DeCare Dental Networks National Network

Administrative Office Guide

DeCare Dental℠

NETWORKS

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Section 1

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Who Is DeCare Dental Networks National Networks

DeCare Dental – A partner you can trust

DeCare Dental Networks, an affiliate of DeCare Dental, develops dentist networks for clients and business partners locally, nationally and around the world. The company manages more than 20 dental networks in the United States and internationally.

Collectively, these networks serve 3.7 million individuals in 18,000 employer groups – including Fortune 500 corporations, non-profits and government entities.

Our Philosophy

We are an organization dentists trust. We earn your trust through respectful, high-quality service. We pay reimbursement well above the national average, based on our evaluations of nationwide fee schedules.

We offer higher reimbursement because we realize fees are not the critical factor in the cost of dental care. The critical factor in the cost of dental care is the type of services provided and their frequency. Because of this philosophy, we select relationships with dentists whose treatment patterns tend to be conservative and preventative and consistent with published scientific literature.

Free Yourself From Administrative Hassles

- Rapid and accurate payment to dentists
- No need to submit pre-determinations, radiographs or diagnostic aids
- Many of our members receive services from participating dentists only
- Personal dentist representatives available to assist you
- Dentist friendly – high satisfaction rate among participating doctors

Who Is DeCare Dental Networks National Networks, continued

Fast Facts

Dentists

We contract with dentists individually, and the contract is valid for all locations where the practice is needed for employee locations.

Specialists in endodontics, periodontics, oral surgery and orthodontics receive enhanced reimbursement for treatments unique to the specialty area. Services or treatments not unique to the specialty area (for example, radiographs, exams) will be reimbursed at the general practitioner rate. We outline specialty fees by ZIP code area in our Maximum Schedule of Allowance.

There are no restrictions on billing non-covered services. The patient pays the dentist directly for these services.

Dentist file claims for covered services on behalf of the member – and we send payment directly to the dentist.

Patients

Patients are not required to pre-select a dentist. Freedom of choice is a hallmark of DDN.

While patients are free to use any licensed dentist without a referral, they receive their maximum benefits from their dental plan if they see network dentists – whether general practitioners or specialists.

Member identification cards listing DeCare Dental Networks will make it easy to identify patients with access to the network and will list a phone number to call with any questions.

How to Contact DeCare Dental Networks National Network

The Provider Relations staff at DeCare Dental Networks is committed to building a long-term relationship with contracted providers. We guarantee the highest level of customer service by having a representative available to take your calls Monday through Thursday 7:30 AM - 5:00 PM CST and Friday 7:30 AM – 4:30 PM CST. If you happen to leave a message, we will return your call within 24 hours.

Use the following phone numbers to receive prompt response to your questions.

General Information: Provider Networking	Provider Relations 1-800-658-4187
General Information: Claims	Customer Service 1-800-587-6857
Verify Member Eligibility	Customer Service 1-800-587-6857
Member Questions:	Customer Service 1-800-587-6857
Mail Claims/Pre-estimates	DDHI P. O. Box 1348 Minneapolis, MN 55440
Mail Provider Information/Changes	DDN P. O. Box 1175 Minneapolis, MN 55440-1175

What is a Dental Plan?

Dental benefit plans are better characterized as financial assistance plans rather than as insurance. Unlike true insurance plans, which are designed to protect against major loss, dental benefit plans provide financial assistance to members and their families to encourage regular visits to the dentist, which are essential to maintaining oral health. Most dental plans are structured to provide coverage that meets the basic needs of the general population.

Specific dental care needs vary for each individual and should be discussed with the patient. Depending on the member's oral health circumstances the dental plan may or may not cover all of their needs, and should not be the sole determinant of the dental treatment that they receive.

Do Dental Plans differ from Medical Health plans?

Yes, they do. The largest difference between dental coverage and a health plan is this:

Most ***medical plans*** are designed to cover services that are medically necessary to treat specific conditions or diseases. This allows the flexibility to respond to individual medical needs and treatment requirements to avoid significant financial burden. Additionally, laws may mandate an employer and/or health care provider to provide certain coverage levels.

Dental versus medical care: the fundamental differences.

Dental conditions are rarely fatal and largely preventable, and dental services are less costly and often predictable.

A ***dental plan*** serves a different purpose. An employer offers a dental benefit plan to provide financial assistance to meet general dental care needs. Because dental services are less costly and more predictable than medical care, dental plans typically feature a specific set of benefits and coverage parameters and are not always designed to address each individual's specific dental treatment needs.

How is the actual benefit plan determined?

The ***employer*** determines the combination and extent of dental benefits for an employees program. DeCare Dental Networks National Network (DDN) is responsible for administering the plan, making appropriate payment according to the plan benefits and maintaining the integrity of our various provider networks. If a union represents the member, the combination and dental benefits provided is negotiated via the collective bargaining process.

What is a Dental Plan, continued

No additional costs for members

All dentists who participate in the DDN network agree to accept DDN's reimbursement as payment in full for covered services. The "hold harmless" provisions in DDN's contract with dentists mean that when a member sees participating DDN dentist, the member cannot be billed for the balance of the fee the dentist would normally have charged for that service.

If a dentist is not participating in a particular DDN, can a subscriber still go to that dentist?

If the members employer has a benefit option for out-of-network coverage the members may see a non-participating dentist. The non-participating dentist may bill for the difference between what DDN pays and what the dentist charges for the service, resulting in higher out-of-pocket costs for the patient.

Select Dental Plan Highlights:

- You are contracted with DeCare Dental Networks National Network
- Members are free to choose any contracted dentist in the network
- Members are free to choose any contracted specialist in the network, no referrals needed
- Fee-for-service network
- Electronic claim submission accepted
- Dedicated Provider Relations staff available
- No required pre-determinations

If you have questions regarding participation in the network, contact a DDN representative at 1-800-658-4187 or email ddn@decare.com.

Responsibilities:
DeCare Dental Networks National Network, Dentist, and Members

Responsibilities of DeCare Dental Networks National Network

DeCare Dental Networks National Network (DDN) is responsible for administering the dental plan, making appropriate payment according to the plan benefits and maintaining the integrity of our various dental networks. DDN is under obligation to:

- Process submitted claims correctly for your DDN patients within 30 calendar days. However, many dentists receive payment within 10 business days (on claims submitted electronically – in 72 hours).
- Make payment directly to your office
- When notified update dentist/dental office records with current dental practice information (i.e., fee schedule, credentialing information, address changes, Tax Identification Number (TIN) information, etc.) on a timely basis.
- Help the member and dental office understand the different benefit plans.

Responsibilities of the Dentist

As a participating dentist you agree to recommend and provide dental services in the best interest of each individual patient's oral health needs. You are also obligated to:

- File claims for your DDN patients timely and correctly.
- Accept direct payment from DDN.
- Ensure that members will not be charged more than the pre-established coinsurance amount for covered dental services. In other words, you agree not to balance bill patients any difference between the DDN approved amount and your usual fee, if any.
- Submit diagnostic aids (such as x-ray films) as necessary.
- Cooperate with state or local peer review committees and with dental consultants, as well as fee verification and periodic record reviews by DDN.
- Update DDN's Professional Services area with your most current dental practice information (i.e., credentialing information, address changes, Tax Identification Number (TIN) information, etc.) on a timely basis or as requested

Responsibilities:
DeCare Dental Networks National Network, Dentist, and Members, Continued

Responsibilities of the DDN Member

Depending on a member's oral health circumstances, the dental plan may or may not cover all of his or her treatment needs. The member agrees that coverage levels should not be the sole determinant of the dental treatment they receive. Members are responsible for:

- Verifying that the dentist is still participating in the network, or to understand what it means to see a non-participating dentist.
- Providing a current identification card at each dental visit as required by the dental office.
- Discussing treatment options and costs with the dentist/dental office staff.
- Understanding the benefit plan and be familiar with the dental benefits covered by their dental program. Members should call Customer Service if they have questions about coverage.

Section 2

HIPAA
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Identification Cards

How to End Contracting Dentist Agreement

Updating Dentist & Dental Office Information
Address
Tax Identification Number (TIN)

HIPAA Privacy Policy

DECARE DENTAL NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DeCare Dental understands that medical information about you and your health is personal, and we are committed to protecting your medical information. Individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI").

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information as to whether the service has been previously provided.

Payment: We disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use your PHI in order to process your claims.

Health Care Operations: We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law from doing so.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

HIPAA, continued

Individual Rights

In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints or concerns, please contact

DeCare Dental
P.O. Box 9304
Minneapolis, MN 55440-9304

For more information, read the Department of Health and Human Services' Summary of Privacy Rights.

HIPAA – National Provider Identifier (NPI)

If you are a provider who submits electronic or paper claims in Minnesota* claims, you must apply for an NPI and understand the requirements for its use.

What is the NPI?

The National Provider Identifier (NPI) is part of the Health Insurance Portability and Accountability Act (HIPAA). The NPI regulation establishes one unique identifying number for each health care provider. This simplification measure will reduce the number of identifiers currently used in health care transactions.

What are the advantages of the NPI?

Use of the NPI will have several advantages, including:

- One unique provider identifier for all health plans to utilize
- A permanent provider identifier that will not change in the event of practice relocation or changes in specialty
- An easier process for health plans to track transactions and avoid duplication

How is my NPI determined?

The NPI is a random ten-digit number (nine digits plus a check digit to detect keying errors). It never expires. It contains no inherent information about the provider, such as state of residence or license number. NPI numbers are administered by the Centers for Medicare and Medicaid Services (CMS), which has contracted with the National Plan and Provider Enumeration System (NPPES). The federal government is also responsible for assisting providers in completing the application and resolving problems associated with an NPI.

Who is required to apply for an NPI?

All health care providers are eligible to receive an NPI. However, only "Covered Entities" are required to obtain an NPI. A dental provider is a "Covered Entity" if he or she transmits electronic transactions governed by HIPAA, primarily electronic claim transactions.

The broad definition of health care "provider" in the federal regulation encompasses all who provide health care services:

Individuals - such as physicians, dentists and pharmacists

Organizations - such as hospitals and clinics

Although dental assistants and hygienists are "providers" and are thus eligible to obtain an NPI, they are only required to do so if they submit claims for their services.

* What if I only submit paper claims?

If you do not submit electronic claims, you are not required to obtain an NPI (except in Minnesota, where providers must submit NPIs on both paper and electronic claims by the federal deadline). However, DeCare strongly encourages you to obtain and use an NPI, once we are prepared to accept it. This will enable you to maintain only one unique identifier for use with all payers.

HIPAA – National Provider Identifier (NPI), continued

When is the deadline?

All HIPAA "Covered Entities" must use NPIs on all claims by May 23, 2007. To ensure a smooth transition, providers are urged to apply for their NPI well in advance of the compliance date.

Clearinghouses are also required to be able to accept and transmit the NPI by May 23, 2007.

Will the NPI replace other numbers I use?

The NPI will replace other identifying numbers currently used in electronic transactions, such as your:

- Numbers issued by plans and insurers (e.g. Blue Cross and Blue Shield number)
- Medicaid provider number
- Medicare provider number
- CHAMPUS number
- Other "legacy" identification numbers

The NPI will not replace numbers used for purposes other than general identification, such as your:

- Social Security Number
- DEA number
- Taxpayer ID number
- Taxonomy number
- State license number

The NPI will replace all other identification numbers, but your Taxpayer ID number (or Social Security Number) will still be required for 1099 purposes.

How do I apply for my NPI?

You only apply for your NPI once, and your NPI is permanently assigned for your lifetime. There is no cost to apply.

You may apply for your NPI either:

Online: Complete a web application and submit it electronically
On Paper: To request a paper application, call NPPES at (800) 465-3203.

HIPAA – National Provider Identifier (NPI), continued

When you apply for your NPI, you will be asked to provide your 10-digit taxonomy code. For quick reference, here are the dental taxonomy codes:

General Practice-1223G0001X
Dental Public Health-1223D0001X
Endodontics-1223E0200X
Oral and Maxillofacial Pathology-1223P0106X
Oral and Maxillofacial Radiology-1223X0008X
Oral and Maxillofacial Surgery-1223S0112X
Orthodontics and Dentofacial Orthopedics-1223X0400X
Pediatric Dentistry-1223P0221X
Periodontics-1223P0300X
Prosthodontics-1223P0700X
Denturist-122400000X

After you receive your NPI, you must furnish any updates to the NPPES. If any of the data you submitted on your application changes, notify NPPES within 30 days of the change.

You may receive notices about the NPI from other health and dental plans, but your unique NPI is used with all plans. Remember to notify each dental plan of your NPI separately.

Where can I go for additional help and information?

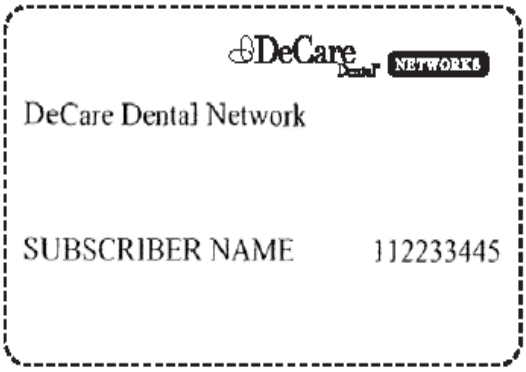
This Web site will have NPI updates so check back periodically. Also, watch your Office Link newsletter for articles on the NPI.

Identification Cards

Each member enrolled in DeCare Dental Networks National Network (DDN) receives an identification card from DDN or his or her employer. The following is a sample of the card issued. At the time of service, ask the member to present their card as verification of coverage.

DDN also recommends that you verify coverage for the day of service. This may be done by calling DDN's Customer Service Department at 800-587-6857.

Front of Card



Back of Card

How To End Contracting Dentists Agreement

To ensure efficient and accurate claims processing, DeCare Dental Networks National Network (DDN) must be notified **in writing** when a dentist or dentist(s) wish to end participation in the network. The following information is needed:

- The full name of the dentist(s) who is/are terminating.
- Identify the state of licensure of the dentist(s) who is/are terminating.
- The license number of the dentist(s) who is/are terminating.
- The dental office locations where the dentist(s) have practiced.
- The signature of the dentist(s) who is/are terminating.

This information should be sent to:

DeCare Dental Networks
Attention Professional Services
P.O. Box 1175
Minneapolis, MN 55440-1175

There are different termination requirements, based on the state of participation, as follows:

90-Day Notice: Indiana, Maryland, Nevada, and Oklahoma
60-Day Notice: Colorado, New York, Vermont, Kentucky, Washington, and Maine
30-Day Notice: all other states

The "effective date" is determined by the specific number of days required by a particular state and the date that the request in received by DDN.

Should you choose a day (i.e. first or last day of the month) that is longer than the stated requirements, include this request in your letter to DDN.

Notify your patients that you will no longer be participating in the network and discuss the completion of their current treatment plans. DDN subscribers are also informed that they are to check out-of-network benefits under their benefit contract.

Updating Dentist and Dental Office Information

As a participating dentist, it is important for you to inform DDN of any changes to your practice. This information is vital for accurate claims processing and payment. Please notify DDN in writing (either by mail, email or fax), when any of the following occur:

- Address change
  When a change of address is anticipated, the dental office needs to notify DDN prior to the effective date of changes. Address changes should indicate the date of change and the person(s) affected by the change. Include the dentist's full name, name of practice, state of licensure, and the license number.

- Location is added
  When an additional office location is being established, DDN needs to be notified prior to the effective date of becoming operative. Notify DDN of the business entity name, business entity Tax Identification Number (TIN), office street address, and billing address. Notify DDN of the dentist(s) name(s) and license number(s) of employed or contracted dentist who will bill service through the above named business entity.

- Tax Identification Number (TIN) or Ownership changes
  If the business entity name and/or TIN change, the dentist must complete a new taxpayer identification number request (Substitute Form W-9). Contact the Network Administration Department by phone at 800-658-4187; email ddn@decare.com to request this form.

- Adding new dentist(s)
  This may require additional paperwork, such as completing a Credentialing Application and Contracting Dentist Agreement and credentialing forms. Contact the Network Administration Department for assistance in obtaining the correct information for your office.

- If a Dentist(s) leaves a practice, retires, no longer practices due to medical or other reasons, or is deceased
  All requests should indicate the date of change, dentist's full name, state of licensure, license number, and, if possible, the signature of the dentist(s). Updating DDN with this information will avoid unnecessary mailings to your office.

Calling DDN with a change or showing an address change on a claim will NOT result in the updating of the dentist's address.
Separate written notice is required.

Updating Dentist and Dental Office Information, continued

Committed to working with you

One of the many responsibilities of the Professional Services Department is network contracting and credentialing. The staff is accountable for communicating important information to the dentists as well as the dental office staff. In addition, Professional Service staff can respond to questions on contract issues as well as assist offices with tax identification changes, address changes.

The network representatives continuously develop strong one-on-one relationships with dentists.

Claim Information

Section 3

Claims Submission Tips

Instruction for preparing the "Attending Dentist's Statement" (Claim Form)

Signature Requirements

When More Information is Needed

Explanation of Benefits (EOB)

DeCare Dental Networks National Network Claims Administration Guidelines

Coordination of Benefits (COB)

Clean Claim

Claim Submission Tips

Accurate claims submitted results in faster payment.
To ensure timely claims payment, you may use the following checklist as a tool. Please check the information you are providing for completeness and accuracy.

- State-issued Dentist License Number and Tax Identification Number (TIN)
- Patient's birth date
- Patient's relationship to the member
- Member's birth date
- Member's social security number (SSN) or identification number
- Member/patient's signature
- Current ADA procedure code(s)
- Fee for treatment
- Treatment date(s)
- Tooth number, surface, and quadrant if applicable
- Dentist's signature

Instructions for Preparing The Attending Dentist's Statement (Claim Form)

Information spaces on the American Dental Association (ADA) "Attending Dentist's Statement" (Claim Form) are numbered, and the instructions listed below correspond with these numbers. All applicable data must be entered.

Suggestion: Request that patients complete items 1-15 on the "Attending Dentist's Statement" (Claim Form) as a timesaver.

1. **Patient Name -** Enter first and last name, omitting Mr., Mrs., Miss, or Ms.
2. **Patient Relationship to Employee -** Check "self" if patient is the employee through whom the family obtains its DeCare Dental benefits. It the patient is someone other than the employee, the employee's spouse, or the employee's dependent, print the relationship in the space provided under "other".
3. **Patient Sex -** Indicate whether the patient is male or female.
4. **Patient Date of Birth -** In numeric form, enter the month, day, and year of the patient's birth. The date of birth identifies and accesses on individual computer record to enable processing of the claim.
5. **Full-Time Student -** If the dependent is nineteen years of age or older, print the name and city of the school, if any, where the patient is enrolled full-time. For handicapped dependents, print ***handicapped*** in item number five. If the dependent is under the age of nineteen do not complete this item.
6. **Employee Name and Mailing Address (Covered Person) -** Employee in whose name the benefits are contracted (the DDN member). To enable DDN to mail a notice of payment to the employee, *print* the employee's first and last name as well as their current and complete mailing address (including the apartment number and zip codes).
7. **Social Security Number -** Enter clearly the social security number (SSN) or, if applicable, employee I.D. number for the employee named in item 6.
8. **Employee Birth date -** Enter the numbers of the month, day, and year of the birth date of the employee identified in item 6. This information is necessary for DDN to verify the patient's primary and secondary coverage in most dual coverage situations.
9. **Employer Name and Mailing Address -** Print the name, city, and state of the employer. Include the union local number, if applicable.
10. **Group Number -** This is the guide for determination of patient eligibility. The patient should provide this at the time of the visit. It may be located on the identification card or in the employee's benefits certificate.
11. **Is the Patient covered by Another Plan -** If patient has benefits under more than one program (dual coverage), DDN can assist in processing to the maximum advantage of the patient and dentist. If the patient is covered by another DDN program, (i.e. husband and wife both work at the same employer) indicate DDN Group name and number. Only one form must be submitted if the dual coverage involves two DDN group programs. If covered under another carrier, indicate the name and address of the other carrier. Include the other subscriber's birth date when the claim is for a child.

Instructions for Preparing The Attending Dentist's Statement (Claim Form), continued

12. **Name and address of the Other Employer -** Print name, city and state of the other employer through whom the patient is covered.

13. **Employee/Subscriber Information -** Employee/Subscriber Name: Print the first and last names of the other employee through whom the patient is covered **only** if different from patients. ***Indicate same as #6*.** If **both** coverage's stem from the same employee you indicated in item 6.
    - Employee/Subscriber Social Security Number/ID Number: Only if different from patients.
    - Employee/Subscriber Date of Birth: Only if different form patients.

14. **Relationship to Patient -** Check (X) the relationship of the employee (from item 14a) to the patient. If the employee is someone other than the patient, or the patient's spouse or parent, print the actual relationship in the space provided under "other".

15. **Dentist Name -** The name of the entity that provides dental services as used to apply for your Tax Identification Number (TIN).

16. **Dentist Mailing Address -** Print the billing address to which payment should be made.

17. **Tax Identification Number Data is required -** Print the TIN, which corresponds to the **business entity** listed in item 16. This number is necessary for Federal and State reporting and is carried in DeCare's master files. This may be an employer Identification Number (EIN) or your Social Security Number (SSN) depending upon how you file your tax returns with the IRS.

18. **Dentist License Number Data is required -** The license number of the billing dentist must be used. This is the State Licensed Number **initially** issued you, **not** your annual registration renewal number. The billing dentist, as designated in box 19, may differ from that of the treating dentist, as identified in the Dentist's signature block at the bottom of the claim form. Making this distinction is critical to ensuring claims processing accuracy and efficiency.

19. **Dentist Phone Number -** Necessary for contact regarding claim form information.

20. **Date Patient First Visit -** It is important to establish the beginning date of the current treatment series.

21. **Place of treatment -** Necessary for possible coordination with medical/hospital benefits. (ECF=extended care facility)

22. **Are Radiographs or Models Enclosed?** DDN does not require submission of radiographs. Call your network representative if you have questions.

23. Thru 29. **Special Information -** These questions are intended to prevent loss of processing time because inquiry must be initiated. If any of these conditions apply, check the appropriate box and supply the date of the accident and a brief description in the space to the right. If other coverage, such as a medical plan, or Workmen's Compensation, made a payment for the services provided, enter the amount paid in the space to the right.

Instructions for Preparing The Attending Dentist's Statement (Claim Form), continued

30. **Examination and Treatment Record -** Only one procedure should be listed per line. It is helpful to begin your listing with diagnostic/preventive procedures, followed by dental treatment in sequential order: description of procedure; tooth number (1 through 32 permanent, A through T deciduous); surfaces and quadrant ranges if applicable; completion date of services; and the charged fee.

    - **Surfaces:** Must be identified for all fillings, inlays, etc. Standard reporting of surfaces is as follows: M (mesial), O (occlusal), D (distal), F (facial, buccal, labial), L (lingual) and I (incisal).
    - **Quadrant Ranges:** Quadrant ranges must be identified for certain periodontal and prosthetic services. Reporting should be as follows: U (upper) tooth numbers 1-16; L (lower) tooth numbers 17-32; UR (Upper Right) tooth numbers 1-08; UL (upper left) tooth numbers 9-16; LR (lower right) tooth numbers 25-32; LL (lower left) tooth numbers 17-24.
    - **Procedure code Numbers:** The ADA approved Uniform Codes on Dental Procedures and Nomenclature is the reporting method used by DeCare Dental and are to be the ones used in the completion of the Attending Dentist's Statement.
    - **Service Date:** The date the service was preformed. DeCare Dental makes payments only when services have been completed. This is the seat date or permanent cement date for crowns and bridges: delivery date of completed denture to patient, and date of final instrumentation for root canals. When submitting a claim form for a multi-staged procedure, please complete item 21 on the claim form (first visit date, current series).

31. **Unusual Services -** Remarks for unusual circumstances of treatment.

32. **Dentist and Patient Signatures-** Payment will not be made without the required signatures of both patient and treating dentist. See "Signature Requirements" listed in this section of the Administrative Manual.

Remember to use the most current ADA Attending Dentist's Statement (Claim Form).

Signature Requirements

As a responsible third party dental carrier, DeCare Dental Networks National Network (DDN) requires the signature (or “Signature on File”) of the treating dentist and patient on all claim forms submitted to enable benefit payments to occur.

All approved ADA claim forms provide areas for the signatures of the dentist and or the patient, parent, or guardian. Any staff person authorized by the dentist may enter the dentist’s signature; a stamped facsimile of the dentist’s signature is also acceptable. Whatever method is used, the dentist retains the responsibility for the accuracy of any claims submitted by his or her office.

For the convenience of participating dentists, DDN will process forms for payment with the phrase **Signature on File** entered in the dentist and patient signature blocks. If you want to use this system, you should first obtain a release from your DDN patients and retain the release in your files. The text of the release should be similar to the wording found in the patient signature block on the Attending Dentist’s Statement. You do not need to notify DDN before you begin to use the Signature on File system. Additionally, it is not necessary for you to send DDN copies of any patient releases you may have obtained, as you are responsible for the accuracy of all information, which you submit on claims submitted in this manner.

When More Information is Needed

If, after receiving a claim, DeCare Dental Networks National Network (DDN) determines that more information is needed, a letter may be sent to the patient or the dentist requesting clarification. When the information is returned to DDN, the claim is processed. By responding immediately to these letters, processing delays are minimized. Return a copy of the request letter with your response to help process the claim. If a reply is not received within 30 days, the claim line item will be denied.

Some of the reasons more information may be requested:

- Incomplete subscriber or dependent information.
- Subscriber or dependent information that is inconsistent with the data on file.
- Tooth number(s) or surface(s) are missing.
- Documentation is required for a “by report” procedure (e.g. for emergency treatment or emergency oral examination).
- Information is needed about other carrier’s payment.
- Patient and/or provider signature is missing

Explanation of Benefits (EOB)

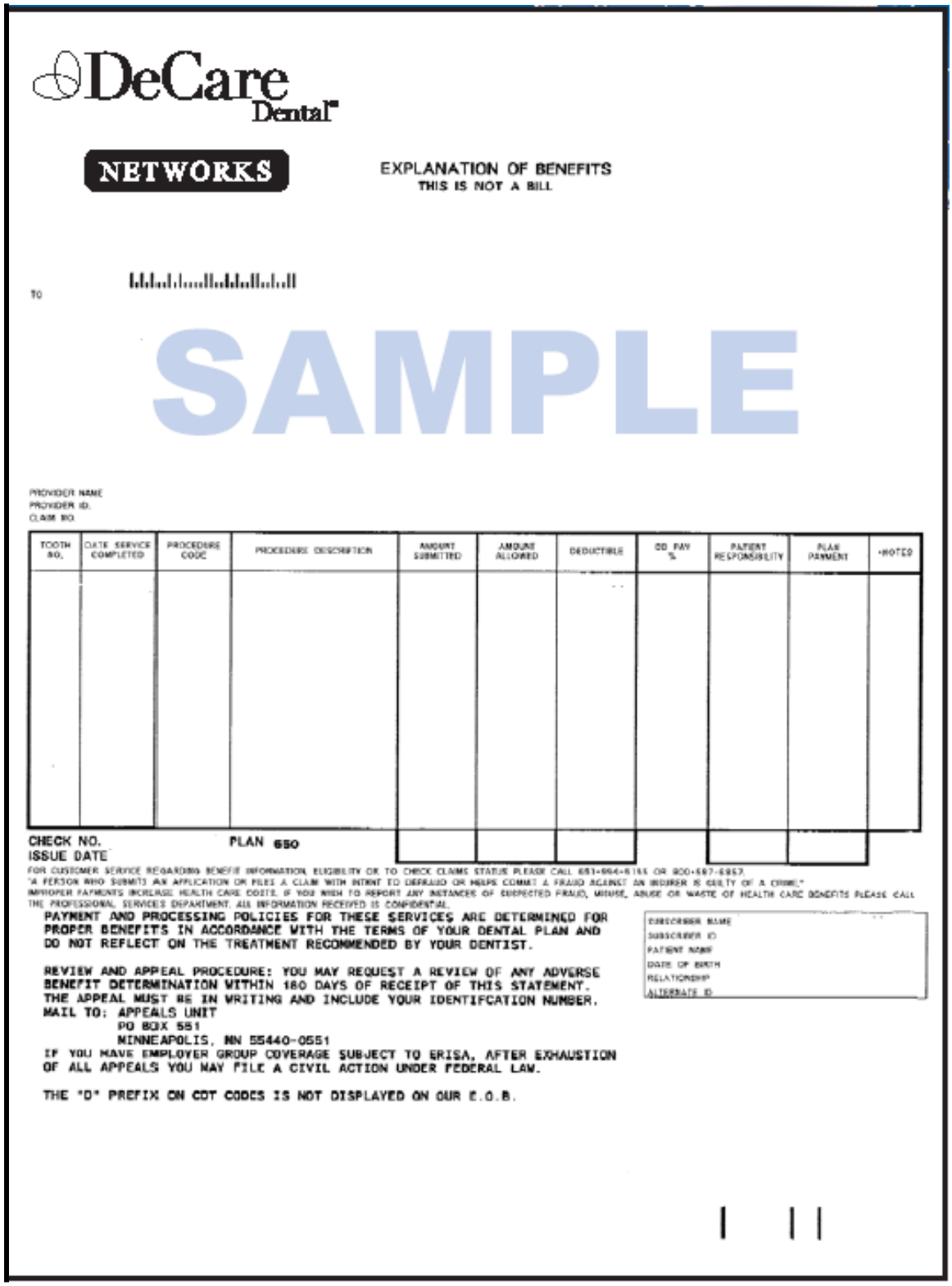
Your office receives an Explanation of Benefits (EOB) for services provided to DeCare Dental Networks National Network (DDN) patients. Your patients will also receive a copy of the EOB if the procedure is not covered.

Please note: We have implemented a "Bulk Check" payment procedure. A bulk check is a check that includes the payment of up to twenty claims adjudicated for a single dentist during each check run cycle. The use of bulk checks is very common in the dental benefits industry. They reduce administrative work and bank costs for dental offices and for DDN.

Column Explanations
(Columns will be completed for each dental procedure)

- **Tooth number or letter -** Use the ADA uniform numbering system: permanent teeth number 1-32; deciduous teeth A-T.
- **Date Service Completed -** Reported date of completion.
- **Procedure Code -** ADA approved uniform procedure code numbers and nomenclature.
- **Procedure Description -** ADA approved uniform code numbers and nomenclature.
- **Amount Submitted -** The amount submitted for each procedure.
- **Amount Allowed -** Amount used to calculate DDN's portion of the payment.
- **Deductible -** Indicates the amount of contract deductible applied, if any.
- **Percent Co-pay -** The percentage used to calculate DDN's portion of the payment based on the member's group's contract terms.
- **Patient Payment -** Amount payable by patient to dentist.
- **Plan Payment -** Amount paid by DDN.
- **Processing Policy -** The lower portion of the EOB will display applicable processing policy definitions and the department within DDN to contact with questions relating to a particular processing policy, if applied.

Explanation of Benefits (EOB), continued



DeCare Dental™

NETWORKS

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

TO

SAMPLE

PROVIDER NAME
PROVIDER ID
CLAIM NO

TOOTH NO.	DATE SERVICE COMPLETED	PROCEDURE CODE	PROCEDURE DESCRIPTION	AMOUNT SUBMITTED	AMOUNT ALLOWED	DEDUCTIBLE	CO PAY %	PATIENT RESPONSIBILITY	PLAN PAYMENT	*NOTES

CHECK NO.
ISSUE DATE

PLAN 650

FOR CUSTOMER SERVICE REGARDING BENEFIT INFORMATION, ELIGIBILITY OR TO CHECK CLAIMS STATUS PLEASE CALL 651-994-6155 OR 800-687-6867.
"A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."
IMPROPER PAYMENTS INCREASE HEALTH CARE COSTS. IF YOU WISH TO REPORT ANY INSTANCES OF SUSPECTED FRAUD, WASTE, ABUSE OR WASTE OF HEALTH CARE BENEFITS PLEASE CALL THE PROFESSIONAL SERVICES DEPARTMENT. ALL INFORMATION RECEIVED IS CONFIDENTIAL.

PAYMENT AND PROCESSING POLICIES FOR THESE SERVICES ARE DETERMINED FOR PROPER BENEFITS IN ACCORDANCE WITH THE TERMS OF YOUR DENTAL PLAN AND DO NOT REFLECT ON THE TREATMENT RECOMMENDED BY YOUR DENTIST.

REVIEW AND APPEAL PROCEDURE: YOU MAY REQUEST A REVIEW OF ANY ADVERSE BENEFIT DETERMINATION WITHIN 180 DAYS OF RECEIPT OF THIS STATEMENT. THE APPEAL MUST BE IN WRITING AND INCLUDE YOUR IDENTIFCATION NUMBER.
MAIL TO: APPEALS UNIT
PO BOX 551
MINNEAPOLIS, MN 55440-0551
IF YOU HAVE EMPLOYER GROUP COVERAGE SUBJECT TO ERISA, AFTER EXHAUSTION OF ALL APPEALS YOU MAY FILE A CIVIL ACTION UNDER FEDERAL LAW.

THE "D" PREFIX ON CDT CODES IS NOT DISPLAYED ON OUR E.O.B.

SUBSCRIBER NAME
SUBSCRIBER ID
PATIENT NAME
DATE OF BIRTH
RELATIONSHIP
ALTERNATE ID

DeCare Dental Networks National Network Claims Administration Guidelines

The following pages contain the DeCare Dental Networks National Network Claims Administration Guidelines.

Claims Administration Guidelines

DeCare Dental℠

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Introduction to DeCare Dental Networks' Claims Administration Guidelines
The Claims Administration Guidelines in this document will provide your office with standard guidelines used by DeCare Dental Networks' (DDN) Plan Clients. Any updates and/or revisions will be communicated to all contracted dentists or dental practices.

Applicability
These claims administration guidelines may be applied to dental coverage for all members of DeCare Dental Networks' Plan Clients. DeCare Dental Health International (the company that performs the administrative functions for DDN's Plan Clients) will administer the dental plan benefits of Plan Clients using these guidelines.

General Guidelines
These guidelines are used in the claim adjudication process and any retrospective review of claims for fraud and abuse evaluation.

General guidelines (GG) related to each category of procedure codes precede the category code listing.

Specific procedure code policies are listed in each category after the codes and nomenclature. Group contract provisions, limitations and exclusions take precedence over processing policies. Since certain contractual items (time limits, frequency of procedures, age limits, etc.) can vary among groups, they have not all been listed with their associated procedure codes.

This document should not be interpreted as comprehensive and encompassing all possible limitations and exclusions. It is recommended that the dental office contact the customer service number for the DDN Plan Client on the member's identification card to determine the limitations and exclusions for each group.

For following definitions apply to the guidelines:

ALLOWABLE: The amount used to calculate the appropriate benefit allowance consistent with "Maximum Schedule of Allowance". Refer to DDN Uniform Policies and Procedures for definition of Maximum Schedule of Allowance.

ALTERNATE BENEFIT: In cases where alternative methods of treatment exist, benefits are provided for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under terms of the **PATIENT'S** coverage. The dentist and **PATIENT** should decide the course of treatment. If the treatment rendered is other than the one **BENEFITED** the difference between allowance and the dentist charge for the actual treatment rendered is collectible from the **PATIENT**.

BENEFITED: Processed for payment subject to DDN's Plan Client's dental benefit contract stipulations including but not limited to co-payments, deductibles, maximums, determination of the **ALLOWABLE** amount, etc.

BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL: When a procedure is **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL**, it should be submitted to the **PATIENT**'s medical carrier first. When submitting, include a copy of the explanation of payment or payment voucher from the medical carrier with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information the procedure will not be **BENEFITED**.

NON-COVERED: If the fee for a procedure is **NON-COVERED**, the fee charged is not payable and is chargeable to the **PATIENT**.

PROVIDER ADJUSTMENT: If the fee for a procedure is **PROVIDER ADJUSTMENT**, it is not **BENEFITED** and is not collectible from the **PATIENT** by a contracting dentist.

IN CONJUNCTION WITH: IN CONJUNCTION WITH means the service is considered part of another procedure or episode of treatment including, but not limited to services being rendered on the same day.

OPTIONAL: Procedures which are not covered, but for which an allowance is provided for a different procedure. This allowance can be applied to the **OPTIONAL** procedure, and the difference between the charged amount and the **ALLOWABLE** amount for the **OPTIONAL** procedure is collectible from the **PATIENT** by a contracting dentist.

PATIENT: The person who receives the treatment or service that is submitted for dental benefits. **PATIENT** may also mean, with respect to financial responsibilities only, the person (if different from the **PATIENT**) who is responsible to the dental office for any payment obligations of the **PATIENT.**

PROCESSED AS: When a procedure is **PROCESSED AS** a different procedure, contracting dentists agree to accept all the limitations, claims administration guidelines, and **ALLOWABLE** amounts that apply to the procedure that is **BENEFITED** by the DDN Plan Client.

All procedures submitted are subject to the following general guidelines (GG):

- Documentation of extraordinary circumstances can be submitted for review by report or on an appeal basis.
- Multi-stage procedures are reported and **BENEFITED** upon completion. The completion date is the date of insertion for removable prosthetic appliances. 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 root canal therapy is the date the canals are permanently filled.
- Many of the claims administration guidelines that follow detail payment procedures are based on the timing and sequence of inter-related procedures. However, the timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the treating dentist based on the **PATIENT'S** dental needs.
- Fees for completion of claim forms, requests for pre-estimates of benefits or pre-determinations of benefits, and submission of documentation enable benefit determination and are not benefits paid by DDN or its Plan Clients. They are not collectible from the **PATIENT** by a contracting dentist.
- Infection control and OSHA compliance are considered to be part of normal office overhead. Therefore, they are included in the fee for each procedure and not collectible separately from the **PATIENT** by a contracting dentist.
- A Plan Client or its administrator DDHI may **DISALLOW** charges for procedures, which were not necessary or failed to meet generally accepted standards of care.
- For payment purposes, local anesthesia is an integral part of the procedure being performed and additional charges are **PROVIDER ADJUSTMENT.**

I. D0100 - D0999 DIAGNOSTIC

CLINICAL ORAL EVALUATIONS D0100 - D0199

(**Reminder**: GG = General Guidelines)

GG - Comprehensive and periodic evaluations include, but are not limited to, evaluation of all hard and soft tissues of the oral cavity, periodontal charting, oral cancer evaluation, blood pressure screenings, and base line EKG. Any additional fee for these procedures is **PROVIDER ADJUSTMENT**.

GG - Clinical oral evaluations are covered by contract and are subject to time limitations established by the group contract.

GG - The fees for consultation, diagnosis, and routine treatment planning are **PROVIDER ADJUSTMENT** as components of the fee for the evaluation, by the same dentist/dental office.

D0120 Periodic oral evaluation

D0140 Limited oral evaluation – problem focused

D0145 Oral evaluation for patient under 3 years of age and counseling with Primary caregiver

Benefits for a child over three years of age will be **PROCESSED AS** periodic evaluations and subject to contractual time limitations.

D0145 includes any caries susceptibility tests or oral hygiene instruction on the same date. When performed on the same date as D0145 any fees for susceptibility test and oral hygiene instruction are **PROVIDER ADJUSTMENT**.

Benefits for D0145 when billed on the same date and by the same dental office as a comprehensive oral evaluation are considered to be included in the comprehensive evaluation as the more inclusive procedure. The fee for D0145 is **PROVIDER ADJUSTMENT**.

D0150 Comprehensive oral evaluation – new or established PATIENT

A comprehensive oral evaluation is payable once per dentist.

Additional evaluations when billed by the same dentist/dental office are **PROCESSED AS** periodic evaluations and subject to contractual time limitations. For patients under age of three, any other comprehensive exam code submitted will be payable as D0145.

D0160 Detailed and extensive oral evaluation problem focused, by report

Detailed and extensive oral evaluation problem focused, by report, may be **PROCESSED AS** a comprehensive oral evaluation for the first encounter with the dentist/dental office and subsequent submissions are **PROCESSED AS** periodic oral evaluations (D0120). For patients under age of three, any other comprehensive exam code submitted will be payable as D0145.

D0170 Re-evaluation - limited, problem focused (established PATIENT; not post-operative visit)

The fees for re-evaluation – limited are **PROVIDER ADJUSTMENT** as a component of another service or procedure.

D0180 Comprehensive periodontal evaluation-new or established PATIENT

Additional evaluations when billed by the same dentist/dental office are **PROCESSED AS** periodic evaluations and subject to contractual time limitations. For patients under age of three, any other comprehensive exam code submitted will be payable as D0145.

RADIOGRAPHS/ DIAGNOSTIC IMAGING D0200 - D0399

GG - Only necessary and appropriate diagnostic services can be charged to the **PATIENT** and DeCare Dental. Fees for unnecessary or inappropriate radiographs are **PROVIDER ADJUSTMENT.**

GG - Fees for duplication (copying) of radiographs is not a covered benefit, nor chargeable to the **PATIENT** by a participating dentist.

GG - The time limitation for radiographs is established by the contract.

D0210 Intraoral-complete series (including bitewings)

An intraoral complete series of radiographs consists of all necessary periapicals and bitewings, usually 14-22 images, intended to display the crowns and roots of all teeth, periapical areas

and alveolar bone. This guideline precludes unbundling of additional radiographs. Bitewings that are processed as part of a D0210 will not be allowed as a separate benefit if the D0210 time limitation has been met.

When a separate fee is requested for a panoramic x-ray (D0330) **IN CONJUNCTION WITH** D0210, the fee for the D0330 is **PROVIDER ADJUSTMENT** as a component of D0210.

D0220 **Intraoral - periapical - first film**

D0230 **Intraoral – periapicals - each additional film**

Individually listed intraoral radiographs are considered a complete series if the number of individual radiographs equals or exceeds fourteen (14) films. The fee in excess of the **ALLOWABLE** amount for a complete series (D0210) is **PROVIDER ADJUSTMENT**.

Working and final treatment radiographs taken for endodontic therapy are considered a component part of the complete treatment procedure, and separate fees for these films are **PROVIDER ADJUSTMENT**.

D0240 **Intraoral-occlusal film**

D0250 **Extraoral-first film**

D0260 **Extraoral-each additional film**

D0270 **Bitewings-single film**

D0272 **Bitewings-two films**

D0273 **Bitewings-three films**

D0274 **Bitewings-four films**

D0277 **Vertical bitewings - 7 to 8 films**

Vertical bitewings go against the time limit frequencies for bitewings in the contract.

The fee for any type of bitewings submitted with a full mouth series are considered part of the full mouth series for payment and benefit purposes. Any fee in excess of the full mouth series is **PROVIDER ADJUSTMENT**.

D0290 **Posterior-anterior or lateral skull and facial bone survey film**

D0310 **Sialography**

D0320 **TMJ arthrogram including injection**

D0321 **Other TMJ films, by report**

D0322 **Tomographic survey**

D0330 **Panoramic film**

A panoramic film, with or without supplemental films (such as periapicals, bitewings, and/or occlusal films) is considered a complete series for time limitations, and any fee in excess of the **ALLOWABLE** amount for a complete series (D0210) is **PROVIDER ADJUSTMENT.** Bitewings that are processed as part of a D0210 will not be allowed as a separate benefit if the D0210 time limitation has been met

Benefits for subsequent panoramic radiographs taken by the same provider within the contractual time limitation for a full mouth series are **NON-COVERED**.

D0340 **Cephalometric film**

A cephalometric film is payable only when done **IN CONJUNCTION WITH** orthodontic benefits.

D0350 **Oral/facial images (includes intra and extraoral images)**

Oral/facial images are **BENEFITED** only once per case **IN CONJUNCTION WITH** orthodontic services. The fees for additional images taken during or after orthodontic treatment are included in the fee for the orthodontics and **PROVIDER ADJUSTMENT**

D0360 **Cone Beam CT – Craniofacial data capture**

D0362 **Cone Beam – Two dimensional image reconstruction using existing data, includes multiple images**

D0363 **Cone Beam – Three dimensional image reconstruction using existing data, includes multiple images**

Cone beam procedures are **NON-COVERED**.

TESTS AND LABORATORY EVALUATIONS D0400 - D0999

GG - When more than two procedures are performed on the same area of the mouth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

D0415 **Collection of microorganisms for culture and sensitivity**

D0416 **Viral culture**

D0417 **Collection and preparation of saliva sample for laboratory diagnostic testing**

D0418	**Analysis of saliva sample**
D0421	**Genetic test for susceptibility to oral diseases**
D0425	**Caries susceptibility tests**
D0431	**Pre-adjunctive diagnostic test that aids in detection of mucosal abnormalities including premalignant and melignant lesions, not to include cytology or biopsy procedures**
	NON-COVERED, unless specified as a covered service by the group contract.
D0460	**Pulp vitality tests**
	The fees for pulp tests are **PROVIDER ADJUSTMENT** when performed on the same date as any other definitive procedure except limited oral evaluation – problem focused or D9110 palliative treatment.
D0470	**Diagnostic casts**
	Diagnostic casts are **BENEFITED** only once per case **IN CONJUNCTION WITH** orthodontic services. The fees for additional casts taken during or after orthodontic treatment are included in the fee for orthodontic treatment and are **PROVIDER ADJUSTMENT**.
	The fees for diagnostic casts taken **IN CONJUNCTION WITH** any other procedure are **NON-COVERED** unless specified as a covered service by the group contract.

ORAL PATHOLOGY LABORATORY

GG- When more than one procedure is performed on the same area of the mouth on the same day, benefits are based upon, but not limited to, the most inclusive procedure and the less inclusive procedure is **PROVIDER ADJUSTMENT**

GG- Fees for the included procedure are **PROVIDER ADJUSTMENT** and not billable to the **PATIENT** by a participating dentist. These inter-related procedures include, but are not limited to, the following hierarchy: D0474 most inclusive, D0473, D0472, D0480 least inclusive.

D0472	**Accession of tissue, gross examination, preparation and transmission of written report**
D0473	**Accession of tissue, gross and microscopic examination, preparation and transmission of written report**
D0474	**Accession of tissue, gross and microscopic examination including assessment of the surgical margins for the presence of disease, preparation, and transmission of a written report**
D0475	**Decalcification procedure**
D0476	**Special stains for microorganisms**
D0477	**Special stains, not for microorganisms**
D0478	**Immunohistochemical stains**
D0479	**Tissue in-site hybridization, including interpretation**
D0480	**Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report.**
	Refers to gross and microscopic evaluations of presumptively abnormal tissue(s) that have been previously excised, includes preparation and transmission of a written report.
D0481	**Electron microscopy - diagnostic**
D0482	**Direct immunoflourescence**
D0483	**Indirect immunoflourescence**
D0484	**Consultation on slides prepared elsewhere**
	Consultation on slides prepared elsewhere is paid as D9310 – Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).
D0485	**Consultation, including preparation of slides from biopsy material supplied by referring source**
	The fees for pathology reports submitted by anyone, other than a licensed dentist are **NON-COVERED**, and the **fee** is collectible from the **PATIENT.**
D0486	**Laboratory accession of transepithelial cytologic sample, microscopic examintaion , preparation and transmission of written report**
	NON-COVERED, unless specified as a covered service by the group contract.
D0502	**Other oral pathology procedures, by report**
	The fees for other oral pathology

procedures **IN CONJUNCTION WITH** routine surgical procedures are **NON-COVERED**, and the **ALLOWABLE** amount is collectible from the **PATIENT**.

D0999 Unspecified diagnostic procedure, by report

This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

II. D1000 - D1999 PREVENTIVE

GG- Dental prophylaxis benefits are determined by contract.

GG- A prophylaxis done on the same date by the same dentist/dental office as a periodontal maintenance, scaling and root planning, or periodontal surgery, is considered to be part of those procedures and the fee for the prophylaxis is **PROVIDER ADJUSTMENT**.

GG- Periodontal maintenance (D4910) is counted toward the contract limitation for prophylaxis. In absence of contract limitations, D4355 should be counted toward the contractual limitation for prophylaxis.

DENTAL PROPHYLAXIS D1000 - D1199

D1110 Prophylaxis-adult

For payment purposes, the distinction between the adult and child dentition is determined by contract. Any fee in excess is **PROVIDER ADJUSTMENT** and not chargeable to the **PATIENT**. In the absence of group contract language regarding age, a person age fourteen (14) and older is considered an adult for benefit determination purposes of a prophylaxis-adult.

D1120 Prophylaxis-child

For payment purposes, the distinction between the adult and child dentition is determined by contract. Any fee in excess is **PROVIDER ADJUSTMENT** and not chargeable to the **PATIENT.** In the absence of group contract language regarding age, a person age thirteen (13) and younger is considered a child for benefit determination purposes of an prophylaxis-child.

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE) D1200 - D1299

GG- A prophylaxis paste containing fluoride or a fluoride rinse is considered a prophylaxis only. Any fee in excess of the **ALLOWABLE** amount for a prophylaxis is **PROVIDER ADJUSTMENT.**

GG- The age limitation for topical fluoride gel or varnish treatments is limited by contract usually through age eighteen (18).

GG- The fees for fluoride gels, rinses, tablets, or other preparations intended for home applications are not benefits.

D1203 Topical application of fluoride - child

D1204 Topical application of fluoride - adult

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients

Benefits for topical fluoride varnish when used for desensitization are **NON-COVERED**.

OTHER PREVENTIVE SERVICES D1300 - D1499

D1310 Nutritional counseling for the control of dental disease

D1320 Tobacco counseling for the control and prevention of oral disease

D1330 Oral hygiene instructions

NON-COVERED, unless specified as a covered service by the group contract.

D1351 Sealant-per tooth

D1352 Preventive Resin Restoration in a moderate to high caries risk patient – permanent tooth

Sealants and/or Preventive Resin Restorations are **BENEFITED** once per tooth on the occlusal surface of permanent first and second molars for **PATIENT'**s through age fifteen (15). The teeth must be free from caries or restorations on the occlusal surface. A sealant or preventive resin restoration done on the same date of service and on the same surface as a restoration is considered a component of the restoration, and the fee for the sealant or preventive resin restoration is **PROVIDER ADJUSTMENT.**

Benefits for sealants or preventive resin restorations are **NON-COVERED** when the **PATIENT'S** claim history indicates a restoration on the occlusal surface of the

same tooth.

The fee for repair or replacement of a sealant or preventive resin restoration by the same dentist/dental office within two (2) years of initial placement is included in the fee for the initial placement and is **PROVIDER ADJUSTMENT**.

Sealants or preventive resin restorations requested after twenty-four (24) months since initial placement are **BENEFITED**, unless the group contract specifies a different time limitation.

SPACE MAINTENANCE (PASSIVE APPLIANCES) D1500 - D1999

GG- The fee for repair or replacement of a space maintainer is not a benefit and is **NON-COVERED**.

GG- Only one space maintainer is provided for a space. Otherwise, the fees are **NON-COVERED.**

GG- The fees for space maintainers for missing primary anterior teeth, all missing permanent teeth, or for persons age fourteen (14)* and over are **NON COVERED**. (*this age varied based on the group contract).

GG- Space maintainer fees include all teeth, clasps and rests. Separate fees for these procedures are **PROVIDER ADJUSTMENT**.

D1510 Space maintainer-fixed unilateral

D1515 Space maintainer-fixed bilateral

D1520 Space maintainer-removable unilateral

D1525 Space maintainer-removable bilateral

D1550 Recementation of a space maintainer

NON-COVERED, unless specified as a covered service by the group contract.

D1555 Removal of fixed space maintainer

BENEFITS for removal of fixed space maintainer by the same dentist/dental office who placed the appliance are **PROVIDER ADJUSTMENT**.
When submitted on the same day as the recementation of a space maintainer, fees are **PROVIDER ADJUSTMENT**.

III. D2000 - D2999 RESTORATIVE

(Benefits for multistage procedures are only available for completed services as determined by the date of insertion.)

GG- The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal, and gingivectomy done on the same date of service as the restoration. A separate fee for any of these procedures is **PROVIDER ADJUSTMENT**.

GG- The fee for replacement of amalgam or composite restorations, same tooth and same surface(s), is **PROVIDER ADJUSTMENT** if done by the same dentist/dental office within twenty-four (24) months of the initial restoration.

GG- When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, on the same day, the benefit allowance is limited to that of one multi-surface restoration. Any fee in excess of the **ALLOWABLE** amount for the multi-surface restoration is **PROVIDER ADJUSTMENT**. A separate benefit may be allowed for a restoration on the buccal or lingual surface(s) of the same tooth.

GG- When restorations not involving the occlusal surface are requested or performed on posterior teeth, the benefit allowance is limited to that of a one-surface restoration. Any fee in excess of the **ALLOWABLE** amount for the one surface restoration is **PROVIDER ADJUSTMENT**.

GG- Benefits are allowed only once per surface in a twenty-four (24) month interval, irrespective of the number or combination of procedures requested or performed. The fee for restoration of a surface within twenty-four (24) months of previous treatment is **PROVIDER ADJUSTMENT** if done by the same dentist/dental office, unless specified as a covered service by the group contract.

GG- If a indirectly fabricated restoration is performed by the same dentist/dental office within twelve (12) months of the placement of an amalgam or composite restoration, the DeCare payment and **PATIENT** co-payment allowance for the amalgam or composite restoration will be deducted from the indirectly fabricated restoration benefit.

GG- Fees are NON-COVERED and collectible from the PATIENT for restorations altering

occlusion, vertical dimension, attrition, abfraction, corrosion, TMD, periodontal, erosion, abrasion, or splinting.

AMALGAM RESTORATIONS (INCLUDING POLISHING) D2140 - D2161

D2140	**Amalgam – one surface, primary or permanent**
D2150	**Amalgam – two surfaces, primary or permanent**
D2160	**Amalgam – three surfaces, primary or permanent**
D2161	**Amalgam – four or more surfaces, primary or permanent**

RESIN-BASED COMPOSITE RESTORATIONS – DIRECT D2330 - D2399

GG- The replacement of the same amalgam or composite restorations within twenty-four (24) months is **PROVIDER ADJUSTMENT** if done by the same dentist/dental office.

GG- Subject to contract language, an **ALTERNATE BENEFIT** may be allowed for resin-based composites placed in posterior teeth.

D2330	**Resin-based composite - one surface, anterior**
D2331	**Resin-based composite - two surfaces, anterior**
D2332	**Resin-based composite - three surfaces, anterior**
D2335	**Resin-based composite - four or more surfaces or involving the incisal angle (anterior)**
D2390	**Resin-based composite crown, anterior**
D2391	**Resin-based composite – one surface, posterior**
D2392	**Resin-based composite – two surfaces, posterior**
D2393	**Resin-based composite – three surfaces, posterior**
D2394	**Resin-based composite –four or more surfaces, posterior**

GOLD FOIL RESTORATIONS D2400 - D2499

An **ALTERNATE BENEFIT** will be allowed for an amalgam or resin restoration, according to the policies for amalgam and resin restorations. The additional fee is the **PATIENT'S** responsibility.

D2410	**Gold foil - one surface**
D2420	**Gold foil - two surfaces**
D2430	**Gold foil - three surfaces**

INLAY/ONLAY RESTORATIONS D2500 - 2699

GG- Onlay benefits are based on the submitted procedure. If an **ALTERNATE BENEFIT** allowance is applied (based on the terms of the contract), the difference between the allowance for the **ALTERNATE BENEFIT** and the onlay is collectible from the **PATIENT**.

GG- For inlay restorations, an **ALTERNATE BENEFIT** will be allowed for an amalgam restoration, according to the policies for amalgam restorations. The additional fee will be the **PATIENT'S** responsibility.

GG- Indirectly fabricated restorations include all models, temporaries and other associated procedures.

Benefits for study models, temporaries, and other associated procedures are **PROVIDER ADJUSTMENT.**

GG- Onlays are considered to cover all of the cusps and include the inlay. Onlays are only **BENEFITED** when the tooth would otherwise qualify for a crown.

D2510	**Inlay - metallic - one surface**
D2520	**Inlay - metallic - two surfaces**
D2530	**Inlay - metallic - three or more surfaces**
D2542	**Onlay - metallic - two surfaces**
D2543	**Onlay - metallic - three surfaces**
D2544	**Onlay - metallic - four or more surfaces**
D2610	**Inlay - porcelain/ceramic - one surface**
D2620	**Inlay - porcelain/ceramic - two surfaces**
D2630	**Inlay - porcelain/ceramic - three or more surfaces**
D2642	**Onlay - porcelain/ceramic - two surfaces**
D2643	**Onlay - porcelain/ceramic - three surfaces**
D2644	**Onlay - porcelain/ceramic -**

	four or more surfaces
D2650	**Inlay - resin-based composite - one surface**
02651	**Inlay - resin-based composite - two surfaces**
02652	**Inlay - resin-based composite - three or more surfaces**
02662	**Onlay - resin-based composite - two surfaces**
02663	**Onlay - resin-based composite - three surfaces**
02664	**Onlay - resin-based composite - four or more surfaces**

CROWNS - SINGLE RESTORATION ONLY
D2700 - D2899

GG- The fees for crowns and onlays are **NON-COVERED** and the **ALLOWABLE** amount is collectible from the **PATIENT** for children under twelve (12) years of age.

For the classification of metals, see the ADA CDT Manual.

GG- Indirectly fabricated restorations include all models, temporaries and other associated procedures. Separate fees for these procedures by the same dentist/dental office are **PROVIDER ADJUSTMENT**.

GG- Laboratory fees and materials, cement bases, impressions, occlusal adjustments, gingivectomies (on the same date of service), and local anesthesia are considered to be included in the fee for a crown restoration, and a separate fee for any of these procedures is **PROVIDER ADJUSTMENT** if performed on the same tooth.

GG- The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, cosmetic,or for periodontal, orthodontic, or other splinting are **NON-COVERED**, and collectible from the **PATIENT**.

D2710	**Crown – resin-based composite (indirect)**
D2712	**Crown – ¾ resin-based composite (indirect)**
D2720	**Crown - resin with high noble metal**
D2721	**Crown - resin with predominantly base metal**
D2722	**Crown - resin with noble metal**
D2740	**Crown - porcelain/ceramic substrate**
D2750	**Crown - porcelain fused to high noble metal**
D2751	**Crown - porcelain fused to predominantly base metal**
D2752	**Crown - porcelain fused to noble metal**
D2780	**Crown - ¾ cast high noble metal**
D2781	**Crown - ¾ cast predominately base metal**
D2782	**Crown - ¾ cast noble metal**
D2783	**Crown - ¾ porcelain/ceramic**
D2790	**Crown - full cast high noble metal**
D2791	**Crown - full cast predominantly base metal**
D2792	**Crown - full cast noble metal**
D2794	**Crown - Titanium**
D2799	**Provisional crown**

Temporary crowns are not a separate benefits and should be included in the fee for the permanent crown. Benefits are **PROVIDER ADJUSTMENT**.

Other Restorative Services
D2900 - D2999

GG- The fee for recementation of an onlay or crown by the same dentist/dental office within six (6) months of initial placement is considered part of the fee for the original procedure and is **PROVIDER ADJUSTMENT**.

GG- Benefits may be allowed to the same dentist/dental office for recementation, but only once in a twelve (12) month interval. Requests for benefits for recementation in excess of once in a twelve (12) month interval are **NON-COVERED**, and collectible from the **PATIENT**.

D2910	**Recement inlay, onlay or partial coverage restoration**
D2915	**Recement indirectly fabricated or prefabricated post and core**
D2920	**Recement crown**
D2930	**Prefabricated stainless steel crown - primary tooth**

The fee for replacement of a stainless steel crown on a primary tooth by the same dentist or dental office within twenty-four (24) months is included in the initial crown placement and is **PROVIDER ADJUSTMENT**.

D2931	**Prefabricated stainless steel crown - permanent tooth**
	The fee for replacement of a stainless steel crown on a permanent tooth within five (5) years is **NON-COVERED**.
D2932	**Prefabricated resin crown**
	A prefabricated resin crown is **BENEFITED** only on anterior primary teeth.
D2933	**Prefabricated stainless steel crown with resin window**
	An **ALTERNATE BENEFIT** will be allowed for a D2932 restoration, subject to all contract limitations. The additional fee is the **PATIENT'S** responsibility.
D2934	**Prefabricated esthetic coated stainless steel crown - primary tooth**
	A prefabricated esthetic coated stainless steel crown is a benefit only on anterior primary teeth.
D2940	**Protective Restoration**
	NON-COVERED, unless specified as a covered service by the group contract.
D2950	**Core buildup, including any pins**
	Substructures are **BENEFITED** only when necessary to retain an indirectly fabricated restoration due to extensive loss of tooth structure from caries or fracture.
D2951	**Pin retention-per tooth, in addition to restoration**
	Pin retention is a benefit, once per tooth. Additional pins on the same tooth are **PROVIDER ADJUSTMENT** as a component of the initial pin placement. The fee for pin retention when billed **IN CONJUNCTION WITH** a buildup is **PROVIDER ADJUSTMENT** as a component of the buildup procedure.
D2952	**Post and core in addition to crown, indirectly fabricated**
	An indirectly fabricated post and core in addition to a crown is **BENEFITED** only on a completed endodontically treated tooth. An indirectly fabricated post and core for an anterior tooth is **BENEFITED** only when there is insufficient tooth structure to support an indirectly fabricated restoration.
D2953	**Each additional indirectly fabricated post - same tooth**
	The fees for additional posts involving the same tooth are **PROVIDER ADJUSTMENT** as a component of the first post.
D2954	**Prefabricated post and core in addition to crown**
	A prefabricated post and core in addition to crown is payable only on a completed endodontically treated tooth. A prefabricated post and core is **BENEFITED** only when there is insufficient tooth structure to support an indirectly fabricated restoration.
D2955	**Post removal (not in conjunction with endodontic therapy)**
	The fee for post removal is **PROVIDER ADJUSTMENT** as a component of the fee for the retreatment if performed by the same dentist/dental office. This code is **NON-COVERED** in accordance with exclusions of group contracts.
D2957	**Each additional prefabricated post in the same tooth**
	The fees for additional posts involving the same tooth are **PROVIDER ADJUSTMENT** as a component of the first post.
D2960	**Labial veneer (resin laminate) – chair side**
D2961	**Labial veneer (resin laminate) – laboratory**
D2962	**Labial veneer (porcelain laminate) – laboratory**
	Labial veneers are **NON-COVERED** in accordance with exclusions of group contracts.
D2970	**Temporary Crown (fractured tooth)**
	Temporary crowns are not separate benefits and should be included in the fee for the permanent crown. Benefits are **PROVIDER ADJUSTMENT**. When a provisional crown is billed as a long-term care for a fractured tooth, it may be BENEFITED subject to individual consideration.
D2975	**Coping**
	Copings are considered a specialized procedure.. Additional fees are **NON-**

COVERED.

D2980	**Crown repair, by report**
D2999	**Unspecified restorative procedure, by report**

This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

IV. D3000 - D3999 ENDODONTICS

GG- The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within twenty-four (24) months of initial treatment is **PROVIDER ADJUSTMENT** as a component of the fee for the original procedure**.**

GG- The fees for direct or indirect pulp caps are **PROVIDER ADJUSTMENT** when provided on the same date as the final restoration for the same tooth or a sedative filling.

PULP CAPPING D3100 – D3199

D3110	**Pulp cap-direct (excluding final restoration)**
D3120	**Pulp cap-indirect (excluding final restoration)**

PULPOTOMY D3200 – D3299

D3220	**Therapeutic pulpotomy (excluding final restoration)**

Therapeutic pulpotomy is limited to primary teeth. A pulpotomy provided on a permanent tooth is **NON-COVERED.**

D3221	**Pulpal debridement, primary and permanent teeth**
D3222	**Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development**

NON-COVERED in accordance with exclusions of group contracts.

D3230	**Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)**
D3240	**Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)**

ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE) D3300 - D3399

GG- The fee for root canal therapy includes treatment x-rays and temporary restorations. Any additional fee above the **ALLOWABLE** amount for the root canal therapy is **PROVIDER ADJUSTMENT**.

D3310	**Endodontic therapy - anterior (excluding final restoration)**
D3320	**Endodontic therapy - bicuspid (excluding final restoration)**
D3330	**Endodontic therapy - molar (excluding final restoration)**

The fee for palliative treatment is **PROVIDER ADJUSTMENT** when done **IN CONJUNCTION WITH** root canal therapy by the same dentist/dental office on the same date of service.

Incompletely filled root canals are not payable, and the fee for the endodontic therapy is **PROVIDER ADJUSTMENT**.

D3331	**Treatment of root canal obstruction; non-surgical access**

This procedure is considered a component of a root canal. The fee for the procedure is **PROVIDER ADJUSTMENT**.

Post removal is not included in this procedure.

D3332	**Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth**

This code is **NON-COVERED** in accordance with group contracts.

D3333	**Internal root repair of perforation defects**

The fee for this procedure is **PROVIDER ADJUSTMENT** if reported on a permanent tooth.

The fee is **NON-COVERED** if reported on a primary tooth.

ENDODONTIC RETREATMENT D3340 - D3349

GG- The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within twenty-four (24) months of initial treatment is **PROVIDER ADJUSTMENT** as a component of the fee for the original procedure**.**

GG- Separate fees for removal of posts, pins, old root canal filling material and procedures necessary to prepare the canal and place the canal filling are **PROVIDER ADJUSTMENT** as included in the fee for the retreatment.

D3346	**Retreatment of previous root canal therapy - anterior**
D3347	**Retreatment of previous root canal therapy - bicuspid**
D3348	**Retreatment of previous root canal therapy - molar**

APEXIFICATION/RECALCIFICATION PROCEDURES D3350 – D3359

GG- If the apex is fully developed, this treatment is not indicated and benefits are **NON-COVERED**.

D3351	**Apexification/recalcification pulpal regeneration - initial visit (apical closure, calcific repair of perforations, root resorption, etc.)**
D3352	**Apexification/recalcification pulpal regeneration – interim medication replacement (includes apical closure, calcific repair of perforations, root resorption, etc.)**
D3353	**Apexification/recalcification - final visit (includes completed root canal therapy, apical closure, calcific repair of perforations, root resorption, etc.)**
D3354	**Pulpal Regeneration – includes completed regenerative treatment of an immature permanent tooth with necrotic pulp**

APICOECTOMY/PERIRADICULAR SERVICES D3400 - D3499

D3410	**Apicoectomy/periradicular surgery - anterior**
D3421	**Apicoectomy/periradicular surgery - bicuspid (first root)**
D3425	**Apicoectomy/periradicular surgery – molar (first root)**
D3426	**Apicoectomy/periradicular surgery (each additional root)**

The fee for a biopsy is **PROVIDER ADJUSTMENT IN CONJUNCTION WITH** other surgery at the same site/same day.

D3430	**Retrograde filling - per root**

D3450	**Root amputation - per root**

The fee for root amputation is **PROVIDER ADJUSTMENT** when performed **IN CONJUNCTION WITH** an apicoectomy.

D3460	**Endodontic endosseous implant**

NON-COVERED in accordance with exclusions of group contracts.

D3470	**Intentional reimplantation (including necessary splinting)**

NON-COVERED in accordance with exclusions of group contracts.

D3910	**Surgical procedure for isolation of tooth with rubber dam**

The fee for isolation of a tooth with a rubber dam is **PROVIDER ADJUSTMENT** as a component of the fee for the procedure performed.

D3920	**Hemisection (including any root removal), not including root canal therapy**
D3950	**Canal preparation and fitting of preformed dowel or post**

If reported **IN CONJUNCTION WITH** core buildups, this service is **PROVIDER ADJUSTMENT**.

D3999	**Unspecified endodontic procedure, by report**

This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

V. D4000 - D4999 Periodontics

GG- When more than one (1) periodontal or surgical procedure is provided on the same teeth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

GG- Periodontal services are only **BENEFITED** when performed on natural teeth for treatment of periodontal disease. Benefits for these procedures when billed **IN CONJUNCTION WITH** implants, ridge augmentation, extraction sites and/or periradicular surgery are **NON-COVERED** and the **ALLOWABLE** amount is collectible from the **PATIENT**.

GG- Laser disinfection is considered a technique, and not a procedure. The fees are PROVIDER ADJUSTMENT.

SURGICAL SERVICES D4100 - D4299

GG- Periodontal surgical procedures include all necessary post-operative care, finishing procedures, and evaluations for three (3) months, as well as any surgical re-entry for three (3) years. When a surgical procedure is billed within three (3) months of the initial surgical procedure, the surgery is **PROVIDER ADJUSTMENT**. Additional surgery is **PROVIDER ADJUSTMENT** for three (3) years by the same dentist/dental office.

GG- Periodontally involved teeth, which would qualify for surgical pocket reduction benefits under procedure codes D4210, D4211, D4240, D4241, D4260, and D4261 must be documented to have at least 5mm pocket depths.

GG- Full quadrant fees for procedures submitted by quadrant are available when a minimum of four (4) qualified diseased teeth are documented anywhere in the quadrant.

GG- The following categorizes procedures for reporting and adjudicating by quadrant, or individual tooth in order to expedite claims processing.

Quadrant – D4210, D4230, D4240, D4260, D4341

One to three teeth, per quadrant D4211, D4231, D4241, D4261, D4342

Per Tooth – D4268, D4273, D4276

GG- Providing more than two D4245, D4265, D4266, D4267, D4268, D4270, D4271, D4273, D4275, D4276 or osseous grafts within any given quadrant is considered highly unusual and additional submissions are only considered on a by report basis. Anything more than two (2) sites in a quadrant are **PROVIDER ADJUSTMENT**.

D4210	**Gingivectomy or gingivoplasty four or more contiguous teeth or tooth bounded space – per quadrant**
D4211	**Gingivectomy or gingivoplasty one to three teeth per quadrant**
	The fee for gingivectomy or gingivoplasty - is **PROVIDER ADJUSTMENT** when performed **IN CONJUNCTION WITH** the preparation of a crown or other restoration.
D4230	**Anotomical crown exposure – four or more contiguous teeth per quadrant**
D4231	**Anotomical crown exposure – one to three teeth per quadrant**
	D4230/D4231 are considered primarily cosmetic in nature and therefore NON-COVERED if the group contract excludes cosmetic procedures.
D4240	**Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant**
	D4240 includes root planing and therefore would not precede or follow nonsurgical root planning in the same episode of treatment.
D4241	**Gingival flap procedure, including tooth planing - one to three teeth per quadrant**
D4245	**Apically repositioned flap**
	D4241 and D4245 includes root planing and the fee for root planing will be **PROVIDER ADJUSTMENT** if it precedes or follows a D4241 or D4245 within the same episode of treatment.
D4249	**Clinical crown lengthening - hard tissue**
	The fee for crown lengthening is **PROVIDER ADJUSTMENT** when performed **IN CONJUNCTION WITH** osseous surgery on the same teeth.
	Crown lengthening is payable per site, not per tooth, and is a benefit only when bone is removed and sufficient time is allowed for healing. The fee for crown lengthening is **PROVIDER ADJUSTMENT** when performed on the same date as crown preparation, impression or restorations.
	This code may be **NON-COVERED** in accordance with group contracts and if **NON-COVERED,** the fee is collectible from the **PATIENT**.
D4260	**Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant**
D4261	**Osseous surgery (including flap entry and closure - one to three teeth, per quadrant**
	No more than two (2) quadrants of osseous surgery on the same date of service are **BENEFITED** Unless an appeal is submitted with additional information.

For benefit purposes, the fee for osseous surgery includes crown lengthening, anatomical crown exposure, osseous contouring, distal or proximal wedge surgery, scaling and root planning, gingivectomy, frenectomy and flap procedures.

A separate benefit may be available for soft tissue grafts, osseous grafts, exostosis removal, hemisection, extraction, apicoectomy, root amputations, and new attachment procedures.

D4263	**Bone replacement graft - first site in quadrant**
D4264	**Bone replacement graft - each additional site in quadrant**

Benefits are available only when billed for natural teeth. Benefits for these procedures when billed **IN CONJUNCTION WITH** implants, ridge augmentation, etc. are **NON-COVERED**.

D4265	**Biologic materials to aid in soft and osseous tissue regeneration**

The fee for this procedure is **NON-COVERED.**

D4266	**Guided tissue regeneration – resorbable barrier, per site**
D4267	**Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)**

The fee for this procedure is **NON-COVERED.**

D4268	**Surgical revision procedure, per tooth**

If treatment is performed by the same office/dentist within thirty-six (36) months, the fee for the procedure is **PROVIDER ADJUSTMENT**

The contractual limits would apply and the fee would be **NON-COVERED**, if not performed by the same dentist/dental office or is after the thirty-six (36) months.

D4270	**Pedicle soft tissue graft procedure**
D4271	**Free soft tissue graft procedure (including donor site surgery)**

The benefit for pedicle and free soft tissue grafts is per site.

When multiple, non-adjacent grafts are provided within a single quadrant, the fee is limited to the lesser of the **ALLOWABLE** amount for a full quadrant of osseous surgery (D4260) or two (2) sites. Any fee in excess of lesser of the **ALLOWABLE** amount for D4260 full quadrant or two (2) graft sites is **PROVIDER ADJUSTMENT** unless there is documentation of special need.

D4273	**Subepithelial connective tissue graft procedure, per tooth**
D4274	**Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)**
D4275	**Soft tissue allograft**
D4276	**Combined connective tissue and double pedicle graft**

A maximum of two (2) sites are benefited unless extraordinary circumstances and documentation is provided. Frenultctomy and/or frenuloplasty is **PROVIDER ADJUSTMENT** when done in conjunction with soft tissue graft.

NON-SURGICAL PERIODONTAL SERVICES D4300 - D4399

D4320	**Provisional splinting - intracoronal**
D4321	**Provisional splinting - extracoronal**

The fee for splinting is **NON-COVERED**.

D4341	**Periodontal scaling and root planing - four or more teeth per quadrant**
D4342	**Periodontal scaling and root planing, one to three teeth per quadrant**

In the absence of a contractual time limitation on frequency of benefits for D4341/D4342, retreatment performed by the same dentist/dental office within twenty-four (24) months of initial therapy is **PROVIDER ADJUSTMENT**. The fee for retreatment done by a different dentist within twenty-four (24) months is **NON-COVERED**.

The fee for prophylaxis (D1110) is **PROVIDER ADJUSTMENT** when done on the same date of service as D4341/D4342.

The fee for a D4341/D4342 billed **IN CONJUNCTION WITH** periodontal surgery procedures is **PROVIDER ADJUSTMENT** as a component of the surgical procedure.

D4355	**Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis**

In the absences of a contractual

limitation, benefits for D4355 in excess of one in a lifetime are **NON-COVERED**.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report

Benefits are **NON-COVERED**.

OTHER PERIODONTAL SERVICES
D4900 - D4999

D4910 Periodontal maintenance

Benefits for D4910 include prophylaxis, scaling and root planing procedures. Benefits for these procedures are **PROVIDER ADJUSTMENT** when billed **IN CONJUNCTION WITH** D4910.

Benefits for D4910 when billed within three (3) months of periodontal therapy are **PROVIDER ADJUSTMENT**.

D4920 Unscheduled dressing change (by someone other than the treating dentist)

The definition of the same dentist/dental office includes different dentists in the same dental office.

The fee for a dressing change submitted by a dentist of the same office is **PROVIDER ADJUSTMENT** as a component of the surgical procedure.

D4999 Unspecified periodontal procedure, by report

This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

VI. D5000 - D5899 PROSTHODONTICS (REMOVABLE)

GG- The fees for cast restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures in excess of the **ALLOWABLE** amounts are **PROVIDER ADJUSTMENT**.

GG- Multistage procedures are reported and **BENEFITED** upon completion. The completion date is the date of final insertion.

GG- Characterizations, staining, overdentures, or metal bases are considered specialized procedures. An **OPTIONAL** allowance is made for a conventional denture. Any additional fee is the **PATIENT'S** responsibility.

GG- Restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion (wear), cosmetic or for periodontal, orthodontic or other splinting are not a benefit. Benefits are **NON-COVERED**.

GG- The fee for full or partial dentures includes any reline/rebase, adjustment, or repair required within six (6) months of delivery.

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)
D5000 - D5199

D5110 Complete denture - maxillary

D5120 Complete denture - mandibular

D5130 Immediate denture - maxillary

D5140 Immediate denture - mandibular

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)
D5200 - D5399

GG- A fixed bridge and a removable partial denture are not benefited in the same arch. The benefit is limited to the allowance for the partial removable denture.

GG- Fixed bridges or removable partials are not a benefit for **PATIENTS** under age sixteen (16).

D5211 Maxillary partial denture-resin base (including any conventional clasps, rests, and teeth)

D5212 Mandibular partial denture-resin base (including any conventional clasps, rests, and teeth)

D5213 Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)

D5214 Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)

D5225 Maxillary partial denture – flexible base (including any clasps, rests, and teeth)

D5226 Mandibular partial denture – flexible base (including any clasps, rests, and teeth)

D5281 Removable unilateral partial denture-

	one piece cast metal (including clasps and teeth)

ADJUSTMENTS TO DENTURES D5400 - D5499

GG- The fees for full or partial dentures include any adjustments or repairs required within six (6) months of delivery. If performed by the same dentist/dental office within six (6) months of initial placement, the fees for adjustments or repairs are **PROVIDER ADJUSTMENT**.

GG- In absence of a contract limitation, adjustments to complete or partial dentures are limited to two (2) adjustments per denture per twelve (12) months (after the initial six (6) months have elapsed)

D5410	**Adjust complete denture - maxillary**
D5411	**Adjust complete denture - mandibular**
D5421	**Adjust partial denture - maxillary**
D5422	**Adjust partial denture – mandibular**

REPAIRS TO COMPLETE DENTURES D5500 - D5599

GG- Repairs of complete or partial dentures if performed within six (6) months of initial placement are **PROVIDER ADJUSTMENT**.

D5510	**Repair broken complete denture base**
D5520	**Replace missing or broken teeth-complete denture (each tooth)**

REPAIRS TO PARTIAL DENTURES D5600 - D5699

D5610	**Repair resin denture base**
D5620	**Repair cast framework**
D5630	**Repair or replace broken clasp**
D5640	**Replace broken teeth - per tooth**
D5650	**Add tooth to existing partial denture**
D5660	**Add clasp to existing partial denture**
D5670	**Replace all teeth and acrylic on cast metal framework (maxillary)**
D5671	**Replace all teeth and acrylic on case metal framework (mandibular)**

DENTURE REBASE PROCEDURES D5700 - D5729

GG- The fee for a rebase includes the fee for relining. The fee for a reline billed **IN CONJUNCTION WITH** (within six (6) months of) a rebase is **PROVIDER ADJUSTMENT.**

GG- The fee for a rebase includes adjustments required within six (6) months of delivery. The fee for an adjustment billed within six (6) months of a rebase is **PROVIDER ADJUSTMENT**.

D5710	**Rebase complete maxillary denture**
D5711	**Rebase complete mandibular denture**
D5720	**Rebase maxillary partial denture**
D5721	**Rebase mandibular partial denture**

DENTURE RELINE PROCEDURES D5700 - D5799

GG- The fee for a reline includes adjustments required within six (6) months of delivery. The fee for an adjustment billed within six (6) months of a reline is **PROVIDER ADJUSTMENT**.

D5730	**Reline complete maxillary denture (chair side)**
D5731	**Reline complete mandibular denture (chair side)**
D5740	**Reline maxillary partial denture (chair side)**
D5741	**Reline mandibular partial denture (chair side)**
D5750	**Reline complete maxillary denture (laboratory)**
D5751	**Reline complete mandibular denture (laboratory)**
D5760	**Reline maxillary partial denture (laboratory)**
D5761	**Reline mandibular partial denture (laboratory)**

OTHER REMOVABLE PROSTHETIC SERVICES D5800 - D5899

D5810	**Interim complete denture (maxillary)**
D5811	**Interim complete denture (mandibular)**

Temporary (interim) complete dentures are **NON-COVERED.**

D5820	**Interim partial denture (maxillary)**
D5821	**Interim partial denture (mandibular)**

A temporary (interim) partial denture is **BENEFITED** only in children age sixteen (16) or under for missing anterior permanent teeth.

D5850	**Tissue conditioning, maxillary**
D5851	**Tissue conditioning, mandibular**

The fee for tissue conditioning is **PROVIDER ADJUSTMENT** if performed

on the same day the denture is delivered or a reline/rebase is provided.

D5860	**Overdenture-complete, by report**
D5861	**Overdenture-partial, by report**
	An overdenture is considered a specialized procedure and is not a benefit. An **OPTIONAL** allowance designated by an employer group is made for a conventional denture, and any excess fee is the **PATIENT'S** responsibility.
D5862	**Precision attachment, by report**
D5867	**Replacement of replaceable part of semi-precision or precision attachment (male or female component)**
	The fee for a precision attachment/replacement attachment is **NON-COVERED**.
D5875	**Modification of a removable prosthesis following implant surgery**
	The fees for implant services are **NON-COVERED.**
D5899	**Unspecified removable prosthodontic procedure, by report**
	This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

VII. D5900 - D5999 MAXILLOFACIAL PROSTHETICS

GG- The fees for maxillofacial prosthetics are **NON-COVERED.**

D5911	**Facial moulage (sectional)**
D5912	**Facial moulage (complete)**
D5913	**Nasal prosthesis**
D5914	**Auricular prosthesis**
D5915	**Orbital prosthesis**
D5916	**Ocular prosthesis**
D5919	**Facial prosthesis**
D5922	**Nasal septal prosthesis**
D5923	**Ocular prosthesis, interim**
D5924	**Cranial prosthesis**
D5925	**Facial augmentation implant prosthesis**
D5926	**Nasal prosthesis, replacement**
D5927	**Auricular prosthesis, replacement**
D5928	**Orbital prosthesis, replacement**
D5929	**Facial prosthesis, replacement**
D5931	**Obturator prosthesis, surgical**
D5932	**Obturator prosthesis, definitive**
D5933	**Obturator prosthesis, modification**
D5934	**Mandibular resection prosthesis with guide flange**
D5935	**Mandibular resection without guide flange**
D5936	**Obturator prosthesis, interim**
D5937	**Trismus appliance (not for TMD treatment)**
D5951	**Feeding aid**
D5952	**Speech aid prosthesis, pediatric**
D5953	**Speech aid prosthesis, adult**
D5954	**Palatal augmentation prosthesis**
D5955	**Palatal lift prosthesis, definitive**
D5958	**Palatal lift prosthesis, interim**
D5959	**Palatal lift prosthesis, modification**
D5960	**Speech aid prosthesis, modification Treatment prostheses**
D5982	**Surgical stent**
D5983	**Radiation carrier**
D5984	**Radiation shield**
D5985	**Radiation cone locator**
D5986	**Fluoride gel carrier**
D5987	**Commissure splint**
D5988	**Surgical splint**
D5991 **D5992** **D5993**	**Topical medicament carrier** Adjust maxillofacial prosthetic appliance , by report **Maintenance and cleaning of a maxillofacial prosthesis (extra of intraoral) other than required adjustments**
D5999	**Unspecified maxillofacial prosthesis, by report. This code is PROVIDER ADJUSTMENT and reviewed on an appeal basis for benefit payment or denial.**

VIII. D6000 - D6199 IMPLANT SERVICES

GG- The fees for implant services are **NON-COVERED**. Unless the contract specifies that implant services are a benefit by an employee group.

D6010	**Surgical placement of implant body: endosteal implant**
D6012	**Surgical placement of interim implant body for transitional prosthesis: endosteal implant**

	If the employee group has implant coverage, this would be considered part of the transitional (interim) prosthesis, which is not a covered benefit.
D6040	**Surgical placement: eposteal implant**
D6050	**Surgical placement: transosteal implant**

IMPLANT SUPPORTED PROSTHETICS

GG- An **OPTIONAL** allowance designated by an employer group is made for a conventional denture, partial, pontic or crown, and any excess fee is the **PATIENT'S** responsibility.

GG- Where benefited by contract, fees for the connection of an implant to natural tooth bridge is **PROVIDER ADJUSTMENT.**

D6053	**Implant/abutment supported removable denture for completely edentulous arch**
D6054	**Implant/abutment supported removable denture for partially edentulous arch**
D6055	**Dental implant supported connecting bar**
D6056	**Prefabricated abutment**
D6057	**Custom abutment**
D6058	**Abutment supported porcelain/ceramic crown**
D6059	**Abutment supported porcelain fused to metal crown (high noble metal)**
D6060	**Abutment supported porcelain fused to metal crown (predominantly base metal)**
D6061	**Abutment supported porcelain fused to metal crown (noble metal)**
D6062	**Abutment supported cast metal crown (high noble metal)**
D6063	**Abutment supported cast metal crown (predominantly base metal)**
D6064	**Abutment supported cast metal crown (noble metal)**
D6094	**Abutments supported crown (titanium)**
D6065	**Implant supported porcelain/ceramic crown**
D6066	**Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)**
D6067	**Implant supported metal crown (titanium, titanium alloy, high noble metal)**
D6068	**Abutment supported retainer for porcelain/ceramic FPD**
D6069	**Abutment supported retainer for porcelain fused to metal FPD (high noble metal)**
D6070	**Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)**
D6071	**Abutment supported retainer for porcelain fused to metal FPD (noble metal)**
D6072	**Abutment supported retainer for cast metal FPD (high noble metal)**
D6073	**Abutment supported retainer for cast metal FPD (predominantly base metal)**
D6074	**Abutment supported retainer for cast metal FPD (noble metal)**
D6194	**Abutments supported retainer crowns for cast metal FPD (titanium)**
D6075	**Implant supported retainer for ceramic FPD**
D6076	**Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)**
D6077	**Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)**
D6078	**Implant/abutment supported fixed denture for completely edentulous arch**
D6079	**Implant/abutment supported fixed denture for partially edentulous arch**

OTHER IMPLANT SERVICES

D6080	**Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis**
D6090	**Repair implant supported prosthesis, by report**
D6091	**Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment**
	NON COVERED unless group contract specifies that this implant code is a covered benefit.
D6092	**Recement implant/abutment supported crown**
D6093	**Recement implant/abutment supported fixed partial denture**
	Fees are **PROVIDER ADJUSTMENT** if done within six months of the initial seating date by the same dentist/dental

office. Benefits may be paid for one recementation after six months have elapsed since the initial placement. Subsequent requests for recementation by the same dentist/dental office are **NON-COVERED**.

Theses procedures are a covered benefit only for groups that have implant coverage.

D6095	**Repair implant abutment, by report**
D6100	**Implant removal, by report**
D6190	**Radiographic/surgical implant index, by report**

Benefits are **NON-COVERED** Under contracts with implant coverage, diagnostic and treatment facilitating aids are considered a part of definitive treatment and separate benefits for an index to the same dentist/dental office are **PROVIDER ADJUSTMENT**.

D6199	**Unspecified implant procedure, by report**

This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

IX. D6200 - D6999 PROSTHODONTICS, FIXED

(Each abutment and each pontic constitute a unit in a fixed partial denture)

GG- The fees for cast restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures by the same dentist/dental office, is a **PROVIDER ADJUSTMENT**.

GG- Payment will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth.

GG- A fixed bridge and a removable partial denture are not a benefit in the same arch. An allowance for a removable partial denture is made.

GG- Fixed prosthodontics are not a benefit for children under sixteen (16) years of age.

GG- The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), cosmetic or for periodontal, orthodontic, or other splinting are **NON-COVERED**.

GG- An allowance of a conventional fixed prosthesis is provided for porcelain/ceramic or resin bridges. The difference between the **ALLOWABLE** amount for the conventional fixed prosthesis and the **ALLOWABLE** amount for porcelain/ceramic bridge is chargeable to the **PATIENT**.

GG- Multistage procedures are reported and **BENEFITED** upon completion. The completion date is the date of final insertion.

FIXED PARTIAL DENTURE PONTICS D6200 - D6499

D6205	**Pontic-indirect resin-based composite**
D6210	**Pontic-cast high noble metal**
D6211	**Pontic-cast predominantly base metal**
D6212	**Pontic-cast noble metal**
D6214	**Pontic-titanium**
D6240	**Pontic-porcelain fused to high noble metal**
D6241	**Pontic-porcelain fused to predominantly base metal**
D6242	**Pontic-porcelain fused to noble metal**
D6245	**Pontic-porcelain/ceramic**
D6250	**Pontic-resin with high noble metal**
D6251	**Pontic-resin with predominantly base metal**
D6252	**Pontic-resin with noble metal**
D6253 **D6254**	**Provisional pontic** **Interim Pontic**

GG- The fee for a temporary fixed prosthesis is not a separate benefit and should be included in the fee for the permanent prosthesis. The fee for this service is **PROVIDER ADJUSTMENT**.

FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS D6500 – D6699

D6545	**Retainer-cast metal for resin bonded fixed prosthesis**
D6548	**Retainer porcelain/ceramic for resin bonded fixed prosthesis**
D6600	**Inlay - porcelain/ceramic, two surfaces**
D6601	**Inlay – porcelain/ceramic - three or more surfaces**
D6602	**Inlay - cast high noble metal, two surfaces**
D6603	**Inlay - cast high noble metal, three or more surfaces**
D6604	**Inlay - cast predominantly base metal, two surfaces**

D6605	**Inlay - cast predominantly base, metal three or more surfaces**
D6606	**Inlay - casr noble metal, two surfaces**
D6607	**Inlay - cast noble metal, three or more surfaces**
D6608	**Onlay – porcelain/ceramic, two surfaces**
D6609	**Onlay – porcelain/ceramic, three or more surfaces**
D6610	**Onlay - cast high noble metal, two surfaces**
D6611	**Onlay - cast high noble metal, three or more surfaces**
D6612	**Onlay - cast predominately base metal, two surfaces**
D6613	**Onlay - cast predominantly base metal, three or more surfaces**
D6614	**Onlay - cast noble metal, two surfaces**
D6615	**Onlay - cast noble metal, three or more surfaces**
D6624	**Inlay - titanium**
D6634	**Onlay - titanium**

FIXED PARTIAL DENTURE RETAINERS-CROWNS D6700 – D6799

D6710	**Crown – indirect resin based composite**
D6720	**Crown-resin with high noble metal**
D6721	**Crown-resin with predominantly base metal**
D6722	**Crown-resin with noble metal**
D6740	**Crown-porcelain/ceramic**
D6750	**Crown-porcelain fused to high noble metal**
D6751	**Crown-porcelain fused to predominantly base metal**
D6752	**Crown-porcelain fused to noble metal**
D6780	**Crown-¾ cast high noble metal**
D6781	**Crown-¾ cast predominantly base metal**
D6782	**Crown-¾ cast noble metal**
D6783	**Crown-¾ porcelain/ceramic**
D6790	**Crown-full cast high noble metal**
D6791	**Crown-full cast predominantly base metal**
D6792	**Crown-full cast noble metal**
D6793	**Provisional retainer crown**
D6794	**Crown-titanium**
D6795	**Interim Retainer Crown**

GG- The fee for a temporary fixed prosthesis is not a separate benefit and should be included in the fee for the permanent prosthesis. The fee for this service is **PROVIDER ADJUSTMENT**.

OTHER FIXED PARTIAL DENTURE SERVICES D6900 - D6999

D6920 Connector bar

NON-COVERED, unless the contract specifies that it is a benefit.

D6930 Recement fixed partial denture

The fee by the same dentist/dental office within six (6) months of the seating date is **PROVIDER ADJUSTMENT** as a component of the fee for the original procedure.

Benefits (after six (6) months have elapsed since the initial placement) are limited to once in a twelve (12) month period, unless there is a contract limitation.

D6940 Stress breaker

D6950 Precision attachment

NON-COVERED, unless the contract specifies that it is a benefit.

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated

D6972 Prefabricated post and core in addition to fixed partial denture retainer

A post and core is **BENEFITED** only on a successfully endodontically treated tooth.

A post and core is **BENEFITED** only when there is insufficient tooth structure to support an indirectly fabricated restoration.

D6973 Core buildup for retainer, including any pins

Substructures are **BENEFITED** only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or fracture.

D6975 Coping-metal

NON-COVERED, and is collectible from the **PATIENT**.

D6976 Each additional indirectly fabricated post - same tooth

The fees for additional posts involving the same tooth are **PROVIDER ADJUSTMENT** as a component of the

first post.

D6977	**Each additional prefabricated post – same tooth**
	The fees for additional posts involving the same tooth are **PROVIDER ADJUSTMENT** as a component of the first post.
D6980	**Fixed partial denture repair, by report**
D6985	**Pediatric partial denture, fixed**
	The fee for this service is **NON-COVERED**.
D6999	**Unspecified fixed prosthodontic procedure, by report**
	This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

X. D7000 - D7999 ORAL AND MAXILLOFACIAL SURGERY

GG- The fee for all oral and maxillofacial surgery includes routine post-operative care.

GG- Fees for exploratory surgery and unsuccessful attempts at extractions are not payable by DeCare or chargeable to the **PATIENT**.

EXTRACTIONS-INCLUDES LOCAL ANESTHESIA, SUTURING, AND ROUTINE POST-OPERATIVE CARE D7000 - D7199

D7111	**Extraction, coronal remnants – deciduous tooth**
	This procedure is considered part of any other (primary) surgery in same site on the same date and the fee is **PROVIDER ADJUSTMENT**.
D7140	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**

SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, AND ROUTINE POST-OPERATIVE CARE) D7200 - D7259

D7210	**Surgical removal of erupted tooth including elevation of the mucoperiosteal flap if indicated and removal of bone and/or section of tooth**
D7220	**Removal of impacted tooth-soft tissue**
D7230	**Removal of impacted tooth-partially bony**
D7240	**Removal of impacted tooth-completely bony**
D7241	**Removal of impacted tooth-completely bony, with unusual surgical complications**
D7250	**Surgical removal of residual tooth roots (cutting procedure)**
D7251	**Coronectomy – intentional**
	The fee for root recovery is **PROVIDER ADJUSTMENT** if submitted for the same date of service as a surgical extraction done by the same dentist/ dental office.

OTHER SURGICAL PROCEDURES D7260 - D7299

D7260	**Oroantral fistula closure**
D7261	**Primary closure of a sinus perforation**
	PROVIDER ADJUSTMENT if done on the same day by the same dentist/dental office as a D7241.
D7270	**Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth**
	The fee includes removal of the splint by the same dentist/ dental office. A separate fee for these services is **PROVIDER ADJUSTMENT**.
D7272	**Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)**
	NON-COVERED, unless the contract specifies that it is a benefit. If contract covers this procedure, benefits would be paid under their orthodontic benefit.
D7280	**Surgical access of an unerupted tooth**
	Benefits are payable under the contracts orthodontic coverage in groups that have orthodontic coverage.
D7282	**Mobilization of erupted or malpositioned tooth to aid eruption**
	This procedure is by report**.** When done **IN CONJUNCTION WITH** other surgery in this immediate area, the fee is **PROVIDER ADJUSTMENT.**
D7283	**Placement of device to facilitate eruption of impacted tooth**
	Benefits are payable under the contracts orthodontic coverage in groups that have orthodontic coverage.

D7285	**Biopsy of oral tissue-hard (bone, tooth)**
D7286	**Biopsy of oral tissue-soft (all others)**
	The fee for biopsy of oral tissue is only payable for oral structures. A pathology report must be included. The fee for a biopsy is **PROVIDER ADJUSTMENT IN CONJUNCTION WITH** other surgery at the same site/same day.
D7287	**Exfoliative cytological sample collection**
	NON-COVERED, unless the contract specifies that it is a benefit.
D7288	**Brush biopsy – transepithelial sample collection**
	The fee for brush biopsy is **NON-COVERED**.
D7290	**Surgical repositioning of teeth**
	Benefits are payable under the contracts orthodontic coverage in groups that have orthodontic coverage.
D7291	**Transseptal fiberotomy/supra crestal fiberotomy by report**
	Transseptal fiberotomy is considered by report and is subject to contractual limitations.
D7292	**Surgical placement: temporary anchorage device: (screw retained plate) requiring surgical flap**
D7293	**Surgical placement: temporary anchorage device requiring surgical flap**
D7294	**Surgical placement: temporary anchorage device without surgical flap**
	Anchorage device benefits are **NON-COVERED** and the fee is chargeable to the patient.
D7295	**Harvest of bone for use in autogenous grafting procedure**

ALVEOLOPLASTY-SURGICAL PREPARATION OF RIDGE FOR DENTURES
D7300 - D7339

GG - A quadrant is defined as four or more continuous teeth and/or teeth spaces (not to cross the midline).

D7310	**Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant**
D7311	**Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces per quadrant**
	The fee by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions is **PROVIDER ADJUSTMENT**. The fee for surgical extractions includes an alveoloplasty.
D7320	**Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant**
D7321	**Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant**
	A bounded tooth space counts as one space irrespective of the number of teeth that would normally exist in the space.

VESTIBULOPLASTY
D7340 - D7399

GG - All procedures are **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL**.

D7340	**Vestibuloplasty-ridge extension (secondary epithelialization)**
D7350	**Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)**

SURGICAL EXCISION OF SOFT TISSUE LESIONS
D7400 - D7429

GG- All procedures are **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL.**

D7410	**Excision of benign lesion us to 1.25 cm**
D7411	**Excision of benign lesion greater than 1.25 cm**
D7412	**Excision of benign lesion, complicated**
D7413	**Excision of malignant lesion up to 1.25 cm**
D7414	**Excision of malignant lesion greater than 1.25 cm**
D7415	**Excision of malignant lesion, complicated**
	The fee for excision of hard & soft tissue lesions is **PROVIDER ADJUSTMENT** on the same date as other surgery in the

same site.

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS D7430-D7469

GG- All procedures are **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL.**

GG- The fees for these procedures are **PROVIDER ADJUSTMENT** unless the pathology laboratory report is submitted upon appeal.

D7440	**Excision of malignant tumor - lesion diameter up to 1.25 cm**
D7441	**Excision of malignant tumor - lesion diameter greater than 1.25 cm**
D7450	**Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm**
D7451	**Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm**

The fee for excision of hard & soft tissue lesions is **PROVIDER ADJUSTMENT** on the same date as other surgery in the same site.

D7460	**Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm**
D7461	**Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm**
D7465	**Destruction of lesion(s) by physical methods, by report**

EXCISION OF BONE TISSUE
D7470-D7599

GG- All procedures are **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL.**

D7471	**Removal of lateral exostosis – (maxilla or mandible)**
D7472	**Removal of torus palatinus**
D7473	**Removal of torus mandibularis**
D7485	**Surgical reduction of osseous tuberosity**
D7490	**Radical resection of mandible with bone graft**

SURGICAL INCISION
D7500-7599

GG- All procedures are **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL**.

D7510	**Incision and drainage of abscess-intraoral soft tissue**
D7511	**Incision and drainage of abscess-intraoral soft tissue-complicated**

The fee for surgical incision is **PROVIDER ADJUSTMENT** when done on the same date and by the same dentist/ dental office as endodontics, extractions, palliative treatment, or other definitive service.

D7520	**Incision and drainage of abscess-extraoral soft tissue**
D7521	**Incision and drainage of abscess-intraoral soft tissue-complicated**

BENEFITED only if a dentally related infection is present. The fee for treatment is **NON-COVERED**.

D7530	**Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue**
D7540	**Removal of reaction producing foreign bodies, musculoskeletal system**
D7550	**Partial ostectomy/sequestrectomy for removal of non-vital bone**
D7560	**Maxillary sinusotomy for removal of tooth fragment or foreign body**

TREATMENT OF FRACTURES-SIMPLE D7600-7699

GG- All procedures are **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL**.

GG- A separate fee for splinting, wiring or banding is **PROVIDER ADJUSTMENT**.

D7610	**Maxilla-open reduction (teeth immobilized, if present)**
D7620	**Maxilla-closed reduction (teeth immobilized, if present)**
D7630	**Mandible-open reduction (teeth immobilized, if present)**
D7640	**Mandible-closed reduction (teeth immobilized, if present)**
D7650	**Malar and/or zygomatic arch-open reduction**
D7660	**Malar and/or zygomatic arch-closed reduction**
D7670	**Alveolus-closed reduction, may include stabilization of teeth**
D7671	**Alveolus, open reduction, may include stabilization of teeth**

D7680	**Facial bones-complicated reduction with fixation and multiple surgical approaches**

TREATMENT OF FRACTURES-COMPOUND D7700-D7799

GG- All procedures are **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL**.

GG- A separate fee for splinting, wiring or banding is **PROVIDER ADJUSTMENT**.

D7710	**Maxilla-open reduction**
D7720	**Maxilla-closed reduction**
D7730	**Mandible-open reduction**
D7740	**Mandible-closed reduction**
D7750	**Malar and/or zygomatic arch-open reduction**
D7760	**Malar and/or zygomatic arch-closed reduction**
D7770	**Alveolus-open reduction, stabilization of teeth**
D7771	**Alveolus, closed reduction stabilization of teeth**
D7780	**Facial bones-complicated reduction with fixation and multiple surgical approaches**

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS. Procedures, which are an integral part of a primary procedure, should not be reported separately. D7800-D7899

GG- All procedures are not a benefit unless covered under a TMJ rider and subject to coverage under medical.

D7810	**Open reduction of dislocation**
D7820	**Closed reduction of dislocation**
D7830	**Manipulation under anesthesia**
D7840	**Condylectomy**
D7850	**Surgical discectomy, with/without implant**
D7852	**Disc repair**
D7854	**Synovectomy**
D7856	**Myotomy**
D7858	**Joint reconstruction**
D7860	**Arthrotomy**
D7865	**Arthroplasty**
D7870	**Arthrocentesis**
D7871	**non-arthroscopic lysis and lavage**
D7872	**Arthroscopy-diagnosis, with or without biopsy**
D7873	**Arthroscopy-surgical: lavage and lysis of adhesions**
D7874	**Arthroscopy-surgical: disc repositioning and stabilization**
D7875	**Arthroscopy-surgical: synovectomy**
D7876	**Arthroscopy-surgical: discectomy**
D7877	**Arthroscopy-surgical: debridement**
D7880	**Occlusal orthotic device, by report**
D7899	**Unspecified TMD procedure, by report**

REPAIR OF TRAUMATIC WOUNDS D7900-D7910

GG- Repair of traumatic wounds is limited to oral structures.

D7910	**Suture of recent small wounds up to 5 cm**

COMPLICATED SUTURING (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure) D7911-D7919

GG- Complicated suturing is limited to oral structures and subject to coverage under medical.

D7911	**Complicated suture - up to 5 cm**
D7912	**Complicated suture - greater than 5 cm**

OTHER REPAIR PROCEDURES D7920-7999

GG- All procedures except D7960, D7970, and D7971 are **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL**.

D7920	**Skin grafts (identify defect covered, location and type of graft)**
D7940	**Osteoplasty-for orthognathic deformities**
D7941	**Osteotomy - mandibular rami**
D7943	**Osteotomy - mandibular rami with bone graft; includes obtaining the graft**
D7944	**Osteotomy - segmented or subapical-per sextant or quadrant**
D7945	**Osteotomy - body of mandible**
D7946	**LeFort I (maxilla-total)**
D7947	**LeFort I (maxilla-segmented)**
D7948	**LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft**
D7949	**LeFort II or LeFort III-with bone graft**

D7950	**Osseous, osteoperiosteal, or cartilage graft of the mandible-autogenous or nonautogenous, by report**
D7951	**Sinus augmentation with bone or bone substitutes**
D7953	**Bone replacement graft for ridge preservation – per site**
	If the contract covers dental implants this procedure may be a benefit at the time of extraction. A site is equal to one tooth (extraction site).
D7955	**Repair of maxillofacial soft and hard tissue defects**
D7960	**Frenulectomy (frenectomy or frenotomy) separate procedure not incidental to another procedure**
D7963	**Frenuloplasty**
	Frenulectomy/Frenuloplasty is **PROVIDER ADJUSTMENT** when billed **IN CONJUNCTION WITH** any other surgical procedure(s) in the same surgical area by the same dentist/dental office.
D7970	**Excision of hyperplastic tissue-per arch**
	Excision of hyperplastic tissue is **PROVIDER ADJUSTMENT** when billed **IN CONJUNCTION WITH** other surgical procedure(s) in the same area by the same dentist/dental office.
D7971	**Excision of pericoronal gingiva**
	Excision of pericoronal gingival is **PROVIDER ADJUSTMENT** when billed **IN CONJUNCTION WITH** other surgical procedure(s) in the same area by the same dentist/dental office.
D7972	**Surgical reduction of fibrous tuberosity**
D7980	**Sialolithotomy**
D7981	**Excision of salivary gland, by report**
D7982	**Sialodochoplasty**
D7983	**Closure of salivary fistula**
D7990	**Emergency tracheotomy**
D7991	**Coronoidectomy**
D7995	**Synthetic graft-mandible or facial bones, by report**
D7996	**Implant-mandible for augmentation purposes (excluding alveolar ridge), by report**
D7997	**Appliance removal (not by the dentist who placed the appliance), includes removal of archbar**
	NON-COVERED, unless the contract specifies that it is a benefit.
D7998	**Intraoral placement of fixation device not in conjunction with a fracture**
	This procedure is **PROVIDER ADJUSTMENT IN CONJUNCTION WITH** any surgical fracture procedure by the same dentist/dental office. Splinting, wiring or banding Is considered part of the complete procedure.
D7999	**Unspecified oral surgery procedure, by report**
	This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

XI. D8000 - D8999 ORTHODONTICS

GG- Since there is no unique code for Invisalign procedures, the Dental Policy Committee suggests the benefit is based on the approved fee for conventional orthodontics. Any additional fee up to the submitted amount for Invisalign is **NON-COVERED** and is chargeable to the patient.

Limited Orthodontic Treatment

D8010	**Limited orthodontic treatment of the primary dentition**
D8020	**Limited orthodontic treatment of the transactional dentition**
D8030	**Limited orthodontic treatment of the adolescent dentition**
D8040	**Limited orthodontic treatment of the adult dentition**

INTERCEPTIVE ORTHODONTIC TREATMENT

D8050	**Interceptive orthodontic treatment of the primary dentition**
D8060	**Interceptive orthodontic treatment of the transitional dentition**

COMPREHENSIVE ORTHODONTIC TREATMENT

D8070	**Comprehensive orthodontic treatment of the transitional dentition**
D8080	**Comprehensive orthodontic treatment of the adolescent dentition**
D8090	**Comprehensive orthodontic treatment of the adult dentition**

MINOR TREATMENT TO CONTROL HARMFUL HABITS

D8210	**Removable appliance therapy**
D8220	**Fixed appliance therapy**

OTHER ORTHODONTIC SERVICES

D8660	**Pre-orthodontic treatment visit**
D8670	**Periodic orthodontic treatment visit (as part of contract)**
D8680	**Orthodontic retention (removal of appliance, construction and placement of retainer (s)**
D8691	**Repair of orthodontic appliance**
D8692	**Replacement of lost or stolen retainer**
D8693	**Rebonding or recementing; and/or repair, as required, of fixed retainers**

This procedure is included in the orthodontic case fee. A separate fee is **PROVIDER ADJUSTMENT** by the same dentist/dental office.

D8999	**Unspecified orthodontic procedure, by report**

This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial.

XII. D9000 - D9999 ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT
D9000-D9199

D9110	**Palliative (emergency) treatment of dental pain-minor procedure**

Palliative treatment includes all procedures necessary for the relief of pain. Evaluation is not considered as the relief of pain.

Palliative treatment is **PROVIDER ADJUSTMENT** when billed on the same date as definitive treatment by the same dentist/dental office.

D9120	**Fixed partial denture sectioning**

This procedure is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extractions or other treatment. If this code is part of the process of removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and separate fee for this code is **PROVIDER ADJUSTMENT**.

A separate fee for polishing and recontouring of the retained portion of the prosthesis is **PROVIDER ADJUSTMENT**.

ANENSTHESIA
D9200-D9299

GG- The fee for local anesthesia is **PROVIDER ADJUSTMENT** when performed **IN CONJUNCTION WITH** any other procedure.

GG- The fee for general anesthesia/IV sedation is a benefit only when administered by a properly licensed dentist **IN CONJUNCTION WITH** covered complex oral surgery procedure(s).

GG- The fee for general anesthesia/IV sedation is **NON-COVERED** when billed by anyone other than a licensed dentist.

D9210	**Local anesthesia not in conjunction with operative or surgical procedures**
D9211	**Regional block anesthesia**
D9212	**Trigeminal division block anesthesia**
D9215	**Local anesthesia in conjunction with operative or surgical procedures**
D9220	**Deep sedation/general anesthesia – first 30 minutes**
D9221	**Deep sedation/general anesthesia – each additional 15 minutes**
D9230	**Administration of nitrous oxide, anxiolysis, analgesia**

NON-COVERED, unless the contract specifies that it is a benefit.

D9241	**Intravenous conscious sedation/analgesia - first 30 minutes**
D9242	**Intravenous conscious sedation/analgesia – each additional 15 minutes**
D9248	**Non-intravenous conscious sedation**

NON-COVERED, unless the contract specifies that it is a benefit.

PROFESSIONAL CONSULTATION
D9300-9399

D9310	**Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)**

NON-COVERED, unless the contract specifies that it is a benefit.

The fee for a consultation is **PROVIDER ADJUSTMENT** when billed **IN CONJUNCTION WITH** an evaluation or definitive service

PROFESSIONAL VISITS
D9400-D9599

GG- The fees for all procedures are **NON-COVERED**.

D9410	**House/extended care facility call**
D9420	**Hospital or ambulatory surgical center call**
D9430	**Office visit for observation (during regularly scheduled hours) - no other services performed**
D9440	**Office visit - after regularly scheduled hours**
D9450	**Case presentation, detailed and extensive treatment planning**

DRUGS
D9600-9899

GG- The fees for all procedures are **NON-COVERED**.

D9610	**Therapeutic parenteral drug, single administration**
D9612	**Therapeutic parenternal drugs, two or more administrations, different medications**
D9630	**Other drugs and/or medicaments, by report**

MISCELLANEOUS SERVICES
D9900-D9999

GG- The fees for all procedures are **NON-COVERED**.

D9910	**Application of desensitizing medicaments**
D9911	**Application of desensitizing resin for cervical and/or root surface, per tooth**
D9920	**Behavior management, by report**
D9930	**Treatment of complications (post-surgical)- unusual circumstances, by report**

PROVIDER ADJUSTMENT when done by the first treating dentist/dental office.

D9940	**Occlusal guards, by report**
D9941	**Fabrication of athletic mouthguard**
D9942	**Repair or reline of occlusal guard**

If covered contractually, the fee for the adjustment or repair of the occlusal guard are **PROVIDER ADJUSTMENT** if performed by the same dentist/dental office within six (6) months of initial placement.

D9950	**Occlusion analysis-mounted case**
D9951	**Occlusal adjustment-limited**
D9952	**Occlusal adjustment-complete**
D9970	**Enamel microabrasion**
D9971	**Odotoplasty 1-2 teeth; includes removal of enamel projections**
D9972	**External bleaching per arch**
D9973	**External bleaching per tooth**
D9974	**Internal bleaching per tooth**
D9999	**Unspecified adjunctive procedure, by report**

This code is **PROVIDER ADJUSTMENT** and reviewed on an appeal basis for benefit payment or denial

Coordination of Benefits (COB)

Coordination of Benefit Tips

- In most cases, children are covered first by the parent whose month and day of birth is earlier. The parents' year of birth is not relevant in determining primary and secondary coverage.
- When both the primary and secondary programs are DeCare Dental Networks National Network (DDN) groups, send only one treatment form clearly marked with secondary coverage information.
- Prevent confusion by writing broadly across the face of The Attending Dentists Statement the amount of the primary carriers payment. In these cases, the larger the writing, the better. Do not attach a copy of the other carriers' explanation of benefits. **Do not highlight with marker;** marker often obliterates the information highlighted when copied.

Private insurance carriers are primary when the patient is also covered under a state-funded program such as Medicaid.

COB Determination Factors

Birthday Rule

The birthday rule determines the primary carrier for dependent children. This rule defines the primary insurance carrier as the carrier of the parent whose birthday (month and day) occurs first in a calendar year. For example, if a dependent child's mother was born on May 1st and the father was born on May 5th, the mother's plan is the primary carrier and pays first. The parent's years of birth do not matter, only the months and days of birth.

Custody Cases

In cases where a dependent child of divorced parents has dual coverage, the following rules apply:

- If one parent has been awarded custody, then the child is covered by that parents coverage first and the non-custodial parents coverage second.
- If the parent with custody remarries, the custodial parents coverage pays first and the stepparents coverage second.
- If the custodial parent does not have other coverage, but the child's stepparent does, then the stepparent's coverage pays first and the non-custodial parents coverage, if any, pays second.
- If there is joint custody and there is no specific court decree that establishes responsibility for one parent over the other, the birthday rule applies. (See birthday rule above.)
- A court can decide that some other rule should apply.

Sometimes it is not possible to determine which coverage should pay first even after checking these rules. In this case, the dental plan that has covered the person longer usually pays first.

Coordination of Benefits (COB), continued

Medical Coverage

In cases of accident or TMJ, DDN will generally be primary if the other coverage is not principally a dental program.

Coordinating Benefits with Two or More DeCare Dental Plans

If two or more DeCare Dental programs cover a patient, indicate both programs on the claim, submit it to DeCare Dental, and the benefits will be coordinated. The payment for each DeCare Dental program's benefits will be made separately. Submit only one claim.

Non-Duplication of Benefits

Occasionally, a contracting group will want to include "Non-duplication of Benefits" clause in their plan. Under this clause, when the DDN plan is secondary, it will pay no more than it would have paid if it were the primary plan, minus what the primary plan has already paid.

No Dual Coverage

Occasionally, by request of the contracting group, a DDN program contract may state that persons in the same family who are employees of the same employer may not be enrolled in their dental plan as dependents. Under such contract, no person may be enrolled both as an employee and as a dependent, and no person will be considered as a dependent of more than one employee. Only the employee who is considered to be the head of household may enroll a child who may be eligible as a dependent of more than one employee.

Pre-Determination of Estimated Benefits

When a Pre-determination of Benefits is submitted to DDN, the estimated benefit will be calculated as if there were no dual coverage. When the Pre-determination of Benefits Voucher is returned for payment along with the primary coverage information, DDN will coordinate the benefits.

Clean Claims

What is a clean claim?

DeCare Dental Networks National Network (DDN) defines a "clean claim" as a claim that has none of the following defects (in other words claims do not have incorrect information or are missing the following information):

- Patient date of birth (DOB)
- Provider Tax Identification Number (TIN)/Social Security Number (SSN)
- Provider license number
- Group number
- Subscriber Social Security Number (SSN) or Primary Member Identification (PMI)
- Current ADA procedure codes
- Patient relationship code
- Patient name
- Subscriber address
- Provider signature
- Patient signature or evidence of Signature on File (SOF)
- Submitted charged amounts/ Fee information
- Patient gender
- Coordination of Benefits (COB) Information (to include Subscriber DOB)
- Student status information
  (only when over age 19 & information not on membership file)
- Group number
- Tooth number, letter, range, surface
- Required x-rays or periodontal charting

In addition, when the following information is missing from a claim form, it causes a claim to be returned to the provider without being entered onto the claims system or onto prompt pay tracking. If the provider corrects the missing information and returns the claim, prompt pay tracking will begin from the date the corrected claim is received.

- Missing patient name
- Missing subscriber name and address
- Missing provider TIN/SSN and license number
- Missing provider signature
- Missing patient signature

Compliance Program

Section 4

Fraud and Abuse

Fraud and Abuse

DeCare Dental Networks National Network (DDN) has written and implemented a formalized Fraud and Abuse Compliance Program that is in compliance with the state statutory requirements for fraud and abuse prevention and detection. Trained licensed dental health care professionals organized within the Professional Services Division at DDN administer this program. This division is responsible for conducting investigations of potential fraud, abuse, or non-compliance with DDN and Uniform Policies and Procedures.

All participating dentist's claim submissions are subject to review and/or audit for fraud and abuse prevention and detection in accordance with State and Federal law.

If DDN has reason to believe insurance fraud has been committed, all information is submitted to the authorities in accordance with the state of Minnesota insurance anti-fraud statute –Minnesota Statues §60A.951 to 60A.955.

Quality Assurance

Section 5

Dentist Credentialing

Provider Grievance Resolution Program

Dentist Credentialing

The goal of DeCare Dental Networks National Network (DDN) is to establish long-term relationships with qualified dentists who share the commitment to continuously improving the quality of dental care.

Credentialing refers to the process of screening, making fair approval decisions and the continuous evaluation of a network dentists ability to meet specific participation requirements.

Each participating dentist must successfully complete the following:

- A Contracting Dentist Agreement
- A completed Credentialing Application.
- A copy of a current dental license for each state in which the dentist practices.
- A copy of the current DEA, if the dentist holds such a registration.
- A copy of the specialty certification (if applicable).
- Copy of the declaration page for Professional Liability insurance with limits of $1 million /$3 million.
- **Written verification which includes your National Provider Identifier number (Individual AND/OR Clinic)**
- Completed W9 form for each entity and the appropriate Tax Identification Number (TIN) or Social Security Number (SSN).

Employer groups and consumers require dental and health plans to credential professionals who participate in a plan's network. The credentialing process provides assurances that dentists, who participate in a plan's network, have met these uniform standards.

Dentists are initially credentialed based on participation requirements. Dentists are re-credentialed every four years.

Information obtained or gathered as part of the credentialing or re-credentialing process is treated confidentially and protected by DDN.

A dentist is not considered a participating provider and added to a network until all participation and credentialing requirements are met.

Provider Grievance Resolution Program

DeCare Dental Networks National Network (DDN) is committed to member satisfaction and quality care is demonstrated through a formal provider grievance resolution program that effectively and promptly addresses patients' concerns regarding administration, quality of care, and network specific issues.

A participating dental office should provide both a level of patient care and open communication to facilitate the immediate internal resolution of patients' concerns. Concerns, which cannot be satisfactorily answered or concluded within the dental office, will be resolved through the formal grievance procedures established by DeCare Dental Networks Professional Services Department. Participating dentists shall comply and provide all necessary documentation to resolve patient grievances, complaints, and/or inquiries. A participating dentist agrees to cooperate in resolution of a quality of care grievance in accordance with Minnesota Statute §145.61. The requirement to cooperate is found in DDN's Uniform Policies and Procedures.

It is expected that a participating dentist will cooperate fully in DDN's investigation of all provider grievances.

DDN will make every reasonable effort to resolve provider grievances within 30 days of receipt.

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Electronic Capabilities

Section 6

DeCare Dental Networks Website

DDN Office
Dentist Applications

- Coverage Summary
- Claims Inquiry
- Benefits Inquiry
  (Available January 2009)

DDN Newsroom
Oral Health Resources

Electronic Claims Submission (ECS)

ECS Guidelines

DDN Office
www.decare.com/ddnoffice

Using DeCare Dental Networks (DDN) website can save you time and provide you with important information regarding submitting claims and contacting us. You will also have access to a list of participating specialists, frequently asked questions, and relevant forms & literature.

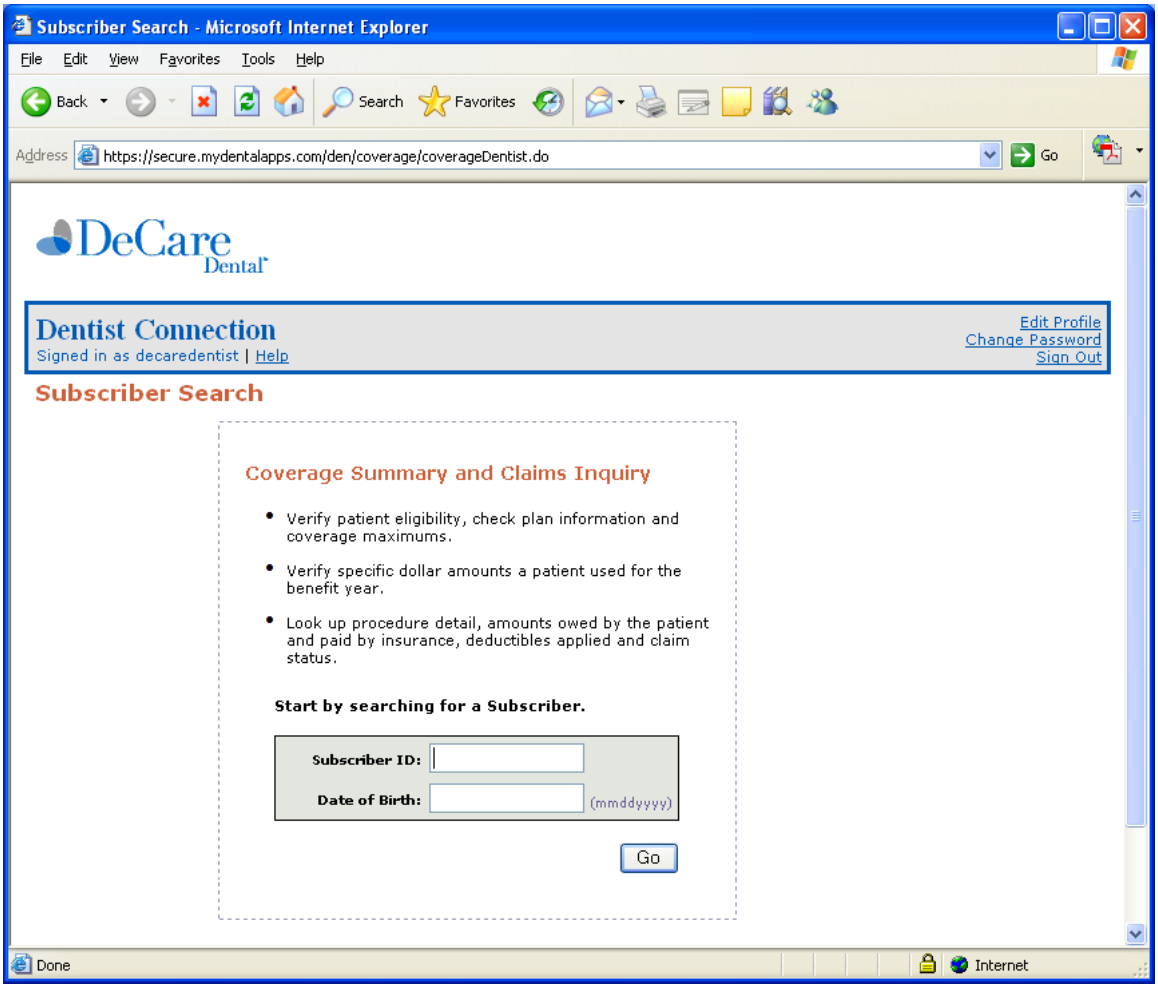
The above picture represents the website homepage. The links located on the upper left hand side of the screen represents locations for general information on DDN.

The *DDN Office,* located on the lower left hand side of the screen contains information that assists you with administration of your office. Topics include ***Specialist Listing, Q & A, National Provider Identifier (NPI), Contracting Information, Where to File Claims, Forms & Literature, Group Information and how to Contact DDN.***

Section 6

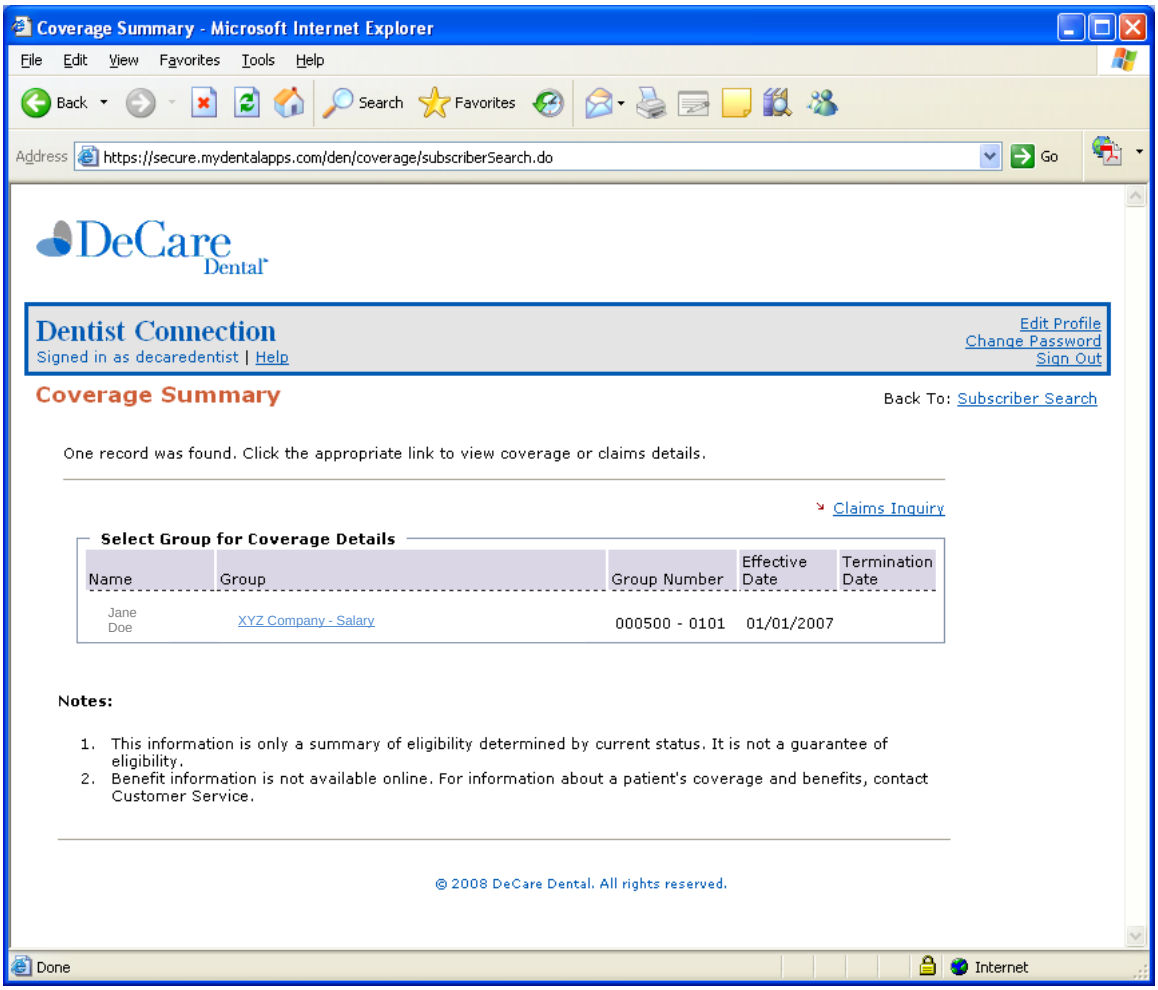
Coverage Summary

The Coverage Summary and Claims Inquiry Applications will allow you to search for member eligibility, plan information and coverage maximums. It will also provide claims detail.



Section 6

Coverage Summary, Continued

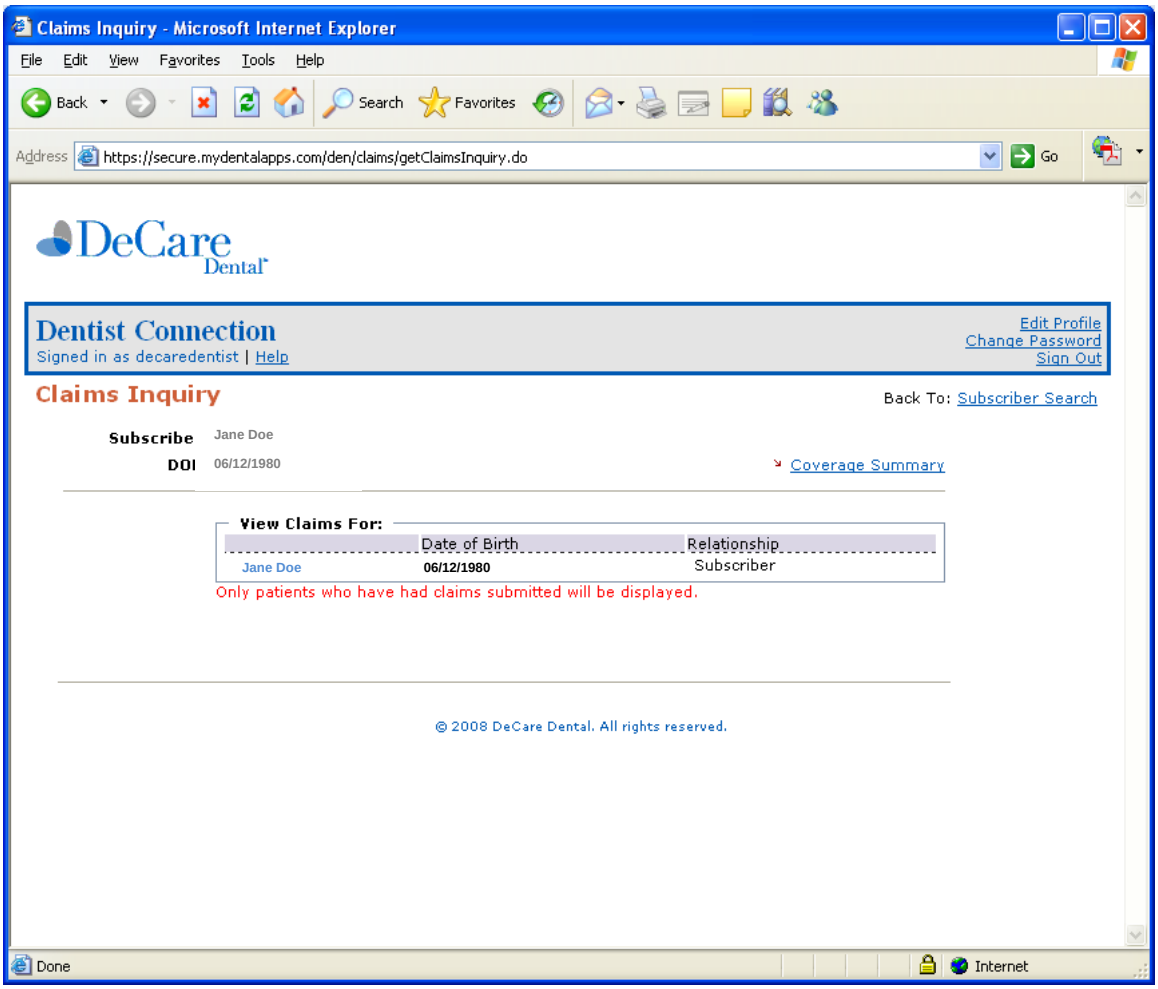


Section 6

Coverage Summary, Continued

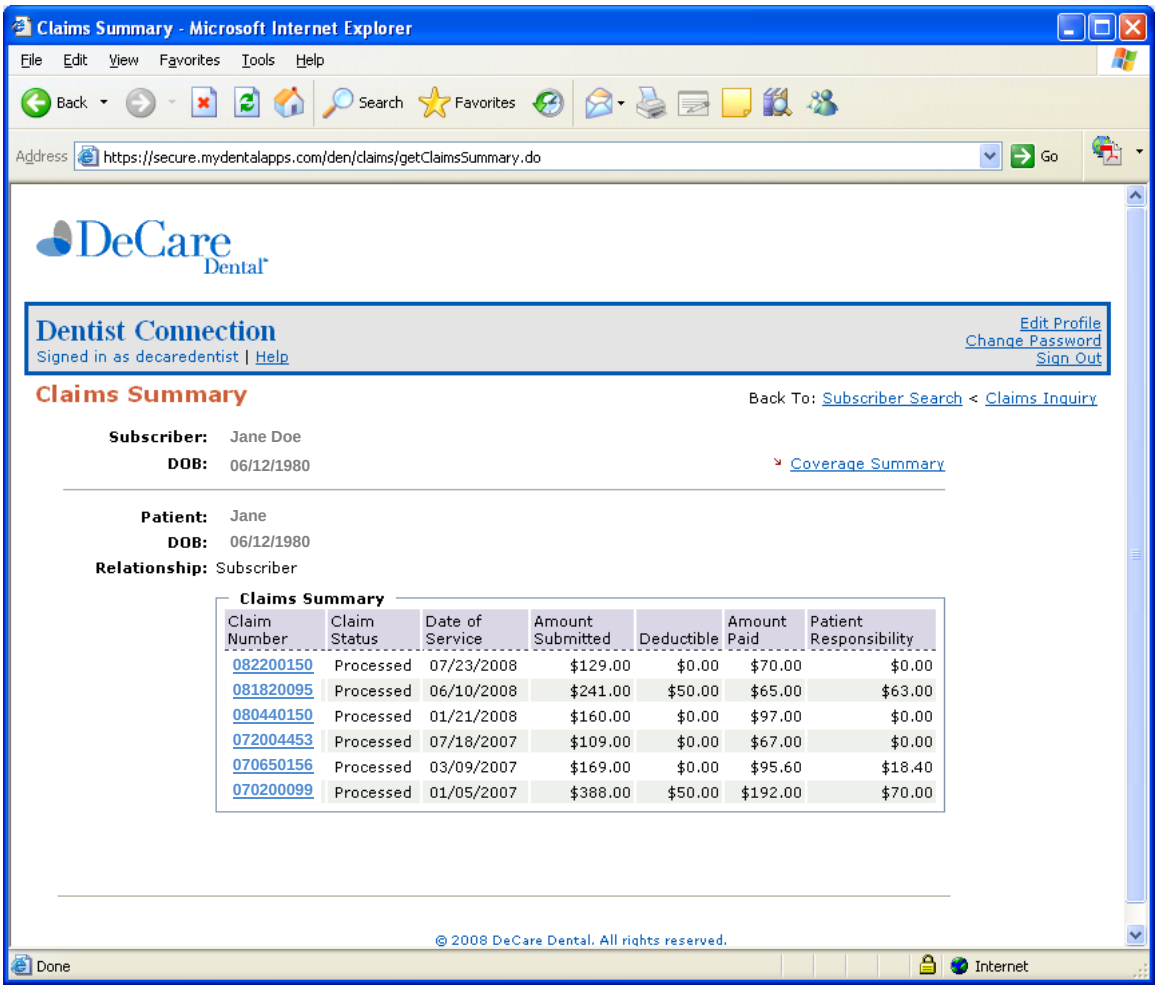
Section 6

Claims Inquiry



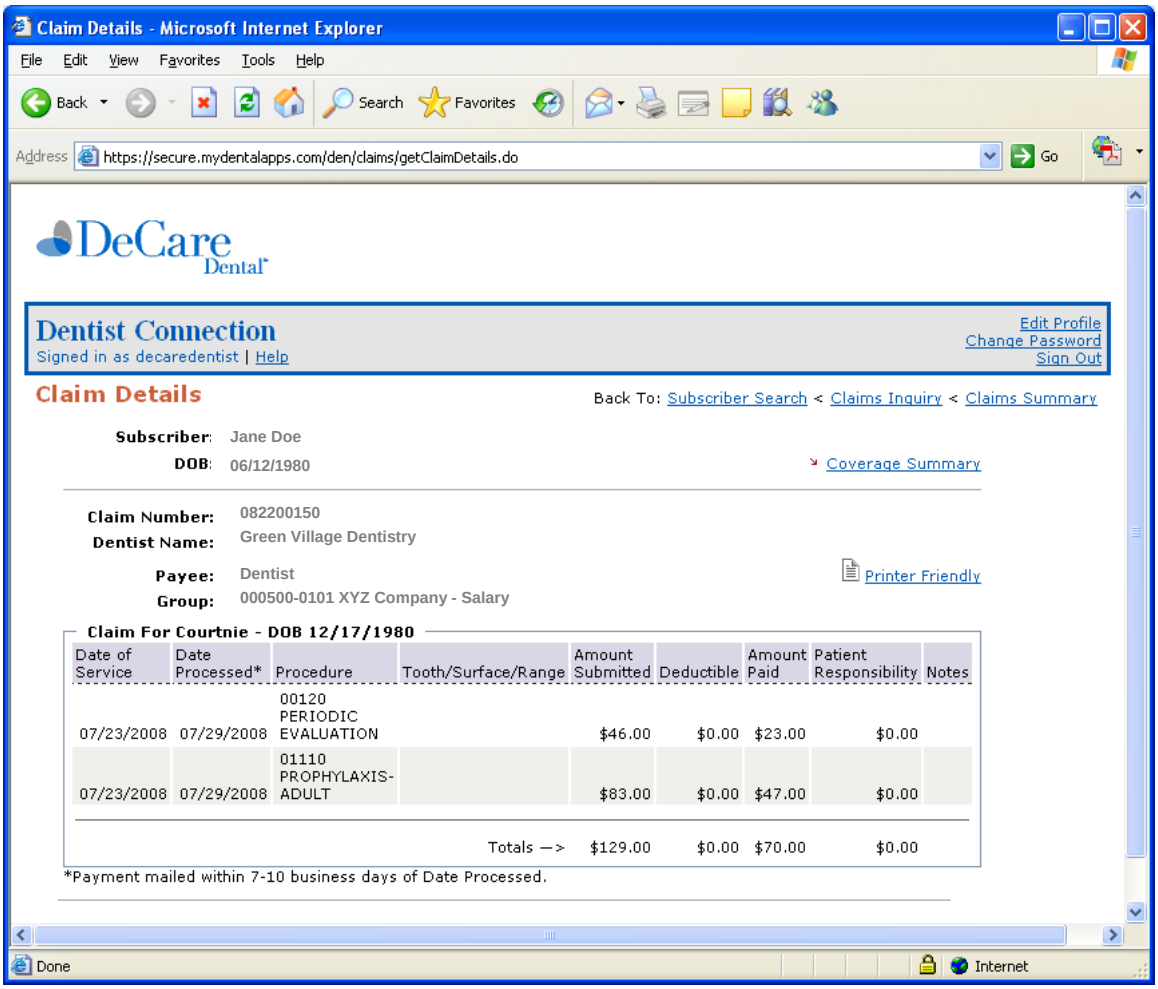
Section 6

Claims Inquiry, Continued



Section 6

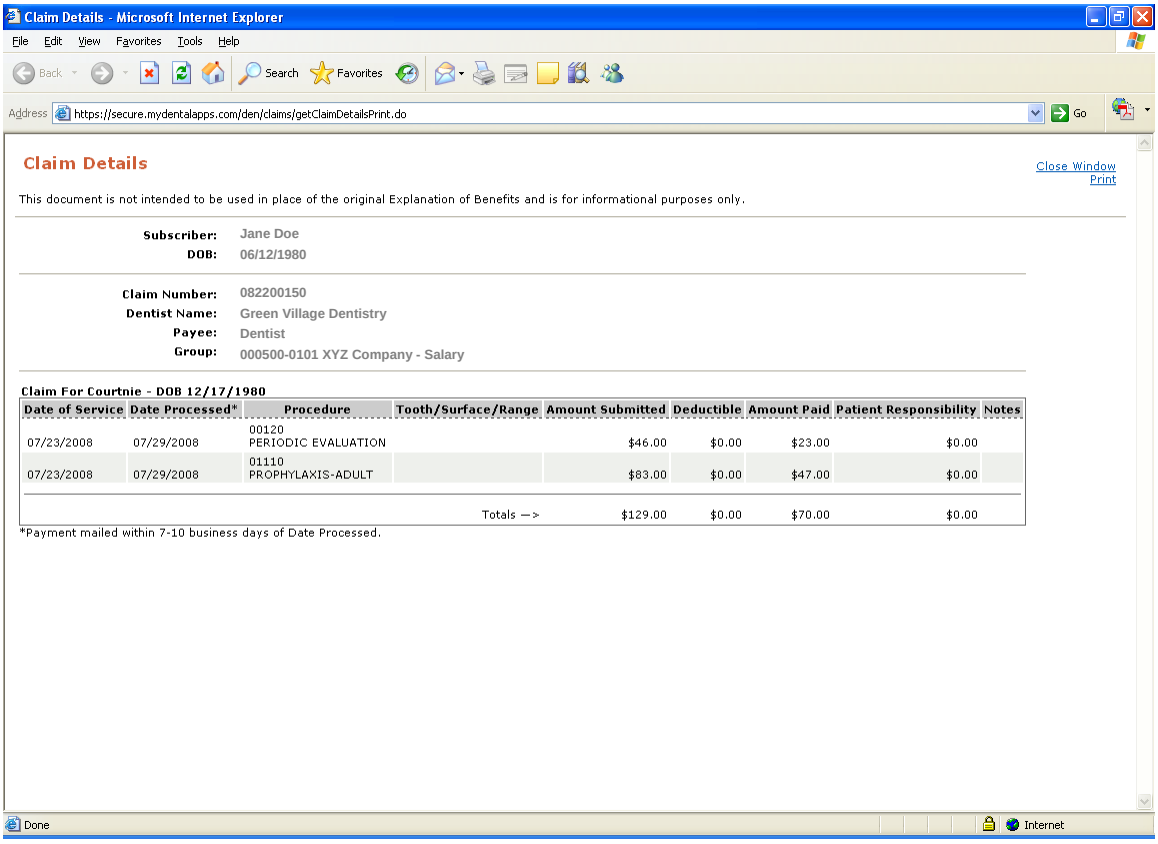
Claims Inquiry, Continued



Section 6

Claims Inquiry, Continued

Printer Friendly version of Claims Detail (very similar to EOB)



Section 6

Benefits Inquiry *(Available January 2009)*

Oral Health Resources

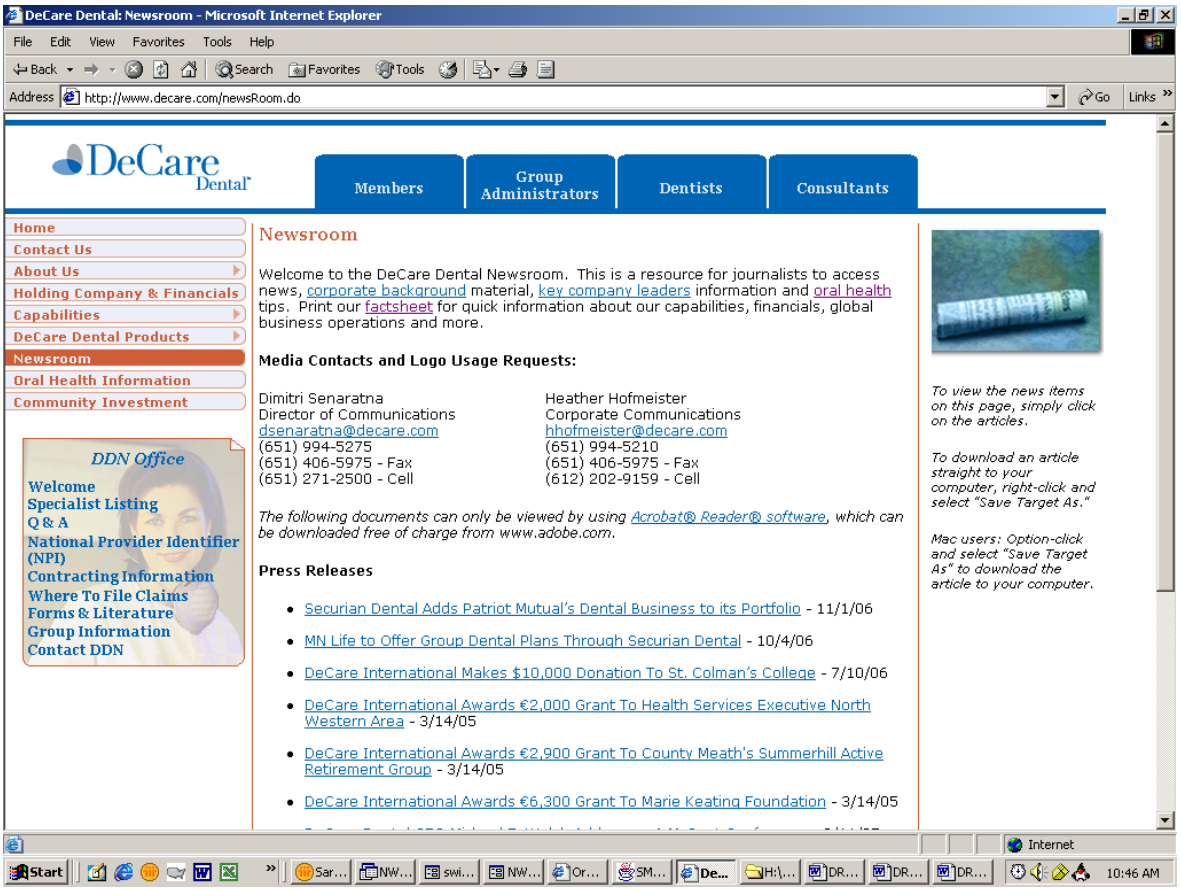
The links located on the upper left hand side of the DeCare Dental Networks (DDN) website homepage represents locations for general information. One location within that area is: Oral Health Information. Oral Health Information contains oral health articles.

DDN is committed to improving the oral health of all our members. The more informed members are about their dental health; the more likely they are to practice prevention and participate in their dental treatment.

The above example of the Oral Health Information section of the website contains a variety of oral health articles. These articles may be downloaded by the web user and printed for future use.

DDN Newsroom

The Newsroom is a resource to access news, corporate background material, key company leaders information, and oral health tips. Print our fact sheet for quick information about our capabilities, financials, global business operations and more.



The above example of the Newsroom section of the website contains a variety of news related articles. These articles may be downloaded by the web user.

Section 6

Electronic Claim Submission (ECS)

Electronic Claims Submission (ECS) is a growing trend in the dental industry. This simple, streamlined method of claims submission has grown in popularity across the country, mostly because of cost savings and faster payment turnaround it provides.

Implementing ECS is simple, straightforward

Most dental offices currently use a practice management system or billing software with the capability to generate electronic claims submission. In most instances, the electronic claims submission feature is already available on your billing software or can be installed at a nominal cost by your software agent. Additionally, a modem and possibly an extra phone line are needed to send claims electronically. If you have used a modem before, you shouldn't have any problem sending claims. If you don't have experience using a modem, you should spend some time familiarizing yourself with your software's communication capabilities. Any questions should be direct to your practice management software vendor.

Faster turnaround of claim payment

When you send your claim electronically, DeCare Dental Networks (DDN) receives it within one to two days. Once we receive your claim, it is processed automatically. The flow of a paper claim involves opening mail, sorting, imaging and keying in the data. More than 98 percent of all paper claims are processed within 10 days, with electronic claims being processed at least five days faster.

Cost savings on paper forms, envelopes and postage

When you send your claims electronically, you eliminate the need to print and mail claims. This reduces the cost of preprinted forms or paper, as well as envelopes and postage. The cost of submitting a paper claim can be up to $6, whereas submitting an electronic claim costs approximately 50 to 75 cents (clearinghouse charge). ECS also streamlines your filing. Your vendor may charge you for submitting claims. Be sure to check with your vendor to find out about their policy. Remember, there is no charge from DDN for claims submitted electronically.

Less administrative time

When you send in your claims electronically, you eliminate the need to print, sort and mail claims. This allows you office staff to utilize their time more efficiently.

Confirmation of claim receipt

When you send your claim electronically, you receive a confirmation report from your clearinghouse that it has been received.

Quicker response on missing information

When you send your claim electronically, you receive response reports from DDN listing any missing information at the time of claim receipt. This allows your office to respond in a timelier manner-rather than waiting for payment, only to find out that the claim requires more information.

Electronic Claim Submission (ECS), continued

No re-keying of information by DDN

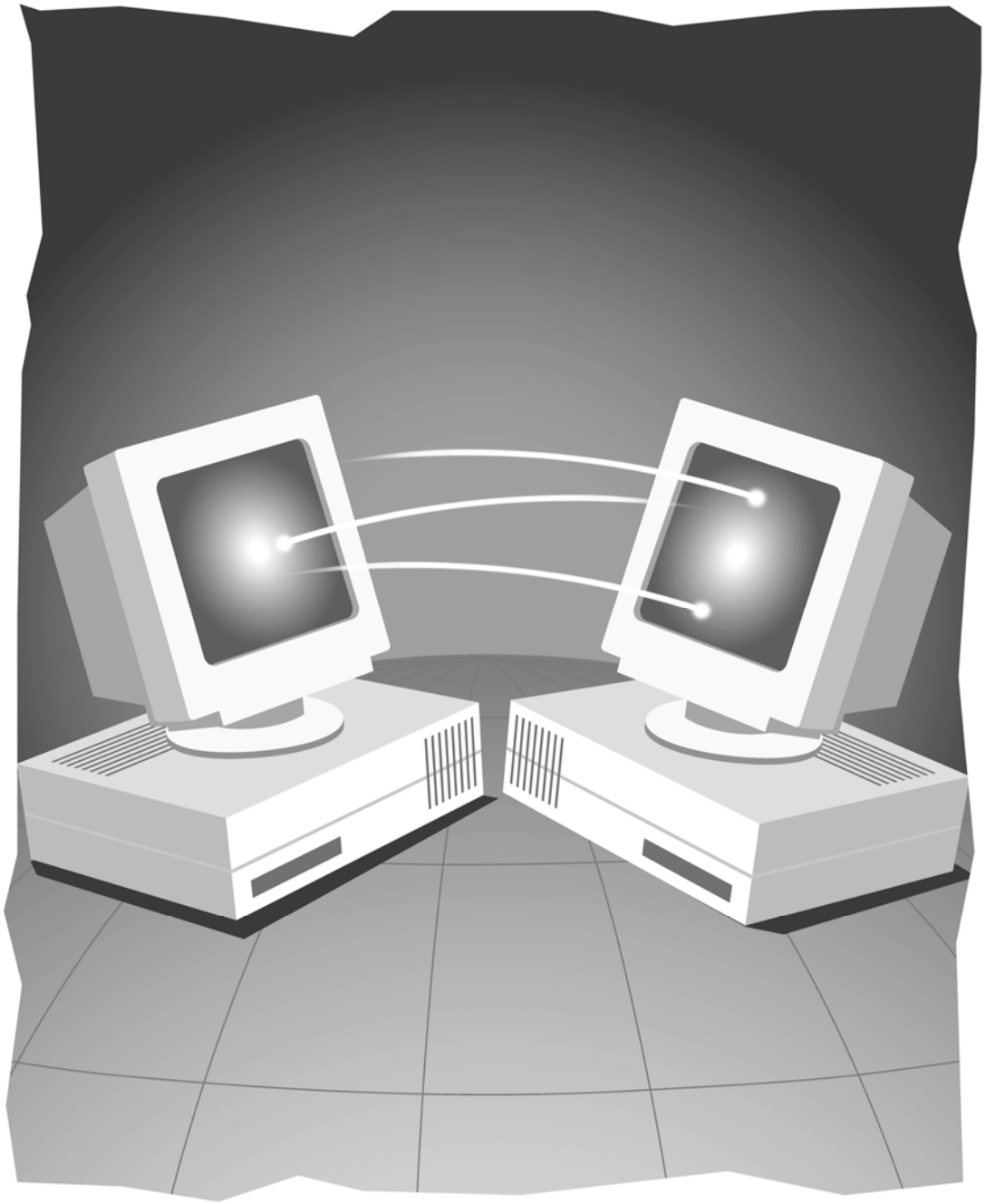
When you send your claim electronically, DDN receives the same information that you have typed into your computer. This means fewer re-keying errors.

Need more information

Refer to the Electronic Claims Submission (ECS) Guidelines.

Electronic **C**laims **S**ubmission

The Future of Dental Claims



DeCare Dental℠

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Introduction

Your office has invested in up-to-date clinical equipment to provide quality care for your patients. You've devoted time and energy to learning the latest clinical advancements in dentistry. You no doubt have applied modern management techniques to your business practices.

Like the majority of dental offices, you have probably invested in a computer system to perform scheduling and produce statements. To maximize your investment and take advantage of the most advanced form of claims submission, you should utilize electronic claims submission (ECS).

An electronic claim is a "paperless" claim that is sent to an insurance company over phone lines from your computer and modem. By submitting electronic claims, you no longer need to print and mail claims. Electronic claims are received and processed faster than paper claims that are mailed.

As health care and marketplace reform continues, this is the future of claims submission and processing. Sending claims from your computer will save you time and money and speed the processing of your claims.

Dentists who may or may not be participating in DeCare Dental Network's National network are eligible to submit claims electronically.

Why Submit Electronically?

Five reasons to start submitting electronic claims today:

1. **Maximize your computer's capability**

   Get your money's worth from your office computer by submitting electronic claims. Many practice management systems have electronic claims components included or available at minimal cost. If you are considering computerizing, ask for a software package that includes electronic claims submission capability.

2. **Minimize cash flow disruptions**

   Electronic claims are processed faster, which means faster payment.

3. **Reduce paperwork**

   Electronic claims submission reduces your office paperwork burden, saves money on supplies and postage and frees staff to handle other important tasks, such as customer relations and patient care.

4. **Make filing insurance claims easier**

   Streamline the process for filing insurance claims by submitting them electronically. All you need to do is input the information into your computer and with the press of a button, claims are sent. Claims are sent to a clearinghouse specializing in electronic claims submission, which then forwards claims to DeCare Dental International Dental Health International and other insurance carriers.

5. **Receive claim status information**

   The clearinghouse edits claims before sending them on to DeCare Dental Health International, and claims with missing or invalid information are returned to you. You will receive electronic confirmation of receipt of your claims. Additional messages will be sent electronically from DeCare Dental Health International as claims are processed. This is not available with paper submission.

Getting Started

To send claims electronically to DeCare Dental Health International, you will need:

- To establish a relationship with a software vendor specializing in electronic claims submission
- A computer
- Software for submitting claims
- A fax compatible modem connected to a telephone line

If you have a modem, you should not have any problems sending claims. If you do not, you should familiarize yourself with your software's communications capabilities. If you have questions or concerns, contact your practice management software vendor. They can provide you with the necessary instructions for submitting claims electronically.

DeCare Dental Health International does not charge dental offices for electronic claims submitted to the claims center. Your software vendor and the clearinghouse may charge you for submitting claims. Be sure to check with your software vendor.

DeCare Dental Health International accepts Electronic Claims Submission for the following plans:

- ❖ DeCare Dental Health International (Plan 650)

Technical Requirements

DeCare Dental Health International has no requirements regarding the type of computer hardware or software you use to submit electronic claims, provided that the system used is able to:

- Submit claims to a clearinghouse that can direct them to DeCare Dental Health International's claim center.
- Construct the electronic version of the claims according to the rules in the Health Insurance Portability and Accountability Act (HIPAA) 837D format.
- Receive DeCare Dental Health International's Electronic Claims Transmission Reports and allow your dental office to print or review them on a computer screen.

These technical requirements are the responsibility of your vendor, who supplies your dental office with the necessary hardware and practice management software.

Submitting Electronic Claims

There are three basic steps to follow when submitting your electronic claim:

1. Enter the claim information

Your software vendor will advise you on how to enter claim information using your computer system. Please ensure all information is entered completely and accurately. Claims that require X-rays or attachments must be submitted on paper along with the necessary documentation.

2. Transmit data

Your vendor will advise you on how to use your modem to transmit claim information. The clearinghouse will receive the claims submitted by your office as they are transmitted, and will forward them to DeCare Dental Health International during the next business day. If multiple clearinghouses are involved, an additional day may be required. DeCare Dental Health International edits and adjudicates the claims.

3. Retrieve and review reports

Your software vendor will also advise you on how to retrieve your Electronic Claims Transmission Reports. These reports are generated by the clearinghouse and serve as confirmation that DeCare Dental Health International has received your claims as well as an explanation of any problems.

Special Considerations

Claims with Other Payers (Coordination of Benefits)

If DeCare Dental Health International is the primary Payer for a Coordination of Benefits (COB) claim, your office may submit the claim using the normal rules. If DeCare Dental Health International is the secondary Payer, the claim should be submitted to DeCare Dental Health International's claim center on paper. The primary Payer's payment amount should be provided with the claim.

Claims Rejected from Electronic Claims Submission

DeCare Dental Health International will reject claims that are not eligible for electronic submission (such as claims requiring X-rays). Your office will be notified of this rejection in the Electronic Claims Transmission Reports, which are sent to your system after the claim is submitted.

If a claim is electronically rejected by DeCare Dental Health International for missing or invalid information, make the appropriate corrections on your system and resubmit the claim as directed. If you are resubmitting electronically and no changes have been applied to the claim, the claim will be rejected as a duplicate claim.

Processed Claims Needing Adjustments and Resubmission or Appeal

Any corrections to a claim submitted previously must be resubmitted on the Explanation of Benefits (EOB), (e.g. a tooth number or code change). Claims that need to be corrected and resubmitted should be resubmitted on paper as follows:

1. Make the corrections on the EOB.
2. If your office wishes to appeal the payment or denial of a claim, an explanation of your position regarding the appeal should be written on the EOB with a signature from the treating dentist.

Codes to identify quadrants

Use the following codes for claims that require reporting areas of the oral cavity or quadrants:

FM = 01 - 32	UR = 01 - 08	UL = 09 - 16	LL = 17 – 24
LR = 25 - 32	UA = 01 - 16	LA = 17 - 32	

The following codes require a quadrant or range:

Preventive	01510	01515	01520	01525
Oral and Maxillofacial Surgery	D7472	D7473	D7960	D7970

Frequently Asked Questions

Q. ***Am I authorized to submit claims electronically?***

A. Yes; when you submit at least one claim electronically you will be automatically authorized based on the information on that claim.

Q. ***I submitted a claim and I haven't been paid yet. Should I submit it again?***

A. Prior to resubmitting, please call DeCare Dental Health International's Customer Service Center at 1-800-587-6857 to check on the status of the claim. Indicate that the claim was sent electronically.

Q. ***I have a question about an electronic claim. Whom should I call?***

A. Call DeCare Dental Health International's Customer Service Center at 1-800-587-6857. DeCare Dental Health International's customer service representatives are trained to handle calls on claims submitted both electronically and on paper. If asking questions about an electronic claim, please be sure to indicate that the claim was sent electronically.

Q. ***How do I become an electronic claims provider?***

A. If you are already sending electronic claims to other Payers, just make sure you have the correct Payer ID for DeCare Dental Health International. Send these claims as you normally would.

Q. ***How long will it take to receive payment for an electronic claim?***

A. You should receive payment within one to two weeks from DeCare Dental Health International's receipt of the claim. Request for additional information or clinical review may delay the payment.

Q. ***When I call in about an electronic claim, how should I identify myself?***

A. Simply identify yourself as an electronic claims provider and indicate that the claim about which you are calling was sent in electronically.

Q. ***What is a Payer ID?***

A. A Payer ID is a five-character designator used to route your claim for processing. You will use your clearinghouse's Payer ID to first route the claim. The clearinghouse will then use DeCare Dental Health International's Payer ID, **07035** to route the claim to the processing center. A list of clearinghouses and their associated Payer IDs is included in this booklet for your convenience (see Electronic Claim Clearinghouses/Vendors section).

Electronic Claims Transmission Reports

Reports are generated both by the clearinghouse and by DeCare Dental Health International. These reports serve as notification that your electronic claims have been received. The report from DeCare Dental Health International is the Electronic Claims Transmission Report. It contains a list of claims submitted and explains what action has occurred on each claim. Any claims not adjudicated during the initial submission will also appear on this report.

Contents of the Electronic Claims Transmission Reports

The heading on the Electronic Claims Transmission Reports identifies the report title, the provider information, and the date and time the report was produced.

Field	Definition
Insured's SSN	Social Security Number of the subscriber for whom the claim was submitted.
Claim Date	Date the claim was sent in by the provider's office.
Date Received	Date the claim was received.
Claim Amount	Dollar amount submitted on the claim from the provider's office.
Patient Name	Name of the patient for the claim submitted.
Claim ID	Both the plan number (e.g. 650) and claim number assigned to the incoming claim.
Results	Brief description of the action that has initially occurred on the claim. If the claim is still open, any additional updates will appear on the Electronic Claims Response Report. If the claim is closed, you will see the message "EOB to follow."
Description	Brief description of why the claim is pending. This field will only appear on open claims.
Action	Brief description of the action required by the provider's office. This field will only appear on open claims.

Use the Electronic Claims Transmission Report on a daily basis to confirm that DeCare Dental Health International's claim center has received your electronic claims. This is your confirmation from DeCare Dental Health International of receipt of electronic claims before they send payments and explanation of benefits to providers and subscribers. Updates to any open claim will also appear on the report, in the same format as below.

Sample Output of the Electronic Claims Transmission Report

103/29/00 DeCare Dental Health International Electronic Transmission Report Page 1

01:32:55 DD:650472529611//1

ECS50B Electronic Claims Daily Report

JAMES A DENTIST
1234 E HWY 1
Any City, ST 12345
D0XDD7

Patient Number	Insured's SSN	Claim Date	Date Received	Claim Amount
1234567890	XXX-XX-XXXX	03/13/03	03/28/03	$181.00

Patient Name: XXX XXXXXX
Claim ID: XXX-XXXXXXXXXX
RESULT: Claim has been accepted for adjudication.
Claim has been adjudicated. EOB to follow.

0987654321	YYY-YY-YYYY	03/13/03	03/28/03	$274.00

Patient Name: YYY YYYYYY
Claim ID: XXX-YYYYYYYYYY
RESULT: Claim Received and in process.
Coverage being reviewed.
DESCRIPTION: Coverage will be manually verified. On subsequent claims, please verify that the correct member ID and Date of Birth are submitted.
ACTION: Coverage will be reviewed and claim will be updated for correct processing. Do not resubmit electronically. Any corrections should be made on the EOB once received.

How to Register for ECS

You are registered for ECS when DeCare Dental Health International receives your first electronic claim.
To ensure that your claims are processed, you must send the following information on the ECS claim:

TIN (Tax Identification Number)
State Issued License Number
Name (Provider)

Troubleshooting ECS Problems

- If you have not received your ECS report, call your vendor for more information.
- If you have received your ECS report and claims that you have sent do not appear on this report, call your vendor.
- If you have received your ECS report and have a question regarding details on paid or denied claims, call DeCare Dental Health International Customer Service at 1-800-587-6857. For easy reference, please identify your clearinghouse contact information (See next page for a list of contacts).

Electronic Claims Clearinghouses/Vendors

This list is for reference only and is not intended as a comprehensive directory of vendors. DeCare Dental Health International does not recommend or endorse any specific claims clearinghouse.

Clearinghouse	Telephone
Practice Works	(800) 262-8593
Envoy WebMD	(800) 845-6592
Apex	(801) 785-9580
Lindsay Technical Consultants	(888) 941-8967

DeCare Dental Health International, LLC
3560 Delta Dental Drive
Eagan, MN 55122-3166

Forms and Communications

Section 7

Information Request Forms

National Provider Identifier (NPI) Form
Information Change Form
Substitute W-9

Newsletters and Other Communication(s)

Use of DeCare or Sponsor Logo or ServiceMark

Information Request Forms

The following pages contain samples of Information Request Forms including:

- National Provider Identifier (NPI) Form
- Information Change Form (for address, dental office name changes, etc.)
- Substitute W-9

Note: If you are in need of a Contracting Dentist Agreement or Credentialing materials, please contact your Network Representative at 1-800-658-4187.

NATIONAL PROVIDER IDENTIFIER (NPI)

The NPI is a unique 10-digit identification number for health care providers that will be used by all health plans. Health care providers and all health plans and health care clearinghouses will use the NPI's in the administrative and financial transactions specified by HIPAA.

Due to the requirements from the United States Department of Health and Human Services, all providers must use their NPI on electronic claims. The NPI compliance date for this change over is May 23, 2007.

There are three categories of the NPI:

- Individual: Dentists
- Organization: Hospitals and Clinics
- Sub-Parts:

Dentist Full Name: _____

Individual NPI: ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___

Business Tax Identification Number: ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___

Business Entity: _____

Business Name: _____

Business Address: _____

Organization NPI: ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___

For information regarding Sub-Part NPI please contact:

Web Address: www.nppes.cms.hhs.gov
Phone Number: 1-800-465-3203

Sub-Part NPI (If applicable) ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___

Print Signer's Name: _____ Office Phone: _____

Signature: _____ Date: _____

Please copy this page and attach for any additional
Organization and/or Sub-part National Provider Identifiers

Information Change Form

Submit change of address to:

DeCare Dental Networks
P.O. Box 1175
Minneapolis, MN 55440-1175

Fax: 1-800-658-4186

OLD ADDRESS

Name _____

Address _____

_____

Phone _____

Fax _____

NEW ADDRESS

Name _____

Address _____

_____

Phone _____

Fax _____

DeCare Dental℠

NETWORKS

Request for Taxpayer Identification Number and Certification (SUBSTITUTE FORM W-9)

Instructions: Please type or print clearly. Sign, date and return to requester in the enclosed envelope. **Do not send to the IRS**

Business Entity: Name of the entity that provides dental services per IRS. (As used to apply for your Tax Identification Number (TIN). This appears on Form SS-4, on your Quarterly Withholding Form 941, or on your annual IRS Tax Return.)

_____

Business Name: (Name used to advertise for business, if different from above name.)

_____

Business Address: _____
Address (number, street and apt or suite no.)

_____
City, State and ZIP code

Taxpayer Identification Number (TIN)

Enter your TIN, which corresponds to the business entity listed above. This may be an Employer Identification Number (EIN) or your Social Security Number (SSN) dependent upon how you file your tax returns with the IRS. This is the Tax Identification Number you use when you submit claims.

TIN | | | | | | | | | | **Check one**: This is my ☐ EIN or ☐ SS

Please check appropriate box: ☐ Individual/Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other _____

If you use a different Tax Identification Number at another office location, please copy this form and complete the copied form with the additional Tax Identification Number and office location information.

Qualifying Exemption ☐ Exempt from tax under 501(a)

Reason, if any (check) ☐ **The United States or any of its agencies or instrumentalities**

☐ **A state, the District of Columbia, a possession of the United States, or any of their political subdivisions.**

Certification: (1) I certify under penalty of perjury that the Taxpayer Identification Number I have provided is correct.
(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
(3) I am a U.S. person (including a U.S. resident alien).
Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return.

Signature: _____ **Office Phone:** (____) _____

Print signer's name & title: _____ **Date:** _____

DeCare Dental Networks, LLC
ATTN: National Network
P.O. Box 1175 • Minneapolis, MN 55440-1175
FAX: 1-866-286-8840

See back of form for additional information.

Purpose of Form

A person who is registered to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use From W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. **Certify the TIN you are giving is correct (or you are waiting for a number to be issued),**
2. **Certify you are not subject to backup withholding, or**
3. **Claim exemption from backup withholding if you are a U.S. exempt payee.**

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding?
Persons making certain payments to you must withhold and pay to the IRS 28% of such payments under certain conditions. This is called "backup withholding". Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real Estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.
Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.
Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.
Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Newsletters and Other Communication(s)

Please use the following section to keep DeCare Dental Networks Newsletters and Other Communication Documents.

Use of DeCare or Sponsor Logo or ServiceMark

Dentist shall not promote or publicize the relationship with DeCare Dental or any Sponsor under this agreement without the written consent of DeCare Dental or Sponsor. Except as provided herein, Dentist may not use DeCare Dental's or Sponsor's symbols, trademark or service marks in advertising or promotional materials without the written consent of DeCare Dental or Sponsor.

Frequently Asked Questions

Section 8

FAQ's

Frequently Asked Questions (FAQ's)

Q. Where shall I submit claims and pre-estimates

A. Send claims and pre-estimates to:

DeCare Dental Health International, LLC (DDHI)
PO Box 1348
Minneapolis MN 55440

Q. Can I submit claims electronically?

A. Yes. The Electronic Claims Submission Guide is attached. Your submission code is 07035.

Q. Who is DeCare Dental Health International, LLC?

A. DeCare Dental Health International, LLC (DDHI) is an affiliate of DeCare Dental Networks. DDHI is a licensed third party administrator and will process claims for the plan client.

Q. Will pre-estimates be required?

A. No. Pre-estimates are not required. However, we will respond to pre-estimate requests as a benefit for dentists and members.

Q. Will x-rays be required with claim submission?

A. No. You will not be required to submit radiographs, diagnostic models or clinical narratives when you submit claims or pre-estimate of benefits.

Q. Will my claim payments be affected when DDN begins administering a new plan?

A. No. Claim payments will not be affected unless they are subject to the members benefit contract limitations. Claim payment will be made on the date of completion/insertion. For example, if a dental procedure (crown preparation, root canal therapy or prosthetics) was started on January 4, 2005 and completed on January 16, 2005, the date of service on the claim should be January 16, 2005. Dental procedures requiring more than one visit to complete the treatment should not be subject for claims payment until treatment is completed, except orthodontic treatment.

Q. Will treatment in progress, including orthodontia, be affected when DDN begins administering a new plan?

A. DDHI will process claims upon completion date, except orthodontics. Orthodontic payments will take over where previous plan left off. The provider will need to submit a copy of the original claim form showing the full treatment plan. Payments from DeCare will be made on a quarterly basis.

Frequently Asked Questions (FAQ's), continued

Q. When will I be reimbursed for completed services?

A. Claims will be adjudicated within 10 business days of receipt. ECS will be adjudicated within 24-48 hours. A bulk check will be issued weekly from our claim payer DDHI.

Q. Will Explanation of Benefits (EOB) be issued to the dentist?

A. Yes. It is standard procedure that EOB's will be mailed to dentists for all services. EOB's will be generated to the employee only if procedure is not covered.

Q. How do I locate a dentist contracted with DDN?

A. Members can utilize the Dentist Search on the DeCare website, www.decare.com. Members and providers can call customer service at 1-800-587-6857 to locate a General Practitioner or Specialist in the network.
Contracted providers may access the www.decare.com\ddnoffice to access the directory that lists all contracted specialists.

Q. Who can I contact if I have questions about my network participation status?

A. Contact DDN Provider Relations at 1-800-658-4187. Our dedicated Network Representatives are available Monday through Thursday 7:30 am – 5:00 pm CST and Friday 7:30 am – 4:30 pm CST.

Q. Who am I contracted with?

A. You are a contracted provider with DeCare Dental Networks.