sterile

tray" fee onto DentaQuest members.

DENTAL RECORDS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

CLINICAL CRITERIA GUIDELINES (CCG)

BASELINE CLINICAL EVALUATION DOCUMENTATION

The criteria outlined in DentaQuest's Provider Office Reference Manual (ORM) are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for review, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

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

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to Members and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore, it is essential you review the Benefits Covered Section before providing any treatment.

The clinical criteria presented in this section are the criteria that DentaQuest will use for making medical necessity determinations for prior authorizations, post payment review and retrospective review. In addition, please review the general benefit limitations presented in Exhibit A of this manual for additional information on medical necessity on a per code basis.

Failure to submit the required documentation may result in a disallowed request and/or a

denied payment of a claim related to that request. Prior authorization is required for orthodontic treatment and any procedure requiring in-patient or outpatient treatment in any hospital or surgery center. Some services require pre-payment review, these services are detailed in Exhibit A Benefits Covered in the "Review Required" column.

For all procedures, every Provider in the DentaQuest program is subject to random chart/treatment audits. Providers are required to comply with any request for records. These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

DentaQuest providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the "Patient Record" section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the DentaQuest Provider Panel.

Multistage procedures are reported and may be reimbursed 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. The completion date for endodontic treatment is the date the canals are permanently filled.

CLINICAL DENTISTRY

Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

A. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, prior endodontic treatment(s), fixed bridges, and removable appliances (dentures).

B. Assessment of TMJ status (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented.
C. Documentation of periodontal type, full mouth periodontal probing, and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.
D. Periodontal documentation may include a full mouth periodontal probing in cases where periodontal disease is identified.
E. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx, and floor of the mouth must be documented.
F. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the member's history and risk factors, and must be done at least annually.

RADIOGRAPHS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. An attempt should be made to obtain any recent radiographs from the previous dentist.
C. A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas, and alveolar bone. Frequency limitations exist for a complete series of radiographs
D. Decisions about the types of recall films should also be made by the dentist and based on current ADA/FDA radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures, and time since the patient's last radiographic examination
E. Panoramic x-ray (D0330) is not payable when taken on the same date of service as a complete series (D0210).

RADIOGRAPH DUPLICATION FEE

A. When a member is transferred from one provider to another, diagnostic copies of all x-rays less than two (2) years old should be duplicated for the second provider.
B. If the transfer is initiated by the provider, the member may not be charged any x-ray duplication fees.

C. If the transfer is initiated by the member, many plans allow the provider to charge for the actual cost of copying the x-rays up to a maximum fee of twenty-five dollars ($25.00).
D. This does not apply to Medi-Cal Dental members, and they cannot be charged for x-ray duplicate fees.

ORAL/FACIAL PHOTOGRAPHIC IMAGES

A. 2D Oral/Facial Photographic images (D0350) may only be billed when used for diagnostic purposes if unable to obtain radiographs due to young age or inability to cooperate
B. Routine Photos taken for documentation or patient education purposes are not billable to the plan
C. 2D Oral/Facial Photographic Image obtained Intra-orally or Extra-orally (D0350): 2D oral photographic images only reimbursed as a component of orthodontic records or for diagnostic purposes when radiographs cannot be taken due to a medical condition, physical ability, or cognitive function.
D. Diagnostic Casts (D0470): Diagnostic casts are for the evaluation of orthodontic benefits only and are only payable upon approved orthodontic treatment

PREVENTION

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

D1351 - SEALANT – PER TOOTH

A. Mechanically and/or chemically prepared enamel surface sealed to prevent decay.
B. Sealants on permanent molars are a covered benefit if the incipient caries and resin restoration does not penetrate dentin. If the resin restoration does not penetrate dentin, D1351 is appropriate.
C. Not covered for primary teeth
D. Not covered for 3rd molars except for instances where the 3rd molar has erupted into the place of the 2nd molar if the 2nd molar is not present.

DIAGNOSTIC

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

B. Periodic oral evaluations (Code D0120) of an established patient may only be provided for a patient of record who has had a prior comprehensive examination. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the patient's history and risk factors, and should be done at least annually
C. An oral evaluation of a patient less than seven years of age should include documentation of the oral and physical health history, evaluation of caries susceptibility, and development of an oral health regimen
D. A post-operative office visit for re-evaluation should document the patient's response to the prior treatment

PRE-DIAGNOSTIC SERVICES

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Screening of a patient, which includes a state or federal mandate, is used to determine the patient's need to see a dentist for diagnosis. (D0190)
C. Assessment of a patient is performed to identify signs of oral or systemic disease, malformation, or injury and the potential need for diagnosis and treatment. (D0191)

TREATMENT PLANNING

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Treatment plans should be comprehensive and documented in ink.
C. Treatment plans should be consistent with the clinical evaluation findings and diagnosis.
D. Procedures should be sequenced in an order of need consistent with diagnostic and evaluation findings and in compliance with accepted professional standards. Normal sequencing would include relief of pain, discomfort, and/or infection, treatment of extensive caries and pulpal inflammation including endodontic procedures, periodontal procedures, restorative procedures, replacement of missing teeth, prophylaxis, and preventive care, and establishing an appropriate recall schedule.

INFORMED CONSENT PROCESS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_se ction_05_MOC_SMA.pdf

B. Dentists must document that all recommended treatment options have been reviewed with the member and that the member understood the risks and benefits.
C. Appropriate informed consent documentation must be signed and dated by the member and dentist for the specific treatment plan that was accepted.
D. If a member refuses recommended procedures, the member must sign a specific "refusal of care" document.

POOR PROGNOSIS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_se ction_05_MOC_SMA.pdf
B. Members have the right to elect extraction of a tooth requirement treatment over restoring it.
C. Covered services are available to the member at no charge. In the event that a patient elects to select a non-covered alternate treatment, they are fully responsible for such services. Documentation must clearly show that the member has offered a plan benefit and elected to pay for non-covered services.

PROGRESS NOTES

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_se ction_05_MOC_SMA.pdf
B. The type and amounts of all local anesthetics must be documented, including the amount of any vasoconstrictor present. If no local anesthetic is used for a procedure that normally requires it (i.e., scaling and root planing), the related rationale should be documented.
C. All prescriptions must be documented in the progress notes and copies kept in the chart, including the medication, strength, amount, directions, and number of refills.
D. Transcription of illegible progress notes may be required and is the treating dentist/ dental office's responsibility. Transcription requests may be ordered by DentaQuest as part of grievance resolution, peer review, or other quality management processes. Providers agree to cooperate with any such requests by virtue of their contract.

PALLIATIVE TREATMENT

Responsibility for palliative treatment, even for procedures that may meet specialty care referral guidelines, is that of the contracted dentist. Palliative services are applicable per visit, not per tooth, and include all the treatment provided during the

visit other than necessary x-rays. A description of emergency and palliative treatment should be documented. Palliative treatment is reimbursed when a minor procedure has been performed. Making a diagnosis, rescheduling the member for treatment, referring the member to a specialist, or writing a prescription will not be reimbursed as palliative treatment.

ENDODONTICS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_se ction_05_MOC_SMA.pdf
B. Patients have the right to elect extraction as an alternative to endodontic therapy.

   Note: For benefit purposes providers should document endodontic dates of service as the dates when procedures have been entirely completed, subject to review.

ORAL SURGERY

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_se ction_05_MOC_SMA.pdf
B. Each dental extraction should be based on a distinctly recorded diagnosis for which extraction is the treatment of choice of the dentist and the member.
C. Primary Care Dentists are expected to provide routine oral surgery, including:
D. Uncomplicated extractions & emergency palliative care.
E. Surgical extractions of erupted teeth.
F. Incision and drainage of intra-oral abscesses.
G. Minor surgical procedures and postoperative services.
H. The removal of teeth solely for orthodontic purposes are only covered when comprehensive orthodontic treatment has been approved by DentaQuest.
I. When teeth are extracted, all portions of the teeth should be removed. If any portion of the tooth or teeth is not removed, patient notification must be documented.
J. Post-extraction socket irrigation, regardless of the type of material used, is inclusive with the extraction. Medicaid members cannot be charged for oral surgery irrigation materials including name brands such as “Biopure”.
K. Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.
L. Minor contouring of bone and soft tissues during a surgical extraction are considered a part of and included in a surgical extraction, D7210.

M. Documentation of a surgical procedure should include the tooth number, tissue removed, a description of the surgical method used, a record of unanticipated complications such as failure to remove planned tissue/root tips, displacement of tissue to abnormal sites, unusual blood loss, presence of lacerations and other surgical or non-surgical defects.
N. All extractions must be coded following the current CDT manual in addition to guidelines developed by the ADA.
O. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient.
P. A surgical extraction includes local anesthesia, suturing if needed, and postoperative care following extraction (e.g., dry socket, infection, bleeding, re-suturing).
Q. During our clinical review of requests for extraction of impacted and/or erupted teeth, DentaQuest may determine that treatment better fits the description of a different, more appropriate procedure code. In that situation, DentaQuest may approve the extraction under a different code.

Third molar extractions and Benefit Determinations

A. Reference the MOC for preventive services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. DentaQuest's licensed Staff Dentist adjudicate benefits on a case-by-case basis.
C. Third molar extractions are only covered when listed as a Plan Benefit and there is active pathology present.
D. Definition of Active Pathology: Pain, swelling, bleeding, or infection that is a result of congenital or behavioral disease (i.e. severe oral caries, benign or malignant growths, persistent pericoronitis, non-restorable caries, etc.) and not a result of normal developmental processes (i.e. eruption). Each tooth must qualify individually.
E. Definition of Impacted Tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

The ADA's position is that when coding for the removal of impacted teeth is dependent on the definition of an "anatomical crown". The full entries for these codes, as published in the CDT Manual, are:

- D7230 removal of impacted tooth – partially bony Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- D7240 removal of impacted tooth – completely bony Most or all of the crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

An "anatomical crown" as defined by the ADA's Glossary of Dental Clinical and

Administrative Terms is as follows: anatomical crown: That portion of the tooth normally covered by, and including, enamel.

Given this definition, the "crown" referenced in these codes' descriptors are the portion of the tooth above the cemento-enamel junction. It follows that "part of the crown" should be interpreted as "less than 50% of the entire crown" and "most or all of the crown" should be interpreted as "at least or more than 50% of the entire crown."

A. The prophylactic removal of a tooth or teeth that appear to exhibit an unimpeded path of eruption and/ or exhibit no active pathology is not covered. Removal of third molars to prevent future crowding or misalignment is not covered.
B. The removal of asymptomatic, unerupted, third molars in the absence of active pathology is not covered
C. By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.
D. Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic or photographic presentation will be the determining factor in the determination of coverage
E. All suspicious lesions should be biopsied and examined microscopically

Other Surgical Procedures

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

PERIODONTICS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. All children, adolescents, and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 3 millimeters and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the member's periodontal status as being Within Normal Limits (WNL).
C. Comprehensive oral evaluations should include the quality and quantity of gingival tissues. Following the completion of a comprehensive evaluation, a diagnosis, and treatment plan should be completed.

Periodontal Treatment Sequencing

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members:

https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

D4341/D4342 – Periodontal Scaling and Root Planning

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Periodontal scaling and root planning is not intended for a "difficult cleaning" or to be used "because it has been a long time since the last cleaning." Rather it is a judicious and meticulous treatment procedure to clean the roots of the tooth.
C. Evidence of bone and attachment loss must be present. Radiographic evidence of bone loss must be present. A full-mouth periodontal chart is recommended to demonstrate attachment loss.
D. Prior Authorization for Scaling and Root Planing (procedure codes D4341 or D4342) is ***waived*** for members with pregnant/postpartum status.
    a. However, member must still meet medical necessity criteria for this procedure

When requesting payment for Scaling and Root Planing (procedure codes D4341 or D4342) for members with pregnant/postpartum status, the provider may choose not to submit bitewing radiographs when:

b. *"Pregnant" or "Postpartum" is documented.*
c. *"Patient refused x-rays" will not be acceptable* documentation for non-submission of radiographs.

Definitive Treatment vs. Pre-Surgical Periodontal Scaling and Root Planning

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

Periodontal Scaling and Root Planning - Two Quadrants Per Appointment

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. As a guideline, DentaQuest benefits only two (2) quadrants per appointment. If a clinician recommends and/or completes more than two (2) quadrants per appointment, documentation supporting the additional quadrant(s) must be included with any claim and in the patient's progress notes.
C. Local anesthesia is commonly used. If it is not used, the reason(s) should be documented. The use of topical anesthetics is considered a part of and included in this procedure.
D. Home care oral hygiene techniques should be introduced and demonstrated

E. A re-evaluation following scaling and root planning should be performed. This re-evaluation should be performed at least four to six (4-6) weeks later and include:
    a. A description of tissue response.
    b. Pocket depth changes.
    c. Sites with bleeding or exudate.
    d. Evaluation of the patient's homecare effectiveness.

D4910 – Periodontal Maintenance

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

D1110 – Prophylaxis and D4341/D4342 – Periodontal Scaling and Root Planning

A. Reference the MOC for preventive services criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. The removal of plaque, calculus, and stains from supra-and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation without periodontitis (bone loss). It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing.
C. This procedure:
    a. Should not be reported in conjunction with D1110, D4341, D4342 or D4355
    b. Must be supported by a periodontal chart or photos
    c. Must not show evidence of radiographic bone loss

Soft Tissue Management Programs (STMP)

A. Any collection of periodontal and other services bundled together as a "soft tissue management" program must preserve the member's right to their Medicaid benefit.
B. Members have the benefit for all the periodontal and other codes listed in their plan benefit schedules.
C. Only non-covered services may be presented to the Medicaid member for additional payment.
D. Patients must sign a non-covered services form if they choose to accept soft tissue management procedures in addition to any covered procedures listed in the plan designs.

Periodontal Surgical Procedures

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Prior Authorization
   Prior Authorization is required for all periodontal procedures except for unscheduled dressing change, periodontal maintenance and periodontal scaling and root planning procedures rendered to pregnant/postpartum members regardless of age, aid code and scope of benefits when "Pregnant" or "Postpartum" is documented.

RESTORATIVE

Diagnosis and Treatment Planning

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

Operative Dentistry Guidelines

Placement of restoration includes:

- Local anesthesia
- Adhesives
- Bonding agents
- Indirect pulp capping
- Bases and liners
- Acid etch procedures
- Polishing
- Temporary restorations and
- Replacement of defective or lost fillings is a benefit, even in the absence of decay.

Amalgam Fillings, Safety, and Benefits

A. American Dental Association Statement: Food and Drug Administration Action on Dental Amalgam.
B. The American Dental Association (ADA) has agreed with the U.S. Food and Drug Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used cavity-filling material. Refer to the Statement of Dental Amalgam and additional resource materials at: https://www.ada.org/en/member-center/oral-health-topics/amalgam.
C. The primary objective of restorative dentistry is to remove caries conservatively, preserve tooth structure, and maintain tooth vitality.

D. Restoration of teeth is appropriate when there is radiographic evidence of caries, loss of tooth structure, defective or missing restorations, and/or for post-endodontic purposes.
E. Restorative treatment must be identified using valid procedure codes as found in the current edition of the American Dental Association's Current Dental Terminology (CDT). This source includes nomenclature and descriptors for each procedure code.
F. A filling cannot be billed in cases where decay or a fracture does not extend into dentin.

D1354 - Silver Diamide Fluoride

It is generally accepted that two applications of SDF are necessary to ensure the arrest of active carious lesions. Once it has been determined after the two (2) treatments that caries has been arrested, restorative care is generally not necessary in the primary dentition. The two (2) applications may be placed in intervals at the discretion of the treating dentist, and the benefit will be allowed up to two (2) services per tooth in a lifetime. Per CA MOC, SDF is allowed once every six months, up to ten teeth per visit, for a maximum of four treatments per tooth.

Restorative Services Coverage

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Restorative procedures in operative dentistry include silver amalgam; resin-based composites; direct or indirectly fabricated inlays, onlays, and crowns of various materials; certain prefabricated restorations (i.e. stainless steel or polycarbonate type crowns), as well as the use of various temporary material.
C. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication, and esthetic requirements
D. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite
E. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite. Decay limited to the Incisal edge only, may still be a candidate for a filling restoration if little to no other surfaces exhibit caries or breakdown

Expectations of Treatment:

Treatment results, including margins, contours, and contacts, should be clinically acceptable. Restorative dentistry includes the restoration of hard tooth structure lost,

as a result of caries, fracture, or trauma. The long-term prognosis of the tooth should be good.
Restorative procedures on teeth with poor prognosis are not reimbursed. Criteria for determining teeth with poor prognosis:

A. Caries involving root furcation or below the bone level.
B. Teeth with severe periodontal support (less 50% bone support).
C. Exfoliating Primary teeth.
D. Presence of apical pathology.
E. Payment is based on the number of surfaces restored, not on the number of restorations per tooth, per day; all restorative surfaces shall be considered connected.
F. The provider will not receive reimbursement if replacement of a restoration is billed by the provider who placed the original restoration within the first thirty- six (36) months of initial placement.
G. Restorations for altering occlusion involving vertical dimension and the replacement of tooth structure lost due to attrition, erosion, abrasion, abfraction, and corrosion are not covered.
H. Exception: A class V Facial/Buccal or Lingual surface is allowed in the presence of caries, pathology, or documented medical necessity.
I. Teeth where exfoliation is imminent will not be reimbursed. Reimbursement will include bases or liners, tooth desensitizing materials, and local anesthesia.
J. Reimbursement for one restoration in each tooth surface irrespective of the number or combination of restorations placed or if restoration is on non-contiguous surfaces.
K. Reimbursement for occlusal surface restorations includes extensions onto the occlusal 1/3 of the buccal or lingual surfaces.
L. Reimbursement for interproximal restorations extending onto the buccal or lingual surfaces must have margins that extend 1/3 onto those surfaces and are supported by radiographic evidence.
M. Restorations for cervical abrasion or incisal wear due to bruxism will not be covered without documented medical necessity.
N. The replacement of clinically acceptable amalgam fillings with an alternative material (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture is present.

Restorative Services Guidelines

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Restorative procedures in operative dentistry include silver amalgam; resin-based composites; direct or indirectly fabricated inlays, onlays, and crowns of

various materials; certain prefabricated restorations (i.e. stainless steel or polycarbonate type crowns), as well as the use of various temporary material.

C. The choice of restorative materials depends on the nature and extent of the defect to be restored, the location in the mouth, stress distribution expected during mastication, and esthetic requirements.
D. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite.
E. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite.
F. Restorations for chipped teeth may be covered.
G. The replacement of clinically acceptable amalgam fillings with alternative materials (composite, crown, etc.) is considered cosmetic and is not covered.
H. Restorative procedures for teeth exhibiting a poor prognosis due to gross carious destruction of the clinical crown at/or below the bone level, advanced periodontal disease, untreated periapical pathology or poor restorability are not covered.
I. Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months.
J. For posterior primary teeth that have had extensive loss of tooth structure, the appropriate treatment is generally a prefabricated stainless-steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.
K. When incisal edges of anterior teeth are undermined because of caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may include crowns.
L. Crowns should only be considered when cusp support is needed, and the tooth cannot be treated with a filling restoration.
M. Any alleged "allergies" to amalgam fillings must be supported in writing from a physician who is a board-certified allergist. Any benefit issues related to dental materials and "allergies" will be adjudicated on a case-by-case basis by a licensed DentaQuest dentist consultant.

CROWNS AND FIXED BRIDGES

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Providers should report the dates of service for these procedures to be the dates when the crowns and/or fixed bridges are cemented and delivered, subject to review.

Crown Upgrades

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Individual plan designs may limit the total maximum amount chargeable to a member for any combination of upgrades to a specified dollar amount.
C. Typical upgrades may include:
D. Choice of metal – noble, high noble, titanium alloy, or titanium
E. Porcelain on molar teeth
F. Porcelain margins, by report (porcelain margin upgrades may be reported as D2999 for single crowns or as D6999 for abutment crowns)

Single Crowns – Refer to Plan Benefits for Pre-Estimate Requirements

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. When molar crowns are indicated due to caries, an undermined or fractured off cusp, or the necessary replacement of a restoration due to pathology, the benefit is usually porcelain fused to a base metal crown.
C. Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be more susceptible to fracture than full metal crowns.
D. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontic procedures and such teeth should exhibit a minimum crown/root ratio of fifty percent (50%).

D2950 – Core Build-ups

A. Reference the MOC criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Documentation must show that without a build-up, there is insufficient tooth structure remaining to retain and support a crown.
C. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Likewise, a core buildup is not appropriate due to shallow caries that are likely to be removed during crown preparation.

Post and Core Procedures Include Buildups

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

B. By ADA CDT definitions, each of these procedures includes a "core." Providers may not unbundle procedure D2950 core buildup, including any pins, and report it separately from either of these procedures for the same tooth during the same course of treatment.

Outcomes

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

FIXED PROSTHODONTICS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://dental.dhcs.ca.gov/MCD_documents/providers/MOC_CDT24_Feb_24.pdf
B. When a single posterior tooth is missing on one side of an arch and there are clinically acceptable abutment teeth on each side of the missing tooth, the general choice to replace the missing tooth would be a fixed bridge or implant.
C. When it is necessary to replace teeth on the opposite side of the same arch, the benefit would generally be a removable partial denture instead of a fixed bridge.
D. When up to all four incisors are missing in an arch, the potential abutment teeth are clinically adequate, and implants are not appropriate, possible benefits for a fixed bridge may be evaluated on a case-by-case basis.
E. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and then submitted for any benefit determination request.

Outcomes

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

REMOVABLE PROSTHODONTICS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. Appliances should be designed to minimize any harm to abutment teeth and/or periodontal tissues and to facilitate oral hygiene.

Determination of Functional Occlusion:

A. Per CA MOC: "Lack of posterior balanced occlusion is defined as follows: a. five posterior permanent teeth are missing, (excluding third molars), or b. all four first and second permanent molars are missing, or c. the first and second permanent molars and second premolar are missing on the same side.
B. Removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars (i.e., no opposing occlusion), except when an anterior tooth is missing
C. Removable partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars). Remaining teeth must have a good endodontic prognosis, a good restorative prognosis, and a good periodontal prognosis
D. An interim partial denture may be needed when the remaining teeth have a good prognosis
E. A partial denture may be covered if the patient has an existing partial denture that is not serviceable, or an initial partial denture is being performed and the patient has several missing teeth on both sides of the same arch
F. For a treatment plan that includes both a fixed bridge and a removable partial denture in the same arch, the removable partial denture is considered the covered service
G. A unilateral removable partial denture is rarely appropriate. Best practices include replacing unilateral missing teeth with a fixed bridge or implant
H. Endodontic, periodontal, and restorative treatment should be completed prior to fabrication of a removable partial denture
I. Abutment teeth should be restored prior to the fabrication of a removable partial denture and would be covered if the teeth meet the same standalone benefit requirements of a single crown
J. Removable partial dentures should be designed so that they do not harm the remaining teeth and/ or periodontal tissues, and to facilitate oral hygiene
K. Materials used for removable partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic, and non-abrading to the opposing or supporting dentition
L. Partial dentures with acrylic clasps (such as Valplast or others, also known as "Combo Partials") are considered under the coverage for Codes D5213 and D5214.
M. Proper patient education and orientation to the use of immediate complete or partial dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings, and grievances, and to manage patient expectation

Complete Dentures (Codes D5110 / D5120)

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

Immediate Complete Dentures (Codes D5130-D5140 / D5221-D5224 / D5227-D5228)

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

Replacement of an Existing Complete or Partial Denture(s)

A. Removable complete or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by relining or repair.
B. Complete or partial dentures are not covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic concerns.

Repairs and Relines (Codes D5511-D5660)

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

IMPLANTS

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

General Guidelines

A. A conservative treatment plan should be considered before providing a patient with one or more implants. Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:
    1. Adverse systemic factors such as diabetes and smoking.
    2. Poor oral hygiene and tissue management by the patient.
    3. Inadequate osseo-integration (movable) of the dental implant(s).
    4. Excessive parafunction or occlusal loading.
    5. Poor positioning of the dental implant(s).
    6. Excessive loss of bone around the implant before its restoration.
    7. Mobility of the implant(s) before placement of the prosthesis.
    8. Inadequate number of implants or poor bone quality for long-span prostheses.

9. Need to restore the appearance of gingival tissues in high esthetic areas.
10. When the patient is under sixteen (16) years of age unless unusual conditions prevail.

Restoration

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf
B. The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate guidelines.
C. Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system itself.
D. Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.
E. Jaw relationship and intra-arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

Outcomes

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

ORTHODONTIC SERVICES

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

ADJUNCTIVE SERVICES

A. Reference the MOC for criteria, process, and benefits for Medi-Cal Dental members: https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

SPECIALTY CARE REFERRAL GUIDELINES

The following guidelines outline the specialty care referral process. If expanded or specialty dental services are required, the general dentist or PCD is not expected to deliver services, but to help coordinate the referral and to monitor the outcome.

Reimbursement of specialty services is contingent upon the member's eligibility at the time of service.

Direct Referrals

- DentaQuest provides coverage for complex procedures provided by contracting Endodontists, Orthodontists, Oral Surgeons, Pediatric Dentists, and Periodontists when referral protocol and medical necessity guidelines are met. While members are not required to have a referral to see a specialty dental provider, the PCD should provide the member a referral to a dental specialist if, in their professional judgement, it is required. The PCD will work with the member to select a specialist within the DentaQuest contracted network. To find an in-network specialist, you can search the online dental Provider Directory at https://www.dentaquest.com/en/find-a-dentist or call Member Services: Los Angeles County: 855-388-6257 or Sacramento County: 833-479-1984,
- Second opinions from a Specialist are available to Members upon request.

Standing Referrals for Members with Special Health Care Needs (SHCN)

- DentaQuest will arrange for a Member to receive a standing referral to a Specialist for members with Special Health Care Needs if the Primary Care Dentist determines, in consultation with the Specialist and DentaQuest's Dental Director or the Dental Director's designee, that a Member needs continuing care from Specialist. If a treatment plan is necessary in the course of care and is approved by DentaQuest, in consultation with the Primary Care Dentist, Specialist, and Member, a referral shall be made in accordance with the treatment plan.
- Determinations for standing referrals will be made within three (3) business days from the date the request is made by the Member or the Member's Primary Care Dentist and all appropriate dental records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any is submitted to DentaQuest's Dental Director or the Dental Director's designee.

MEMBER GRIEVANCES AND APPEALS PROCESS
HEALTH NET MEDI-CAL DENTAL

DentaQuest is not delegated for grievances and appeals for HealthNet Medi-Cal Dental. HealthNet Medi-Cal Dental members may file a grievance and/or appeal by calling HealthNet's Member Service Department, creating an account and filing a grievance online, or by printing a grievance and appeals form and mailing or faxing it to the following:

Phone: 800-977-7307/TTY: 711

Online: www.hndental.com

Writing: HealthNet Dental, Appeals & Grievances, PO Box 10348, Van Nuys, CA 91410-

0348

Fax: 1-877-713-6182

DENTAQUEST MEDI-CAL DENTAL

DentaQuest Medi-Cal Dental members who wish to file a grievance and/or appeal, can call DentaQuest's Member Services Department, file a grievance online, or print out a grievance and appeals form and mail it to the following:

Phone: Los Angeles County: 855-388-6257 or Sacramento County: 833-479-1984, TTY: 800-466-7566

Electronically: https://www.dentaquest.com/en/members/california-medicaid-dental-coverage/medi-cal-dmc-dentaquest

Writing: DentaQuest
PO Box 2182
Milwaukee, WI 53201-2182

IMPORTANT INFORMATION

Federal laws state that all Medicaid members have the following grievances and appeals rights:

- Grievances: Members can file a grievance at any time following any incident or action that is the subject of their dissatisfaction.
- Appeals: Members have the right to request an appeal of a decision made by DentaQuest to deny, modify, or pend (delay) a request for payment or treatment, within sixty (60) calendar days from the date of the Notice of Action (NOA) issued by the Plan.
- Providers submitting an appeal on behalf of a member must obtain and supply DentaQuest with a copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf. If DentaQuest does not receive such a document, the appeal cannot be processed.
- Continuation of Benefits: Members who are currently receiving treatment that they want to continue, must submit a request to the Plan within ten (10) calendar days from the date the letter was postmarked or delivered to them, or before the date the health plan states that services will stop. The member's appeal must state that they want to continue receiving treatment during the appeal process.
- Independent Medical Review (IMR): Members who receive a Notice of Appeal Resolution (NAR) from DentaQuest that was denied due to medical necessity, or experimental/investigational may request IMR within one-hundred-eighty (180) calendar days from the date of the NAR letter.
- State Fair Hearings: Medicaid members who receive a NAR from DentaQuest, that is not fully in their favor, may request a State Fair Hearing no later than one-hundred-twenty (120) calendar days from the date on the NAR letter.

- Members may represent themselves at the State Fair Hearing, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements. Members are informed that to get free legal assistance, they may call the Public Inquiry and Response Unit of the Department of Social Services at their toll-free number, 1-800-952-5253.
- Requesting a State Fair Hearing will not affect a member's eligibility for coverage, and members will not be penalized for seeking a hearing. Members may request benefit continuation during an appeal, IMR, or State Fair Hearing by contacting Provider Services at Los Angeles: 855-388-6257 and Sacramento: 833-479-1984
- Expedited/Fast Track Review: In cases in which a member's health or dental function is in immediate danger a request for an expedited grievance, appeal, State Fair Hearing, or IMR may be requested. All requests for expedited review, that meet the criteria, will be resolved within (72) hours from the time of receipt.
- Reference Section X Quality Management for more information on the member grievance and appeals process.

ANTI-DISCRIMINATION

Medi-Cal dental members have the right to file a grievance at any time if they feel that they have been discriminated against in any way. Members may file a grievance with DentaQuest, Department of Managed Health Care, and/or the U.S. Department of Health and Human Services, Office for Civil Rights. Reference Section X Professional Guidelines and Standards of Care for more information on Anti-Discrimination.

Office of Civil Rights
Department of Health Care Services PO Box 997413, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370, 711 (California State Relay) Email: CivilRights@dhcs.ca.gov

TELE-DENTISTRY

Medi-Cal dental Providers have the flexibility to use tele-dentistry as a modality to render services based upon service categories and parameters, using designated CDT codes as is the current policy, when in compliance with ALL the following requirements:

The procedure is a diagnostic (D0100-D0999) or preventive (D1000-D1999) service. Tele-dentistry is not allowable for all other service categories and CDT codes (D2000-D9999) except D9995 and D9996, which are the tele-dentistry modality codes; and D9430 office visit observation (during regularly scheduled hours – no other services performed).

Dental provider billing for services delivered via tele-dentistry must be enrolled as Medi-Cal dental providers. The dental provider rendering Medi-Cal covered benefits or services via a tele-dentistry modality must be licensed in California, enrolled as a Medi-Cal Dental rendering provider, operate within their allowable scope of practice,

and meet applicable standards of care.

Providers must inform the patient before the initial delivery of tele-dental services about the use of tele-dentistry and obtain verbal or written consent from the patient for the use of tele-dentistry as an acceptable mode of delivering dental care services. Providers also need to document when a patient consents to receive services, and such documentation must be maintained in the patient's medical (dental) record.

All services rendered through tele-dentistry must comply with the Manual of Criteria, including documentation requirements to substantiate the corresponding technical and professional components of billed CDT codes.

A patient who receives tele-dentistry services under these provisions shall also have the ability to receive in-person services from the dentist or dental practice or assistance in arranging a referral for in-person services.

The referral to the dentist or dental practice must be documented to use asynchronous tele-dentistry to establish a patient relationship. The procedure does not require an in-person presence of the patient in a dental facility, such as administration of anesthesia, direct visualization, or instrumentation of the mouth by a licensed dentist.

Procedures do not involve the insertion/removal of dental devices or products – such as crowns, implants, removable partials or dentures, or orthodontic appliances.

Tele-dentistry CDT codes

- D9995 (Tele-dentistry – Synchronous; Real – Time Encounter) and
- D9996 (Tele-dentistry – Asynchronous; information stored and forwarded to a dentist for subsequent review).
- D9430 office visit for observation (during regularly scheduled hours – no other services performed)

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies when a member has more than one source of dental coverage. The purpose of COB is to allow members to receive the highest level of benefits up to 100 percent of the cost of covered services. COB also ensures that no one collects more than the actual cost of the member's dental expenses.

- Primary Carrier – the program that takes precedence in the order of making payment
- Secondary Carrier – the program that is responsible for paying after the primary carrier
- Tertiary Carrier - the program that is responsible for paying after the secondary carrier

Identify The Primary Carrier

When determining the order of benefits (making payment) between two coordinating plans, the effective date refers to the first date the plan actively covers a member.

When there is a break in coverage DentaQuest will be primary based on DentaQuest effective date versus the new group effective date.

The table below is a guide to assist your office in determining the primary carrier.

PATIENT IS THE MEMBER	PRIMARY
Member has dental coverage through an employer.	Member coverage is always primary.
Member has dental coverage as an active employee and through the spouse.	Member coverage is primary.
Member has two active insurance carriers; both provide dental coverage.	The carrier with the earliest effective date is the primary.
Member has dental coverage through a group plan and COBRA coverage.	The group plan is the primary.
Member has dental coverage through a group plan and individual or supplemental coverage through another carrier. Note: Supplemental/Individual plans are purchased by the member for added coverage Examples: Student Accident Plans Supplemental Plans, Prepaid Trust Plans.	The group plan is the primary plan.
Member has dental coverage as an active employee of one plan and as a retired employee of another plan.	The active coverage is the primary plan.
Member has two retiree plans.	The plan that covered the member longer is primary.
Member has a retiree plan and spouse holds a group plan	Spouse's group plan is primary.
Member has a government-funded plan and individual or	Individual/Supplemental coverage is

supplemental coverage through another carrier.	the primary plan.
Member has two government-funded plans. One is Federal (Medicare), and the other is State (Medicaid, Medi-Cal, or Value Add).	Federal coverage is primary plan.
Member has dental coverage through a group plan and a government- funded plan.	The group plan is primary.
Member has dental coverage through a retiree plan and a government-funded plan.	The government-funded plan is the primary plan.
Dependent Child and the Birthday Rule.	1. The plan of the parent whose birthday falls earlier in the calendar year (month and day only) holds the primary coverage for dependent children. 2. If both parents have the same birthday, the plan that has covered either of the parents the longest is the primary plan. However, if the other plan follows the "gender rule" with male coverage always primary, DentaQuest will follow the rules of that plan. 3. These rules may be superseded by a court order that establishes the party responsible for the child's coverage. When determining the primary carrier for dependents with dual coverage, verify that both parents are the biological parents before applying the birthday rule. 4. Coverage through the biological parent is primary.

If coverage is through a biological parent and a stepparent residing in the same household.	The biological parent's plan is the primary plan.

PATIENT IS THE DEPENDENT	PRIMARY
If parents are divorced or separated there are two dental plans.	The parent with custody is the primary.
If coverage is through both biological parents and stepparent, in the absence of a court order, if the biological parents are legally separated or divorced.	1. The plan covering the parent with custody or with whom the child resides is the primary. 2. The plan covering the stepparent residing in the same household is the secondary. 3. The plan covering the other biological parent's coverage is the third (tertiary). 4. The plan covering the other stepparent's coverage is the fourth.
If a child has a government-funded plan and group plan through the child's parent. Examples of government-funded plans: • Healthy Families • Medi-Cal Dental • Medicaid • Medi-Cal • Medicare • Healthy Kids • Viva • Scan • Coventry • TRICARE (see note below) Note: TRICARE is a self-funded government plan and does not	The group plan through the parent is the primary.

follow the Active vs. Retiree guidelines. TRICARE follows the effective date regardless of the plan's active or retiree status. The plan with the earliest effective date is considered prime. If a member has a group plan and TRICARE; the group plan will be primary.	

SECTION 5: MANUAL OF CRITERIA AND SCHEDULE OF MAXIMUM ALLOWANCES

Your office can obtain immediate access to the Department of Health Care Services (DHCS) Medi-Cal Dental Provider Handbook, Section 5 – Manual of Criteria (MOC) at:
https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf

SECTION 6: FORMS

Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. Providers can access and acquire both electronic and printable forms via our provider portal website at Providers.dentaquest.com. Once logged in, select the link "Related Documents" to access the following resources:

- Acknowledgment of Disclosure & Acceptance of Member Financial Responsibility Consent Form
- Dental ADA Claim and Authorization Form
- Direct Deposit Form
- HIPAA Companion Guide
- Orthodontic Form Criteria
- Initial Clinical Exam
- Medical and Dental History
- OrthoCAD Submission Form
- Orthodontic Continuation of Care Form
- Provider Change Form
- Recall Examination Form
- Request for Transfer of Records
- Specialty Referral Form
- Incident Report Form

SECTION 7: CODES

Your office can obtain immediate access to the Department of Health Care Services (DHCS) Medi-Cal Dental Provider Handbook, Section 7 – Codes at: https://dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_07_codes.pdf

In addition, reference Section 13 for the covered benefit specifics including age, frequency, and authorization requirements broken out for each CDT code.

SECTION 8: QUALITY MANAGEMENT

PROGRAM DESCRIPTION

The DentaQuest Quality Improvement Oral Health Access Transformation Program (QIOHATP) represents an initiative aimed at addressing disparities in oral health outcomes and access to care across diverse populations. This comprehensive program is designed to catalyze systemic changes within the member population we serve.

Oral health is an integral component of overall health and well-being, yet significant disparities persist based on factors such as race, ethnicity, socioeconomic status, geographic location, and age. These inequities result in disproportionate rates of dental diseases, reduced access to preventive and restorative care, and poorer oral health outcomes for marginalized communities. The far-reaching consequences of these disparities extend beyond oral health, impacting overall quality of life, economic opportunities, and systemic health.

QIOHETP POLICY

The purpose of the QIOHATP is to ensure the highest quality, cost-effective dental care for all California Dental Managed Care enrollees, with an emphasis on dental disease prevention while addressing disparities in oral health outcomes and access to care across diverse populations.

QIOHETP SCOPE

The scope of the QIOHATP activities includes continuous monitoring and evaluation of primary and specialty dental care provided throughout the dental network. In addition, the scope includes systematic processes for evaluating and monitoring all clinical and non-clinical aspects of dental care delivery.

QIOHETP GOALS AND OBJECTIVES

The goals and objectives are comprehensive and support the overall organizational goal of providing the highest quality dental care to members in a cost-effective manner while addressing disparities in oral health outcomes and access to care across diverse populations.

- Continuously review how dental care and services are provided.
- Uphold standards to ensure access to cost-effective, quality care.
- Ensure service delivery system meets standards of excellence.

- Monitor member and provider satisfaction to identify opportunities for improvement.
- Provide services in a culturally competent manner that assists all individuals in obtaining exceptional health care services, including those with complex physical and/or mental health needs, limited English proficiency or reading skills and diverse cultural and ethnic backgrounds.
- Ensure adequate resources are dedicated to the QIOHATP through organizational engagement.
- Identify and examine social determinants of oral health, and barriers to oral health access and literacy.
- Collect data on key oral health indicators for defined population groups, and the enrollee population as a whole.
- Establish and maintain a Quality Improvement Oral Health Equity Transformation Plan and appropriate subcommittees with adequate provider representation.
- Monitor performance measures to determine outcomes of care and trends indicating areas requiring interventions for improvement and continued monitoring to assess interventions for effectiveness.
- Establish and maintain a process for continuously monitoring over- and under-utilization of dental care and services.
- Promote preventive dental health services, patient safety and quality of dental care provided to members.
- Monitor and evaluate the service delivery system including provider network.
- Proactively assess the quality-of-care delivery to identify potential areas for improvements.
- Develop and implement comprehensive quality management and performance improvement projects ("PIP") to address trends and deficiencies identified through monitoring activities, reviews of complaints, oversight of provider activities, utilization management reviews, and member and provider satisfaction survey results.
- Compliance with federal, state, and accreditation requirements
- Identify best practices for quality management and performance improvement.
- Ensure the availability of culturally and linguistically appropriate service through systematic monitoring and improvement activities.
- Allocate and distribute resources necessary to support quality improvement initiatives.
- Provide services in a culturally competent manner that assists all individuals in obtaining exceptional health care services, including those with complex physical and/or mental health needs, limited English proficiency or reading skills and diverse cultural and ethnic backgrounds.

COMMITTEES

Oversight of the QIOHATP is provided through a committee structure, which allows for

the flow of information to and from the Board of Directors. The QIOHATP employs two major Committees and additional sub-committees to ensure that dental care delivery decisions are made independent of financial and administrative decisions. The Committees are as follows:

- Corporate Compliance Committee
- California Quality Improvement Oral Health Equity Committee
- Utilization Management Committee
- Peer Review Committee
- Clinical Quality Committee
- Credentials Committee
- Delegation Oversight Committee
- Population Health Management Committee
- Cultural and Linguistics Committee
- Community Advisory Committee
- Network Adequacy Committee

The CA Quality Improvement and Oral Health Access Committee (QIOHAC) and the Corporate Compliance Committee (QOC) reviews, formulates, and approves all aspects of dental care provided by DentaQuest's Network Providers, including the structure of care, the process and outcome of care, utilization, and access to care, availability, referrals to specialists, continuity of care, safety, appropriateness, and any problem resolution in the dental delivery system identified by the Peer Review or Utilization Management Committees.

The QIOHAC's oversight responsibilities include monitoring the activities of other QIOHAC's components and participants to ensure that approved policies and procedures are followed and that those policies and procedures are effective in meeting the needs of DentaQuest and its members.

The Credentialing Committee is responsible for reviewing, accepting, or rejecting the professional credentials of each applicant dentist and contracted dental provider. The Credentials committee follows the approved policies and procedures of the QOC's in determining whether a provider will be approved or denied as a participant in DentaQuest's provider network.

Dentists are re-credentialed on a three (3) year cycle and as needed. Sixty (60) days before the provider's assigned re-credentialing date, the dentist will receive a written request to submit the required documents to DentaQuest. Failure to comply with re-credentialing requests will result in termination from the network.

The Network Adequacy Committee is responsible for monitoring the number and distribution of primary care and specialty care dentists to ensure an adequate network of providers. Quarterly, the Network Adequacy Committee reports on the geographic distribution ratio of members to the dentist, as well as the analysis of data regarding appointment availability, wait times, and grievances/appeals to determine shortcomings in the network and submits the findings to the QIOHEC for review.

The Peer Review Committee (PRC) ensures that dental care is rendered following the policies, procedures, and standards set by the QOC.

The PRC is responsible for:

- Provider quality of care issues identified through various means, including but not limited to, member grievances/appeals, on-site audits, and chart reviews.
- Potential or pending malpractice issues, National Practitioner's Data Bank reports, and Dental Board of the specified State reports, when requested to do so by the QIOHAC.
- Provider Disputes (i.e., grievances, appeals, terminations, denial of panel participation).
- Member grievances and appeals or other dental care issues.
- Annual review and update of the Specialty Referral Criteria and Guidelines.
- Monitors patterns of disputes and makes recommendations to the Dental Director regarding a doctor, member, or group.

The Utilization Management Committee (UMC) is responsible for reviewing the utilization data as reported by network providers and the subsequent analytical reports to ensure proper utilization and delivery of care.

The UMC evaluates a summary of treatment provided by the entire contracted General Dentist network. The analysis is intended to indicate the number of members seeking treatment and the types of treatment they receive. Further evaluation of specific provider offices allows a determination of how those offices compare to the overall experience of the entire network and how individual provider offices compare to the established network standards.

The Dental Director assesses over and under-utilization of specialty referral trends and reports the findings to the UMC. From these reports, the UMC can also monitor trends in specialty referral denials and make recommendations to the QIOHAC.

The UMC also reviews access and availability and continuity of care issues by reviewing reports of appointment availability, wait times, and the number of actual appointments kept by the members. This will also include an evaluation of the number and location of the general and specialty dentist providers. The UMC addresses negative trends in these areas and makes recommendations for improvements that are forwarded to the QIOHEC.

SURVEYS:

A. Provider Access Surveys: For all Provider offices, DentaQuest conducts quarterly random office contacts to assess the availability of appointments.
B. Member Satisfaction Surveys: Surveys can be generated for members in response to trending information or reports or potential access problems with specific dental offices.

PROVIDER PROFILING PROGRAM

DentaQuest has developed a program that seeks to ensure that the quality of services

delivered to members is maintained at a high level and that the quality of services delivered are in line with a practical and conservative oral health approach. As a benchmark, DentaQuest measures quality and quantity components for individual offices and providers and compares them to all DentaQuest offices and providers in a particular service area. This comparison also allows DentaQuest to ensure that all providers are compensated equitably. DentaQuest recognizes the concept of "community standard", which is readily accepted in the dental legal community, as a comparative measurement tool to profile dentists. At the completion of review activities, providers are educated on findings.

Qualitative and Quantitative Data Management

DentaQuest employs utilization data reports that cover various quantity of service measurements compared on a peer-to-peer basis within a given service area to be consistent with the concept of "community standards" of practice. These reports are configured to reflect preventive practice patterns, treatment sequencing, retreatment patterns, cost data patterns, and benchmark frequencies. Typically, providers or offices with a high ranking on a data management report are subject to further audit and review.

Provider Education and Behavior Modification

When the results of the utilization reports indicate a potential aberrant situation, i.e., re-treatment patterns, or over-utilizing radiographs, a provider may be notified through education or investigation. This process may include referral for a Quality Assurance Assessment, that includes chart reviews. The review may result in provider education with the final objective being modification of behavior to bring the provider within a respectable level of the "community standards" norm. Data management reports provide feedback as to the effectiveness of the preliminary communications with the provider.

Peer Review

DentaQuest maintains a professional staff of dentists who comprise the Peer Review Committee (PRC). The PRC is responsible for the investigation of quality-of-care issues, including allegations of member harm. DentaQuest's PRC renders clinical decisions and/or opinions and appropriately advises appropriate DentaQuest management of any significant credentialing or Fraud, Waste or Abuse issues. These decisions can include but are not limited to:

- Provider Education
- Placement of a provider on a Corrective Action Plan
- Referral to applicable state Board of Dentistry
- Referral to the Credentialing Committee with a recommendation for termination/suspension

PROVIDER SITE QUALITY ASSURANCE ASSESSMENTS

DentaQuest has developed a program that seeks to ensure that all providers and

provider locations are capable of delivering appropriate levels of care to Members. This program includes office site Quality Assurance Assessments.

Pre-assessments, scheduled assessments, and assessments on-demand can be done on-site or by a combination of an on-site facility assessment and the collection of charts and x-rays for review by any of the professional review components. The Independent Quality Assurance Assessment consultant, a PRC member, the Dental Director, or a professional staff member performs quality assessments.

Except for facility pre-assessments of new offices, periodic assessments of existing offices and on-demand assessments combine on-site facility and chart reviews. Chart reviews are performed by licensed dentists who are contracted or employed quality assurance consultants, Peer Review Committee (PRC) members, or the Dental Director. A Provider Partner may also perform facility reviews.

An initial Quality Assurance Assessment of a General Dentist provider will be performed within 12 months of activation of a newly contracted provider office. This assessment includes a review of the charts of assigned DentaQuest Members as well as the dental facility. Offices already contracted have facility and chart assessments on a periodic basis. The assessment frequency may be within 3 months to 36 months, based on the findings of the assessment and on the office's previous QA Assessments.

Orthodontic Quality Assurance Assessments will be performed in offices with a sufficient number of members with active and/or completed treatment.

DentaQuest requires that orthodontic referrals be preauthorized. When preauthorization is given, the member will be assigned to an orthodontic provider. DentaQuest will track the assignments by provider and will quarterly review cumulative assignment and submitted orthodontic claims data. The orthodontic Quality Assurance consultant will perform a facility review and will review a minimum of five DentaQuest member charts.

If the Quality Assurance review is acceptable, with no major deficiencies, the facility will be scheduled for its next periodic review. The next assessment will be scheduled within 24 months. After an office has had two consecutive acceptable assessments, it will be placed on a 36-month review schedule.

If an assessment reveals critical deficiencies, the provider is notified, and a CAP is requested. The Dental Director (or his/her designee) reviews all submitted CAPs and, based on the nature of the deficiencies and the thoroughness of the CAP response, a decision will be made by the Dental Director or PRC as to which procedures (such as shortened re-assessment intervals, follow up visit by a Provider Partner, or demand or follow up assessment) are needed prior to the next periodic review. If a provider fails to adequately respond to a CAP request or if a re-assessment is failed, the Dental Director will order another assessment, order the office closed to new Members, or refer the office to the PRC for potential termination.

A Potential Quality Issue (PQI) may be uncovered by any of the QA tools of the QIOHETP. The finding may prompt the Dental Director or PRC to order an on-demand office assessment or to shorten the re-assessment interval. If an on-demand audit

assessment is required, it is performed within 30 to 120 days. The Dental Director (or his/her designee) reviews the results of an on-demand assessment. As needed, the Dental Director then forwards the result to the appropriate committee. After considering the assessment results with any other appropriate data, the office can be placed on a periodic review schedule, re-assessed again on-demand, closed to new Members until successful passage of a re-assessment, or be terminated.

The Facility/Structure Audit Review measures compliance with the aspects of infection control, radiographic safety, occupational hazard controls, medical emergency procedures and office policies and procedures. The different infection aspects reviewed include personnel protective equipment, hepatitis B vaccination, infectious waste disposal, sterilization, disinfection, and training programs. The Facility Audit Review also monitors provisions of preventive dental health education materials to Members. Critical indicators of the Facility/Structural Review include: a current medical emergency kit and personnel who know its location, Mobile oxygen available with positive pressure, 24-hour emergency system and doctor available, use of adequate barrier techniques, and reusable instruments and handpieces sterilized. A deficiency on any critical indicator necessitates the formulation of a Corrective Action Plan with a requirement to demonstrate that the Corrective Action has been taken.

Chart/Process Reviews

DentaQuest uses a Dental Chart Assessment form to determine that the level of care delivered by contracted providers meets professional and legal standards of practice. The current General Dental form recognizes the following aspects of care: Medical/Dental History, Diagnostic Information, Progress Notes, Emergency Care, Diagnosis and Treatment Plan, Radiographs, Periodontics, Preventive Care, Restorative, Endodontics, Crown and Prosthetics (for fixed and removable prosthodontics), Oral Surgery, Pedodontics, and Continuity of Care, and follows guidelines developed by the California Association of Dental Plans (CADP). For each aspect of care, appropriate variables are listed. The results for all variables are used to compute an overall chart assessment score. In addition, the QAC has designated three variables as Level 1A indicators that require consistent compliance on all reviewed charts. These critical standards are subject to ongoing review and revision. Currently they include: "complete and comprehensive health history signed by the patient/guardian," "Overall care is clinically acceptable (to the extent it is possible to determine by x-ray and available information)", and "evidence of emergency coverage on a 24-hour basis."

Chart Reviewers

The Independent On-Site Quality Assurance consultant, the Dental Director, or a PRC member completes chart reviews. DentaQuest is a participating member of CADP's shared assessment warehouse and may alternatively choose to view an assessment recently performed by another Knox-Keene licensed dental plan that has been entered into the shared assessment warehouse. In that case the Dental Director (or his/her designee) shall view the shared assessment and may choose to accept the assessment scoring or alternatively to schedule a review by a DentaQuest contracted

consultant, the Dental Director, or a PRC member.

Chart Selection, General Dental Offices

Charts to be reviewed are selected from encounter data submitted to DentaQuest. The office is provided a randomly generated list of member charts to provide for review.

The office is sent a Quality Assessment appointment letter, which includes the list of member names that charts for the assessment are to be selected from, as well as appointment date and instructions for preparing for the assessment. The reviewer will be instructed to select ten charts from the 20 provided that fit the criteria of:

- At least five charts are adult patients with treatment plans that include more procedures than prophylaxis/hygiene.
- At least five have completed treatment and been seen for recall.
- At least one pediatric, one restorative, one completed endodontic, one completed oral surgery, one completed prosthodontic (crown, bridge, partial, denture) and one periodontic case are included.

In the event that the reviewer finds that there are not ten charts from the 20 that fit the criteria, the reviewer may request to see additional DentaQuest member charts and/or will document the lack of acceptable charts in the Quality Assessment report. This may result in a shorter interval until the next periodic review, at the PRC's discretion.

Combined Quality Assessment Scoring

The overall combined assessment score is based on the scores received in both the Facility Reviews and Chart Reviews. The percentage score for each of these components is halved, and then added together. DentaQuest has four ratings for combined assessment scores:

Acceptable:	Combined scores of 90% and greater
Acceptable with Recommendations:	Combined scores less than 90%, but equal to or greater than 80%
Marginally Acceptable:	Combined scores less than 80%, but equal to or greater than 70%
Unacceptable:	Combined scores less than 70%

Facility scores and each section score of the process/chart assessment will also be looked at separately. A combined score of less than 70% or less than 70% on the

facility score will be considered unacceptable. The office will be required to submit a CAP and will be re-assessed in 3-6 months, following acceptance of submitted CAP. (In the case of facility review below 70% with otherwise acceptable process assessment score a trained DentaQuest Provider Partner will visit the office to verify that CAP has been carried out and office will be placed on 18-24 month re-assessment schedule.) Offices that post an overall process score of 70% or above but have less than 50% on any of the section totals will be placed on a 12–18-month re-assessment schedule, depending on the nature of the deficiency. Offices that post combined scores over 70% with no deficient critical indicators, facility score greater than or equal to70% and process section greater than or equal to 50% will generally be placed on 24-month re-review (unless the Dental Director or PRC determines a reason for a more frequent review).

If an assessment reveals critical deficiencies in the process review, the provider is notified and a CAP is requested. The Dental Director (or his/her designee) reviews all submitted CAPs and, based on the nature of the deficiencies and the thoroughness of the CAP response, a decision will be made by the Dental Director or PRC as to whether additional procedures (such as follow up visit by a Provider Partner or demand or follow up audit assessment) are needed prior to the next periodic audit review. If a provider fails to adequately respond to a CAP request or if a re-audit re-assessment is failed, the facility may be re-audited re-assessed again, closed to new Members or referred to the PRC for potential termination. If the re-audit re-assessed is passed, the office will be scheduled for its next periodic audit review.

Offices with deficient critical indicators in the facility assessment must submit a CAP. Re-assessment will depend on the nature of the critical deficiency (e.g. a receipt for purchase of an oxygen tank or emergency medical kit supplies would suffice to verify compliance with CAP, whereas an office visit would be required to verify sterilization procedures). Generally, follow up on critical deficiencies can be accomplished by a trained provider relations representative and will be scheduled, when needed, within three to six months of acceptance of the CAP.

If the office fails a CAP verification re-assessment, the office may be re-assessed again in one to three months and/or closed to new Members and/or recommended for termination.

Offices that are required to submit a CAP are given 30 days to do so. In most cases the Quality Assurance consultant will assist the office to develop and sign off on a CAP at the time of the assessment visit. Offices who do not respond within 30 days are given an additional 15 days and advised that their office will be closed to new Members and subject to termination if response is not received in 15 working days. Offices who still do not respond are informed that they are closed to new Members and may be terminated in 15 days if there is no response to the third notice.

COMPLAINTS, GRIEVANCES AND APPEALS (CG&A) SYSTEM:

DentaQuest adheres to State, Federal, and Plan requirements related to processing inquiries, complaints, and grievances. Enrollees have the right to request continuation

of benefits while utilizing the grievance system. Unless otherwise required by DHCS and Plan, DentaQuest's processes such inquiries, complaints, grievances and appeals consistent with the following:

A. Definitions:

Inquiry: An inquiry is the first contact with the Plan (verbal or written) expressing dissatisfaction from the Member, an attorney on behalf of a Member, or a government agency.

Complaint: A complaint is any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights, health plan administration, claims practices, or provision of services that relates to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system. A complaint is the lowest level of challenge and provides the health plan an opportunity to resolve a problem without it becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.

Grievance: A grievance is an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or health plan employee or failure to respect the enrollee's rights.

Appeal – An appeal is a formal request from an enrollee to seek a review of an action taken by the Health Plan pursuant to 42 CFR 438.400(b). An appeal is a request for review of an action.

B. Complaints/Grievance and Appeals Staff:

DentaQuest's Complaints/Grievance Coordinator receives Member and Provider inquiries, complaints, grievances, and appeals. DentaQuest's Complaints/Grievance Coordinator has office hours from Monday through Friday, 8:00am to 5:30pm PST. The coordinator investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals are notified in writing of the resolution (i.e. Plan, Member, and Provider as applicable). The complaint is closed and maintained on file for tracking and trending purposes.

The Complaints/Grievances Coordinator receives Member and Provider grievances and appeals. The coordinator requests appropriate documentation and forwards the documentation to the dental consultant for review and determination. The decision to uphold or overturn the initial decision is

communicated to the appropriate individuals.

C. Provider Complaints/Grievances/Appeals/Dispute:

Contracted providers have a right to file an appeal for denied claims (which include prepayment review process), prior authorizations and/or referral determinations in accordance with CCR 28 §1300.71. This can be done by submitting a request for appeal in writing with a narrative and supporting documentation to the DentaQuest Provider Appeals Coordinator via mail or fax. All appeals should be sent to the attention of DentaQuest-Provider Appeals, PO Box 2182 Milwaukee, WI 53201-2182 Providers can also call Provider Services at Los Angeles: 855-388-5257 and Sacramento: 833-479-1984, Monday through Friday, 8:00am to 5:30pm to file their complaint and/or appeals.

D. Provider complaints concerning Non-Claims issues:

Providers have three-hundred-sixty-five (365) days to file a written complaint for issues that are not about claims.

Within two (2) business days of receipt of an electronic complaint, DentaQuest will notify the provider that the complaint has been received. In the case of a paper provider dispute, the acknowledgement will be provided (in writing) within fifteen (15) business days of the date of receipt.

DentaQuest will resolve all complaints within thirty (30) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

E. Providers complaints concerning Claims issues (Claim Payment Dispute):

Providers have three-hundred-sixty-five (365) days from the date of final determination of the primary payer to file a written complaint for claims issues.

Within two (2) business days of receipt of an electronic complaint, DentaQuest will notify the provider (in writing) that the complaint has been received. In the case of a paper provider dispute, the acknowledgement will be provided (in writing) within fifteen (15) business days of the date of receipt.

DentaQuest will resolve all claims complaints within thirty (30) days of receipt, in accordance with APL 22-006, and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

F. Medi-Cal (Medicaid) Fair Hearing Process:

Members have the right to ask for a Medicaid Fair Hearing after they exhaust the appeal process. Members can ask for a fair hearing by calling or writing to:

- To the California Department of Social Services
  - State Hearings Division
    - P.O. Box 944243, Mail Station 21-37
      Sacramento, California 94244-2430.

- To the State Hearings Division by fax to (833) 281-0905.
- To the California Department of Social Services at the online hearing request page.

  OR

- You can make a toll-free call to request a State Hearing.
- California Department of Social Services
- Public Inquiry and Response Phone (800) 743-8525 (Voice); (800) 952-8349 (TDD)

  The member's benefits will not stop while the case is reviewed. The benefits will stop if the member is taken out of Medicaid (disenrolled) for any of the reasons. Please note that the member may have to pay for the cost of those benefits if the Medicaid Fair Hearing upholds DentaQuest's action.

G. Policy and Procedures:
Copies of DentaQuest's policies and procedures can be requested by contacting Provider Services at Los Angeles: 855-388-5257 and Sacramento: 833-479-1984

MEMBER GRIEVANCES AND APPEALS (CG&A)

The DentaQuest member CG&A process encompasses investigation, review, and resolution of member issues to DentaQuest and/or contracted providers. As part of our commitment, DentaQuest works to ensure that all members have every opportunity to exercise their rights to a fair and timely resolution to any CG&A.

Members can file a grievance at any time following any incident or action that is the subject of their dissatisfaction.

Appeals: Members have the right to request an appeal of a decision made by DentaQuest to deny, modify, or pend (delay) a request for payment or treatment, within sixty (60) calendar days from the date of the Notice of Action (NOA) issued by the Plan.

Providers submitting an appeal on behalf of a member, must obtain and supply DentaQuest with a copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf. If DentaQuest does not receive such a document, the appeal cannot be processed.

Continuation of Benefits: Members who are currently receiving treatment that they want to continue, must submit a request to the Plan within ten (10) calendar days from the date the letter was postmarked or delivered to them, or before the date the health plan states that services will stop. The member's appeal must state that they want to continue receiving treatment during the appeal process.

Independent Medical Review (IMR): Members who receive a Notice of Appeal Resolution (NAR) from DentaQuest that was denied due to medical necessity, or experimental/investigational may request IMR within one-hundred-eighty (180)

calendar days from the date of the NAR letter.

State Fair Hearings: Medicaid members who receive a NAR from DentaQuest, that is not fully in their favor, may request a State Fair Hearing no later than one- hundred-twenty (120) calendar days from the date on the NAR letter.

Members may represent themselves at the State Fair Hearing, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements. Members are informed that to get free legal assistance, they may call the Public Inquiry and Response Unit of the Department of Social Services at their toll-free number, 1-800-952-5253.

Requesting a State Fair Hearing will not affect a member's eligibility for coverage, and members will not be penalized for seeking a hearing. Members may request benefit continuation during an appeal, IMR, or State Fair Hearing by contacting DentaQuest's Member Services Department toll-free Los Angeles County: 855-388-6257 and Sacramento County: 833-479-1984.

Expedited/Fast Track Review: In cases in which a member's health or dental function is in immediate danger a request for an expedited grievance, appeal, State Fair Hearing, or IMR may be requested. All requests for expedited review, that meet the criteria, will be resolved within (72) hours from the time of receipt.

All contracted provider facilities are required to display member complaint forms.

CG&A RECORDS REQUESTS

Providers are contractually required to provide DentaQuest with copies of all member records as a result of a member CG&A within three (3) business days of a request from the Plan.

All providers are obligated to respond to DentaQuest with a written response to the member's concerns, and all supporting documentation (clinical notes, treatment plans, financial ledgers, x-rays, etc.)

Failure to cooperate/comply with the CG&A process or resolution may lead to disciplinary actions, including but not limited to, termination from the DentaQuest network.

CG&A CULTURAL AND LINGUISTICS

DentaQuest's CG&A system also addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. The system is designed to ensure that all Plan members have access to and can fully participate in the CG&A system.

DentaQuest's members' participation in the CG&A system, for those with linguistic, cultural, or communicative impairments, is facilitated through DentaQuest's coordination of translation, interpretation, and other communication services to assist in communicating the procedures, process, and findings of the G&A system.

DentaQuest provides members whose primary language is not English with translation services. We currently provide translation services in one hundred and fifty (150)

languages. G&A forms can be obtained from DentaQuest's Member Services Department, from a dental provider facility, or the DentaQuest website.

Title III of the Americans with Disabilities Act (ADA) and informed consent doctrine, require that if a patient needs an interpreter or translation services in order to understand the information you are providing to them during a health care visit, then it is your responsibility to provide such services at no cost to the patient (see referenced links below).

Informational References:

- Translation and Interpretation Services | Medicaid
- Increased Federal Matching Funds for Translation and Interpretation Services under Medicaid and CHIP
- Center for Medicaid, CHIP and Survey & Certification (CMCS) Informational Bulletin

The patient should not hire their own interpreter and you may not charge the patient for these services. Additionally, the guidance indicates that a doctor/health care provider should not try to encourage the patient to bring a signing family member or a friend as a way to "save costs". Family members and friends cannot be expected to be neutral and sign everything they hear. They may be emotionally or personally involved with the patient and this may affect their interpreting. Using them as interpreters can also cause problems in maintaining the patient's confidentiality.

To find an appropriate interpreter or translation service you may use the service referenced in the link below that the American Dental Association promotes or you may call DentaQuest for assistance. ADA Member Advantage Programs-Interpretation and Translation Services

To provide excellent service to our members, DentaQuest maintains a process by which members can obtain timely resolutions to their inquiries and complaints. This process allows for:

- The receipt of correspondence from members, in writing or by telephone
- Thorough research
- Member education on plan provisions
- Timely resolution

CG&A SUBMISSION

Members, authorized representatives, and providers on behalf of members can submit a grievance and appeal via telephone by calling DentaQuest's Member Services Department toll-free, or by fax, email, letter, or grievance and appeals form.

Phone: Los Angeles: 855-388-5257 and Sacramento: 833-479-1984Electronically: providers.dentaquest.com

Writing: DentaQuest PO Box 2182, Milwaukee, WI 53201-2182

CORRECTIVE ACTION PLANS

Negative findings resulting from the above activities may trigger further investigation of the provider facility by the Dental Director or his/her designee.

If an access to care problem is identified, corrective action must be taken including, but not limited to, the following:

- Further education and assistance to the provider.
- Provider counseling.
- Closure to new membership enrollment.
- Transfer of patients to another provider.
- Contract termination.
- Investigation results from subcommittees must be reported to the QIOHA Committee.

PROVIDER QIOHATP RESPONSIBILITIES

When a member enrolls with DentaQuest, they select a Provider from the network who is responsible for providing or coordinating all dental care for that member, including referrals to participating specialty care providers. Providers and participating specialty care providers have certain responsibilities to ensure that the care provided to members is given under the appropriate requirements including covered benefits and referrals.

RECORDS REVIEW

Contracted Dental Providers are responsible for the storage and filing of dental records including collection, processing, maintenance, storage, retrieval identification, and distribution in accordance with Federal and State law; and including ensuring that dental records are protected and confidential. Providers are required to obtain consent for treatment. All dental records must be maintained in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy). Contracted Dental Providers must ensure that an individual is delegated the responsibility of securing and maintaining dental records at each provider site.

DentaQuest has established guidelines for the delivery of dental care to Plan members. To generalize, all providers are expected to render dental care under community standards. The guidelines begin below and conclude with the form that our Staff Dentists use to evaluate patient records.

Chart Selection: A minimum of ten (10) randomly selected patient charts will be reviewed.

The use of Electronic Health Records is highly encouraged and promotes the ease of administering the DentaQuest dental programs. A patient record should include the following:

A. Organization

1. The record must have areas for documentation of the following information:
   - Registration data including a complete health history
   - Medical alert predominantly displayed inside chart jacket

- Initial examination data
- Radiographs
- Periodontal and Occlusal status
- Treatment plan/Alternative treatment plan
- Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations
- Miscellaneous items (correspondence, referrals, and clinical laboratory reports)

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:
   - Health history
   - Medical alert
   - Examination/Recall data
   - Periodontal status
   - Treatment plan
3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.

4. The design of the record must ensure that all components must be readily identified to the patient, (i.e., patient name, and identification number on each page).

5. The organization of the record system must require that individual records be assigned to each patient.

B. Content – The patient record must contain the following:

1. Adequate documentation of registration information which requires entry of these items:
   - Patient's first and last name
   - Date of birth
   - Sex
   - Address
   - Telephone number
   - Name and telephone number of the person to contact in case of emergency
   - Information regarding the primary language of the enrollee
   - Information related to the member's needs for translation services
2. An adequate health history that requires documentation of these items:
   - Current medical treatment
   - Significant past illnesses
   - Current medications
   - Drug allergies
   - Hematologic disorders
   - Cardiovascular disorders
   - Respiratory disorders
   - Endocrine disorders
   - Communicable diseases
   - Neurologic disorders
   - Signature and date by patient
   - Signature and date by reviewing dentist
   - History of alcohol and/or tobacco usage including smokeless tobacco, and drugs/substances

  - Summary of significant surgical procedures.
  - Treating provider's signature and/or initials must be documented on each date of service
  - Treating provider's signature and/or initials must contain the profession designation (e.g. DDS,DMD, RDH, CDA)
3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
  - Significant changes in health status
  - Current medical treatment
  - Current medications
  - Dental problems/concerns
  - Signature and date by reviewing dentist
4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:
  - Health problems which contraindicate certain types of dental treatment
  - Health problems that require precautions or pre-medication prior to dental treatment
  - Current medications that may contraindicate the use of certain types of drugs or dental treatment
  - Drug sensitivities
  - Infectious diseases that may endanger personnel or other patients
5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:
  - Blood pressure (Recommended)
  - Head/neck examination
  - Soft tissue examination
  - Periodontal assessment
  - Occlusal classification
  - Dentition charting
6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:
  - Blood pressure (Recommended)
  - Head/neck examination
  - Soft tissue examination
  - Periodontal assessment
  - Dentition charting
7. Radiographs which are:
  - Identified by patient name
  - Dated
  - Designated by patient's left and right side
  - Mounted (if intraoral films
8. An indication of the patient's clinical problems/diagnosis.

9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:
  - Procedure
  - Localization (area of mouth, tooth number, surface)

10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
    - Periodontal pocket depth
    - Furcation involvement
    - Mobility
    - Recession
    - Adequacy of attached gingiva
    - Missing teeth
11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
    - Gingival status
    - Amount of plaque
    - Amount of calculus
    - Education provided to the patient
    - Patient receptiveness/compliance
    - Recall interval.
    - Date
12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
    - Provider to whom consultation is directed
    - Information/services requested
    - Consultant's response
13. Adequate documentation of treatment rendered which requires entry of these items:
    - Date of service/procedure
    - Description of service, procedure and observation. Documentation in treatment must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    - Type and dosage of anesthetics and medications given or prescribed.
    - Localization of procedure/observation. (tooth #, quadrant etc.)
    - Signature of the Provider who rendered the service.
14. Adequate documentation of the specialty care performed by another dentist that includes:
    - Patient examination
    - Treatment plan
    - Treatment status

C. Compliance

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

MEMBER COMPLAINTS, GRIEVANCES AND APPEALS (CG&A)

The DentaQuest member CG&A process encompasses investigation, review, and resolution of member issues to DentaQuest and/or contracted providers. As part of our commitment, DentaQuest works to ensure that all members have every opportunity to exercise their rights to a fair and timely resolution to any G&A.

All contracted provider facilities are required to display member complaint forms.

PROVIDER DISPUTE RESOLUTIONS (PDR)

As a DentaQuest contracted, or non-contracted provider, you have the right to challenge, appeal, dispute, or request reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered), or a decision made by DentaQuest.

DentaQuest will resolve any request for appeal, dispute, or reconsideration submitted for a pre-estimate or on behalf of a member through DentaQuest's Member CG&A Process. A request for an appeal, dispute, or reconsideration submitted for a pre-estimate or on behalf of a member will not be resolved through DentaQuest's PDR Process.

Each PDR must contain, at a minimum, the following information:

- A summary of the appeal, dispute, or reconsideration request
- The provider's name and NPI
- The claim number and date of service under dispute
- The member's name and identification number
- Reason why the initial decision should be reversed
- The name and contact information of the person associated with the submitted request

All PDRS not associated with a claim must distinctly explain the issue and the provider's position. PDRs not including all required information may be returned to the submitter for completion. An amended PDR, including the missing information, may be submitted to DentaQuest within thirty (30) business days of receipt of a returned contracted provider dispute. PDRs sent to DentaQuest must include the information listed above for each contracted provider dispute.

DentaQuest will accept, acknowledge, and resolve all PDRs as follows:

Provider Dispute Resolution (PDR) Single Level			
Topic	**Non-Claim Complaints**	**Claim Complaints**	**Disputes (Appeals)**
Timely Filing Limitation	**Within 365 calendar days from the date of the issue and/or denial issued by DentaQuest**		
Amended Provider Disputes	**Within 30 business days of receipt of a returned PDR missing information**		

Standard Acknowledgement	**Within 5 calendar days of receipt when received by mail**
Electronic Acknowledgement	**Within 2 business days of receipt when received electronically**
Standard Resolution	**Within 30 calendar days from the date of receipt**
Effectuation of payment	**5 business days from the date of the resolution letter**

All contracted provider disputes must be sent to the following address:

- DentaQuest-Provider Appeals, PO Box 2182 Milwaukee, WI 53201-2182
- Providers can also call Provider Services Los Angeles: 855-388-5257 and Sacramento: 833-479-1984Monday through Friday, 8:00am to 5:30pm to file their complaint and/or appeals.

CONTRACTED PDR INQUIRIES

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute can be directed to DentaQuest-Provider Appeals at Provider Services Los Angeles: 855-388-5257 and Sacramento: 833-479-1984

OUR COMMITMENT IS DEMONSTRATED THROUGH OUR ACTIONS

DentaQuest has designated a Privacy Officer to develop, implement, maintain, and oversee our HIPAA Compliance Program. This role also includes assisting in the education and training of our employees regarding HIPAA requirements and implications. As a healthcare provider and covered entity, you and your staff are required to adhere to HIPAA guidelines concerning Protected Health Information (PHI).

DentaQuest has established and implemented corporate-wide policies and procedures to ensure compliance with HIPAA provisions. We are committed to ongoing employee training and education related to HIPAA requirements. Our Notice of Privacy Practices has been disseminated to all necessary entities. Existing members received a copy by mail, while all new members are provided with the Notice along with their member materials.

PROTECTED HEALTH INFORMATION (PHI)

All dental providers and their staff must be fully aware that HIPAA mandates the protection and confidential handling of member PHI. HIPAA requires healthcare providers to implement safeguards to ensure the confidentiality and security of all forms of PHI, whether electronic, verbal, or physical, during transmission or storage. Failure to adequately protect PHI may lead to breaches, enforcement actions, and significant financial penalties, constituting a violation of DentaQuest's provider agreement.

We encourage you to review your office's privacy and security practices to ensure compliance with HIPAA requirements. Please take note of the following reminders regarding the safeguarding of DentaQuest member PHI. If DentaQuest finds that you have transmitted member PHI via a potentially insecure method, or if we are informed of any inadequacies in

safeguarding such PHI, we will reach out to investigate the issue. Non-compliance may result in a Corrective Action Plan (CAP), and continued or severe non-compliance may lead to contract termination.

ELECTRONIC PHI

All dental providers and their offices must ensure referrals, pre-estimate requests, medical records, and other e-PHI are transmitted in a HIPAA-compliant manner, such as using secure fax, secure FTP, encrypted email (which requires member authentication to access email content), or DentaQuest's secure web portal.

Note the following:

- Use of PHI (including member name, ID, or other identifying information) in the subject lines of emails or to name-files is not permitted.
- Use of free email service providers, such as, but not limited to Gmail, Hotmail, and Yahoo, is not a permitted method for transmitting DentaQuest Member PHI.
- Transmission of PHI via text is not permitted.

DentaQuest providers may transmit e-phi using DentaQuest's HIPAA-compliant, secure web portal by following these simple steps:

- Go to https://portal.dentaquest.com
- Go to the Provider menu at the top of the page
- Select Secure Email Portal

Utilize physical and technical safeguards to prevent unauthorized individuals from viewing monitors, and ensure that screens on devices automatically lock after a reasonable period of inactivity. Establish protocols to guarantee that faxes containing PHI are sent to the correct member, applying additional precautions when transmitting particularly sensitive information, such as sensitive diagnoses.

Note: When transmitting PHI to a member, a written request from the member to receive the information electronically through alternative methods may be accommodated, provided that reasonable measures are taken to verify the member's identity and that the potentially unsecured nature of the transmission is disclosed to the member in writing prior to sending the information.

VERBAL PHI

Do not discuss member information in public areas (including waiting rooms, hallways, and other common areas), even if you believe you are masking the member's identity. Ensure conversations within examination rooms or operatories cannot be overheard by those outside of the room. Use heightened discretion when discussing sensitive diagnoses or other sensitive matters, including when such discussions occur with the member in an exam room or operatory.

BEST PRACTICES INCLUDE:

- Implementing appropriate physical safeguards such as closed doors and insulated walls for exam rooms and operatories.

- Implementing ambient music or white noise to cover conversations in common areas.
- Arranging waiting areas to minimize one member overhearing conversations with another.
- Posting a sign requesting that members who are waiting to sign in or be seen, do not congregate in the reception area.
- Ensuring unauthorized persons cannot overhear phone calls and limiting what is communicated by phone and voicemail to the minimum necessary information to accomplish the required purpose. Avoid the use of speaker phones.

TANGIBLE PHI

Do not display or store paper or other tangible PHI in common areas. Do not leave such PHI unattended on desks or in exam rooms or operatories. Never dispose of paper or other tangible PHI in the trash. Use secure methods to destroy and dispose of such PHI (for example, cross-cut shredder). All PHI must be locked away during the close of business (for example, in a locked cabinet). Window blinds must be closed to prevent outside disclosure. Mailing envelopes must not be overstuffed, and mailing addresses must be printed accurately and distinctly to minimize the possibility that mail is lost in transit. When transporting tangible PHI, take precautions to ensure it is not lost in transit, and do not leave tangible PHI in vehicles unattended.

SECTION 9. FRAUD, ABUSE, AND QUALITY OF CARE

DentaQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse are defined as:

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

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

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

Member Fraud: If a Provider suspects a member of ID fraud, drug-seeking behavior, or any other fraudulent behavior should be reported to DentaQuest.

All suspected cases of FWA related to DentaQuest, including, but not limited to, Medicare and Medicaid, should be reported to DentaQuest's FPR. The caller will have the option of remaining anonymous.

Suspected FWA can be reported to:

The DHCS Audits and Investigations (A&I) Program Integrity Unit audits and investigates providers suspected of overbilling or defrauding California's Medicaid program, recovers

overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.

- DHCS Audits and Investigations (A&I) by calling (800) 822-6222
- DHCS Audits and Investigations (A&I) email at stopmedicalfraud@dhcs.ca.gov
- DHCS Audits and Investigations (A&I) Complaint Form though the following website: U.S. Government Recovery Board
- U.S. Government Recovery Board Fraud Hotline: 877-392-3375
- U.S. Mail: Recovery Accountability and Transparency Board Attention: Hotline Operators P.O. Box 27545, Washington, D.C. 20038-7958
    - On-Line Complaint Form: http://www.recovery.gov/Contact/ReportFraud/Pages/FWA.aspx
    - DentaQuest:
        - DentaQuest's Fraud Hotline: (800) 237-9139
        - DentaQuest's Compliance Hotline: (866) 737-3559 and/or
        - Contact your Provider Engagement Representative

Providers are to cooperate fully in any investigation by the DHCS, Medicaid Program Integrity (MPI), or Medicaid Fraud Control Unit (MFCU), or any subsequent legal action that may result from such an investigation.

All final resolutions of a case will include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of California nor precludes the State of California from taking further action for the circumstances that brought rise to the matter.

Providers must report all instances of suspected fraud, waste, and abuse.

DentaQuest expects all providers and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statue
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act US Criminal Codes
- State & Federal False Claims Laws:
- Federal False Claims Act (31 U.S.C. §§ 3729 - 3733)

The Federal False Claims Act is a law that prohibits a person or entity, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal government. The Act also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid.

The Federal False Claims Act broadly defines the terms "knowing" and "knowingly." Specifically, knowledge will have been proven for purposes of the Federal False Claims Act if the person or entity: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information.

The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

"Whistle Blower Protection Act": Private persons are permitted to bring civil actions for violations of the Federal False Claims Act on behalf of the United States (also known as "qui tam" actions) and are entitled to receive percentages of monies obtained through settlements, penalties and/or fines collected. Persons bringing these claims, also known as relators or whistleblowers, are granted protection under the law.

Specifically, any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the Federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorneys' fees and costs.

Anti-Kickback Statute: What is the Anti-Kickback Statute?

The Anti-Kickback Statute is the popular name for the Medicare and Medicaid Fraud and Abuse Statute, 42 U.S.C. § 1320a-7b (b). The AKS is a federal criminal law. It prohibits offering or accepting kickbacks to generate health care business.

The Anti-Kickback Statute or AKS is a healthcare law that prohibits individuals and entities from a willful and payment of "remuneration" or rewarding anything of value – such as position, property, or privileges – in exchange for patient referrals that involve payables by the Federal healthcare programs. These payables include, but are not limited to, drugs, medical supplies, and healthcare services availed by Medicare or Medicaid beneficiaries.

Under the provisions of the Anti-Kickback Statute, the law prohibits the soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or kind.

Stark Law Physician Self-Referral Law: The Physician Self-Referral Law- the Stark Law refers to Section 1877of the Social Security Act (the Act) 42 U.S.C. 1395nn.

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians (including dentists) from referring patients to receive "designated health/dental services" payable by Medicare or Medicaid from entities with which the physician (including dentist) or immediate family member has a financial relationship. Law now insists that any medical professional who provides such a referral to a Medicare or Medicaid patient must concurrently provide written notice of that patient's right to go elsewhere along with a list of nearby alternatives.

Finalizing new, permanent exceptions for value-based arrangements to that will permit physicians and other health care providers to design and enter into value-based arrangements without fear that legitimate activities to coordinate and improve the quality of

care for patients and lower costs would violate the physician self-referral law. This supports CMS' broader push to advance coordinated care and innovative payment models across Medicare, Medicaid, and private plans.

DentaQuest requires all its providers and subcontractors to report violations and suspected violations on the part of its employees, associates, persons, or entities providing care or services to all Medicaid enrollees. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provider medically necessary services, marketing schemes, illegal remuneration schemes, identity theft, or enrollees' medication fraud.

SECTION 10: SPECIAL PROGRAMS

Healthy Behaviors Incentive Programs

These are not currently applicable to Health Net members. If your patient is enrolled in the California Dental Network doing business as DentaQuest they may be eligible for the following member incentive programs.

DentaQuest is committed to promoting oral health and encouraging positive behaviors among our members. We have implemented programs designed to reward and incentivize healthy dental practices. These initiatives aim to motivate our members to prioritize preventative care, maintain regular dental check-ups, and adopt good oral hygiene habits. By fostering a culture of proactive dental health management, we strive to improve oral health outcomes for our members while aligning with state regulations. Providers are encouraged to promote these programs to better support and guide their patients in achieving optimal dental health.

- $20 Amazon Gift Card (All Members)
- Completing the initial Oral Health Risk Screening Form and receiving a preventive dental visit within the first 90 days of enrollment
- $20 Amazon Gift Card (Child Members up to age one)
- First dental home visit by age one.
- $20 Amazon Gift Card (Child Members ages 6-9 and 10-14)
- Receiving a dental sealant on a first or second permanent molar.
- $20 Amazon Gift Card (Child Members)
- Receiving two preventive dental visits in a 12-month period
- $20 Amazon Gift Card (Child Members)
- After a tooth extraction, completing an online assessment on opioid safety and alternative pain management options for acute pain (e.g., NSAIDs and acetaminophen).

DentaQuest pays dentists when they meet certain quality benchmarks. These quality benchmarks include but are not limited to:

- CalAIM
- Prop 56

- Caries Risk Assessments (CRA)
- Annual Dental Visit (ADV)
- Grievance Threshold

For more information about these programs, please contact your local provider engagement representative.

Members can access this information on the DentaQuest website.

SECTION 11: GLOSSARY

Effective April 1, 2025, Current Dental Terminology 2025 (CDT 25) was implemented which created changes to the Federally Required Adult Dental Services (FRADS), Pregnancy, Omnibus Budget Reconciliation Act (OBRA) member emergency, and Member Cap procedures.

For a listing of procedures that qualify under FRAD, RADS, OBRA or Exempt Dental Services, or Exempt Emergency Dental Services, please use this link: April_Provider_Handbook.pdf, Section 10 – CDT-25"

FRADS: Federally Required Adult Dental Services (FRADS) The following procedure codes are reimbursable procedures for Medi-Cal members 21 years of age and older.
RADS: Restored Adult Dental Services (RADS) Effective May 1, 2014, some adult dental benefits have been restored in accordance with Assembly Bill 82 (AB 82).
OBRA: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only
Exempt Dental Services: Procedures that procedures have been identified as always exempt from the $1,800 dental soft cap.
Exempt Emergency Dental Services: Codes may be exempt from the dental soft cap if they are related to an adequately documented emergency service pursuant to W&I Code 14080(a)(1).

Entire Glossary can be found on the Medi-Cal Dental website
https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_11_glossary.pdf

SECTION 12: BULLETIN INDEX

Previously released bulletins can be found on the Medi-Cal Dental website Provider Bulletins page:
https://dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/Provider_Bulletins/ProviderBulletins

Dental All Plan Letters (APLs) are the means by which the California Department of Health Care Services (DHCS) conveys information or interpretation of policy or procedure at the Federal or State levels, and provides instruction to Medi-Cal Dental Managed Care plans on

how to implement these changes on an operational basis. Previously released bulletins along with the Dental All Plan Letters (APLs) can be found on the Medi-Cal Dental website:

Dental Managed Care All Plan Letters (APLs) link:
https://www.dhcs.ca.gov/services/Pages/DentalAllPlanLetters.aspx

SECTION 13: CDT 24 TABLES

Please reference Exhibit A for Codes and Benefits Covered for CA Medi-Cal Children.

Please reference Exhibit B for Codes and Benefits Covered for CA Medi-Cal Adults.