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INTRODUCTION

About AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast

Who we are
AmeriHealth Caritas Pennsylvania, part of the AmeriHealth Caritas Family of Companies is headquartered in Harrisburg and serves approximately 195,000 Medical Assistance recipients in 27 counties of the Lehigh/Capital and New West Health Choices zones. These counties include: Adams, Berks, Cameron, Clarion, Clearfield, Crawford, Cumberland, Dauphin, Elk, Erie, Franklin, Forest, Fulton, Huntingdon, Jefferson, Lancaster, Lebanon, Lehigh, McKean, Mercer, Northampton, Perry, Pike, Potter, Venango, Warren and York Counties.

AmeriHealth Caritas Northeast is also part of the AmeriHealth Caritas Family of Companies. AmeriHealth Caritas Northeast is headquartered in Harrisburg and serves the healthcare needs of approximately 90,000 Medical Assistance beneficiaries in Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming counties.

Our Mission
We Help People:
Get Care
Stay Well
Build Healthy Communities
We have a special concern for those who are poor.

Our Values
Our service is built on these values:
Advocacy
Care of the Poor
Compassion Competence
Dignity
Diversity
Hospitality
Stewardship

Welcome to the AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast (hereafter referred to collectively (where possible) as “the Plan”) Dental Provider Network! The information contained in this Dental Provider Supplement is in addition to the information contained in the Plan’s Provider Manual and is intended to apply only to Dental Providers and to the Plan’s Dental Program. This Dental Provider Supplement includes information on the Plan’s Dental Program that may not be otherwise included in the Plan’s Provider Manual.
**Single point of contact**
To ensure timely, accurate Provider reimbursement and high-quality service, the Plan assigns each geographical region a dedicated Dental Account Executive. Each Dental Account Executive is responsible for building personal relationships with the office managers at each Provider location in the region. This proven approach fosters teamwork and cooperation, which results in a shared focus on improving service, Member participation, and program results.

**Support for Members**
To further reduce costs for Providers while promoting satisfaction, the Plan offers support with transportation issues and appointment scheduling for Members. Providers may also refer Members with health-related concerns to the Plan to address any questions they may have. This highly successful program reduces administrative costs for dentists and routinely sends satisfied, eligible Members directly to Provider practice locations.

**Consistent, transparent authorization determination logic**
The Plan’s trained Dental Program team members use clinical algorithms, which can be customized to ensure a consistent approach for making Utilization Management (UM) determinations. These algorithms are available to Providers through a Provider Services Web site so dentists can follow the decision matrix and understand the logic behind UM decisions. In addition, the Plan fosters a sense of partnership by encouraging Providers to offer feedback about the algorithms. A consistent, well-understood approach to UM determinations promotes clarity and transparency for Providers, which in turn reduces Provider administrative costs.
TECHNOLOGY TOOLS
The Plan takes advantage of technology tools to increase speed and efficiency, and keeps program administration and Provider participation costs as low as possible.

Provider Services Web site: http://dentists.amerihealthcaritas.com

The Plan provides access to a website that contains the full complement of online Provider resources. The website features an online Provider inquiry tool for real-time eligibility, claims status and authorization status. In addition, the website provides helpful information such as required forms, Provider newsletter, Claim status, electronic remittance advice and electronic funds transfer information, updates, clinical guidelines and other information to assist Providers in working with the Plan.

The website may be accessed at http://dentists.amerihealthcaritas.com. The Plan’s Provider Services’ website allows Network Providers direct access to multiple online services. Utilization of the online services offered through the Provider website lowers program administration and participation costs for Providers.

All that’s required is online access to the Internet Explorer Web browser and a valid user ID and password. From Internet Explorer, Providers and authorized office staff can log in for secured access anytime from anywhere, and handle a variety of day-to-day tasks, including:

- Verify Member eligibility.
- Set up office appointment schedules, which can automatically verify eligibility and pre-populate Claim forms for online submission.
- Submit Claims for services rendered by simply entering procedure codes and applicable tooth numbers, etc.
- Submit Prior Authorization requests, using interactive clinical algorithms when appropriate.
- Check the status of submitted Claims and Prior Authorization requests.
- Review Provider clinical profiling data relative to peers.
- Download and print Provider Manuals and dental supplement.
- Send electronic attachments, such as digital x-rays, EOBs, and treatment plans.
- Check patient treatment history for specific services.
- Upload and download documents using a secure encryption protocol.

Feedback
At the Plan, feedback from both Members and Providers is encouraged, logged, and acted upon when appropriate. To measure Provider and Member satisfaction, and to gather valuable feedback for its quality improvement initiatives, the Plan makes surveys available from its websites and through telephone calls. In addition, to help foster a sense of teamwork and cooperation, the Plan invites feedback from Providers about the UM algorithms by direct communication with the Plan’s Dental Director.
PROVIDER WEB PORTAL REGISTRATION AND INTRODUCTION

The Plan’s Provider Web Portal allows us to maintain our commitment to help you keep your office costs low, access information efficiently, get paid quicker and to submit Claims and Prior Authorization requests electronically.

Registration

To register for our Provider Web Portal visit: http://dentists.amerihealthcaritas.com, then you will come to the online dental Provider Web Portal page; select your plan; then click register now.

*Important Note: Due to ongoing upgrades and changes to the website, this screen shot may not reflect the most updated live version.*

No need to Download or Purchase Software

To obtain electronic use of our provider Web Portal all that is required is internet access and a unique user name and password.

- When registering, register “As a payee” so you will have the option to view emittances and be paid electronically. (the Plan will provide you with your unique Payee ID).

Contact the Provider Web Portal team at: 1-855-434-9239, to obtain your Payee ID number.

Once registered, you are now ready to navigate through the web portal and use the available resources and features to help streamline data entry.

To learn more about the features and functions of the Provider Portal, register for the portal or ask for a training webinar, please contact the Portal Support team at: 1-855-434-9239.
Verify Member Eligibility:
- One-step member eligibility verification.
- You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Manage claims
- Submit claims for services performed.
- Review and print or save a list of claims submitted today for your records, before they are sent on for processing.
- Check the status of previously submitted claims.
- Enter additional information such as NEA# under the ‘Notes’ tab.

Manage Authorizations
- Submit authorizations to obtain approval before performing services.
- Attach electronic files, including x-rays and review authorizations submitted today, before they are sent on for processing.
- Check the status of previously submitted authorizations.

From an Authorization Summary, you can:
- Run any applicable authorization guidelines.
- Review a list of documentation required for each procedure code.
- Attach electronic files to the authorization record.
- Attach clearing house reference information to the authorization record.
- Print a copy of the Authorization Summary for your records.

Electronic Funds Transfer
The Plan’s Provider Web Portal services allows us to give you quicker payments by electronic funds transfers (EFTs). The electronic payment offers a direct deposit into your account and allows you to obtain remits quicker on your online account.

To obtain your online remittances, navigate to the “Manage My Documents” page from the Documents tab on the toolbar or by the link on the main page.

To enroll in EFT payment, please complete the following page and return to the Plan via:
- Fax: 262.721.0722 or email: providerservices@sciondental.com
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT
PART I – REASON FOR SUBMISSION
Reason for Submission: ❑ New EFT Authorization ❑ Revision to Current EFT setup (e.g. account or bank changes)

PART II – PROVIDER OR SUPPLIER INFORMATION
Name of Payee:_________________________________________________________________________________
Tax Identification Number: (Designate SSN ❑ or EIN ❑)__________________________________
Address of Payee (City, State, Zip):___________________________________________________________

PART III – DEPOSITORY INFORMATION (Financial Institution)
Bank/Depository Name:__________________________________________________________________________
Depository Routing Transit Number (nine digits – include any leading zeros)
______________________________________________________________________________________________________
Depositor Account Number (up to 10 digits – include any leading zeros)
______________________________________________________________________________________________________
Type of Account (check one) ❑ Checking Account ❑ Savings Account

PART IV – CONTACT INFORMATION
Name of Billing Contact:___________________________________________________________________________
Phone Number of Billing Contact:________________________________________________________________
Email Address of Billing Contact:_________________________________________________________________

PART V – AUTHORIZATION
I hereby authorize AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTRACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature of Authorized Billing Contact:_______________________________________________________
Date:_______________________________________________________________________________
Member Eligibility Verification Procedures and Services to Members

Member Identification Card
The Plan’s Members are issued identification cards regularly. Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if Members have other health insurance.

AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast’s Eligibility Systems:
Enrolled Network Providers may access Member eligibility information through:
- The “Providers” section of the Plan’s website http://dentists.amerihealthcaritas.com
- The Plan’s Interactive Voice Response (IVR) system eligibility line at:
  1-855-434-9241.
- The Plan’s Member Services Department:
  AmeriHealth Caritas Pennsylvania: 1-888-991-7200
  AmeriHealth Caritas Northeast 1-855-809-9200
The eligibility information received from any of the above sources will be the same information. However by utilizing the IVR or the website, you can get information 24 hours a day, 7 days a week, without having to wait for an available Member Services Representative.

Access to eligibility information via the Plan’s Dental Providers website
The Plan’s Dental Provider website: http://dentists.amerihealthcaritas.com currently allows enrolled Network Providers to verify a Member’s eligibility as well as submit claims, by simply logging on to the website at: http://dentists.amerihealthcaritas.com.

Once you have entered the website, click on ‘Providers.’ You will then be able to log in using your password and ID. First time users will have to self-register by utilizing your Plan’s Payee ID, office name and office address. Please refer to your payment remittance or contact the Provider Web Portal team at: 1-855-434-9239 for information regarding your Payee ID.

Once logged in, select “eligibility look up” and enter the applicable information for each Member you are inquiring about. Verify the Member’s eligibility by entering the Member’s date of birth, the expected date of service and the Member’s identification number or last name and first initial. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.
Access to eligibility information via the IVR line

To access the IVR system, simply call the Plan’s Provider Service Department at: **1-855-434-9241** for eligibility and service history. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks or history inquiries, you will have the option to transfer to a Customer Service Representative during normal business hours.

Callers will need to enter the appropriate Tax ID or NPI number, the Member’s recipient identification number, and date of birth. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the Member’s eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a customer service representative.

Directions for using the Plan’s IVR system to verify eligibility:

Call the Plan’s Member Services at:
AmeriHealth Caritas Pennsylvania: **1-888-991-7200**
AmeriHealth Caritas Northeast **1-855-809-9200**

- When prompted, enter your Provider NPI or Tax ID number.
- Follow the additional prompts and enter Member Information using the ID number or SSN.
- When prompted, enter the Member’s ID, less any alpha characters that may be part of the ID, or the SSN.
- When prompted, enter the Member’s date of birth in MM/DD/YYYY format.
- Upon system verification of the Member’s eligibility, you will be prompted to verify the eligibility of another Member, inquire about service history, or choose to speak to a customer service representative.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. If you are having difficulty accessing either the IVR or website, please contact the Plan’s Member Services at:
AmeriHealth Caritas Pennsylvania: **1-888-991-7200**
AmeriHealth Caritas Northeast: **1-855-809-9200**

Transportation Benefits for Certain Members

Members who need assistance with transportation should contact the Plan’s Member Services at:
AmeriHealth Caritas Pennsylvania: **1-888-991-7200**
AmeriHealth Caritas Northeast: **1-855-809-9200**
The Plan offers TTY service for hearing impaired Members at: **1-800-684-5505**.
COVERED BENEFITS

Dental Benefits for Children under the age of 21
Children under the age of 21 are eligible to receive all Medically Necessary dental services. Members do not need a referral from their PCP, and can choose to receive dental care from any provider who is part of the dental network. Participating dentists can be found in our online Provider Directory at:
http://dentists.amerihealthcaritas.com or by calling Member Services at:
AmeriHealth Caritas Pennsylvania: 1-888-991-7200
AmeriHealth Caritas Northeast: 1-855-809-9200

Dental services that are covered for children under the age of 21 include, but are not limited to the following, when medically necessary:
- IV or Non-IV conscious sedation; nitrous oxide analgesia.
- Orthodontics (braces).*
- Initial and periodic oral examinations.
- Periodontal services.
- Dental prophylaxis.
- Fluoride Treatments.
- Root Canals.
- Crowns.
- Sealants.
- Dentures.
- Dental surgical procedures.
- Dental emergencies.
- X-rays.
- Extractions (tooth removals).
- Restorative services.

*If braces were put on before the age of 21, AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast will continue to cover services until treatment for braces is complete, or age 23, whichever comes first, as long as the patient remains dental eligible for Medical Assistance and is still a Member of AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast. If the Member changes to another HealthChoices health plan, coverage will be provided by that HealthChoices health plan. If the Member loses dental eligibility, AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast will pay for services through the month that the member is eligible. If a Member loses eligibility during the course of treatment, you may charge the Member for the remaining term of the treatment after AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast’s payments cease ONLY IF you obtained a written, signed agreement from the Member prior to the onset of treatment. For case specific clarification, please contact the AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast Dental Director.
Dental Benefits for Adults age 21 and older

*See benefit detail grid on pages 38-58 for procedure codes and eligibility criteria.*

Members do not need a referral from their PCP, and can choose to receive dental care from any provider who is part of the dental network.

The following dental services are covered for adult Members 21 years of age and older:

- Check-ups**
- Cleanings**
- IV or Non-IV conscious sedation; *
- Initial and periodic oral examinations**
- Periodontal services* and **
- Dental prophylaxis.
- Root Canals* and **
- Crowns* and **
- Dentures* and **
- Dental surgical procedures*
- Dental emergencies.
- X-rays.
- Extractions (tooth removals).
- Restorative services.

* Prior Authorization is required and medical necessity must be demonstrated.
** Benefit Limit Exceptions may apply.

Please refer to the Benefit Limit Exception process on page 17 of this manual for complete details. Please call Provider Services at 1-855-434-9241 with questions.

- These benefit limit exceptions do not apply if the member is under age 21, or if the member is 21 years of age and older and resides in a long term care facility, or intermediate care facility. These members are exempt from the benefit limitation exception process. However, all current prior authorization policies, parameters and criteria will remain in place. Determination of member residency can be checked when verifying member eligibility either by phone or through the provider web-portal.
- Adults can get 1 dental exam and 1 cleaning per provider/group every 180 days. Additional exam and cleaning would require benefit limit exception.
- D3220 – pulpotomy– will be covered for adults 21 years of age and older for the management of emergent dental pain; coverage for this procedure will be based on standard claim submission without the need for documentation.
- Coverage for re-cementing of crowns without a benefit limit exception.
Once per lifetime, adult members are eligible for:

- Dentures: one removable prosthesis per member, per arch, regardless of type (full/partial)
  - If the member received a partial or full upper denture since April 27, 2015, paid by the Plan, other MCO’s, or the state’s fee-for-service plan, he/she may be able to get another partial or full upper denture. Additional dentures will require a benefit limit exception.
  - If the member received a partial or full lower denture since April 27, 2015, paid by the Plan, other MCO’s, or the state’s fee-for-service plan, he/she may be able to get another partial or full lower denture. Additional dentures will require a benefit limit exception.

Adult Members may be eligible to receive the following services with a benefit limit exception:

- Crowns and related services.
- Root canals and other endodontic services.
- Periodontal services.
- Additional cleanings and exams.

**Medically Necessary Dental Services for Members under 21 years of age**

For members under 21 years of age who require medically necessary dental services not listed as a covered service or beyond the current limits; the dentist should request a waiver through the 1150 Administrative Waiver (program exception) process.

**Missed Appointments**

Enrolled Network Providers are not allowed to charge Members for missed appointments. Please refer to Medical Assistance Bulletin 99-10-14 in the Appendix of the Plan’s Provider Manual.

The Plan offers the following suggestions to decrease the number of missed appointments.

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

If a Member exceeds your office policy for missed appointments and you choose to discontinue seeing the Member, please inform them to contact the Plan for a referral to a new dentist. Providers with benefit questions should contact the Plan’s Member Service Department directly at:
  - AmeriHealth Caritas Pennsylvania: 1-888-991-7200

**Payment for Non-Covered Services**

Network Providers shall hold Members or the Plan harmless for the payment of Non-Covered Services except as provided in this paragraph. Provider may bill a Member for Non-Covered Services if the Provider obtains an agreement in writing from the Member prior to rendering such service that indicates:

- The non-covered services to be provided;
- The Plan will not pay for or be liable for said services.
- Member will be financially liable for such services.
Please refer to the following section for a complete list of covered benefits:

- The Plan’s Authorization Requirements and Benefits Details Grid.
- For members under 21 years of age who require medically necessary dental services not listed as a covered service or beyond current limitations; the dentists should request a waiver through the 1150.
- Administrative Waiver (program exception) process.
- For members 21 years of age or older; network providers may pursue an 1150 waiver/Program Exception request to determine possible coverage for services not included on the Benefits Details Grid.

**Electronic Attachments**

FastAttach™ - The Plan accepts dental radiographs electronically via FastAttach™ for authorization requests and Claims submissions. The Plan in conjunction with National Electronic Attachment, Inc. (NEA) allows Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows secure transmissions via the Internet lines for radiographs, periodontics charts, intraoral pictures, narratives and EOBs.

For more information, or to sign up for Fast Attach, go to [http://www.nea-fast.com](http://www.nea-fast.com) or call NEA at: 1-800-782-5150.
PROCEDURES REQUIRING PRIOR AUTHORIZATION

The Plan has specific dental utilization criteria as well as a Prior Authorization and Retrospective Review process to manage the utilization of services. Consequently, the Plan’s operational focus is on assuring compliance with its dental utilization criteria.

Prior Authorizations will be honored for 180 days from the date they are issued. An approval does not guarantee payment. The Member must be eligible at the time the services are provided. The Provider should verify eligibility at the time of service.

In order to timely process Prior Authorization requests, appropriate supporting documentation on a standard ADA (2012) approved form must be submitted.

Lack of supporting documentation may result in denial of the authorization.

The basis for granting or denying approval shall be whether the item or service is Medically Necessary. Medically Necessary is defined as follows:

A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability.
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member’s family/caretaker and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the Member. All such determinations must be made by qualified and trained practitioners.

During the Prior Authorization process, it may become necessary to have your patient clinically evaluated. If this is the case, you will be notified of a date and time for the evaluation examination. It is the responsibility of the Network Provider to ensure attendance at this appointment. Patient failure to keep an appointment will result in Denial of the Prior Authorization request.

Please refer to the Prior Authorization Requirements and Benefits Grid in this manual for a detailed list of services requiring Prior Authorization.

Prior authorization for SPU/ASC admission for dental services is not required when utilizing a Plan participating facility. Please contact Provider Services with any questions:

AmeriHealth Caritas Pennsylvania: 1-800-521-6007
AmeriHealth Caritas Northeast: 1-888-208-7370
Retrospective Review
Services that would normally require a Prior Authorization, but are performed in an emergency situation, will be subject to a Retrospective Review. Claims for these services should be submitted to the address utilized when submitting requests for Prior Authorization, accompanied by any required supporting documentation. Any Claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.

Benefit Limit Exception Process (Adults age 21 and over)
You can request a benefit exception for services to be provided to adults 21 and over before the services start or after they are finished. You can ask for an exception up to 60 days after the dental services are finished.
The Plan will grant benefit limit exceptions to the dental benefits when one of the following criteria is met:

- The member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the member; or
- The member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the member; or
- Granting a specific exception is a cost effective alternative for the Plan; or
- Granting an exception is necessary in order to comply with federal law.

Benefit Limit Exception for Periodontal Services Only
The member is pregnant, has diabetes or has coronary artery disease and meets clinical dental criteria for periodontal services included in the Plan.

You must send a completed Benefit Limit Exception Request Form and an ADA 2012 form by mail to*:
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast Authorizations, P.O. Box 654 Milwaukee, WI 53201

Include the following information:

- Member’s name, address and ID number.
- The dental service that is needed.
- The reason the exception is needed.
- Supporting documentation from the member’s primary care or specialty care physician.
- Dentist’s name and phone number.

Note: If the benefit limit exception is requested before the dental service begins, you will get an answer, or will be asked to provide additional information, within 21 business days of receipt of the request. If additional information is needed, the Plan will approve or deny the exception request within 21 business days after receiving the additional information. If the benefit limit exception is requested after the dental service is finished, you will get an answer within 30 days. Urgent requests for services not yet started will be responded to within 48 hours.

*You can obtain a Benefit Limit Exception Request Form located at the end of this supplement or on-line at: http://dentists.amerihealthcaritas.com or call Provider Services at: 1-855-434-9241.
Consistent with 55 Pa. Code 1101.31(f)(2)(viii), the provider may not bill the Plan member for payment for services rendered in excess of the dental limits unless:

- The provider informs the member before the service is rendered that the service requires a BLE and the member is liable for the payment if the request for an exception is denied and;
- The provider requests an exception to the limit and the plan denies the request.

**CLAIMS SUBMISSION PROCEDURES**

The Plan receives dental claims in four possible formats. These formats include:

- Electronic claims via the Plan's website: [http://dentists.amerihealthcaritas.com](http://dentists.amerihealthcaritas.com)
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims.

**Electronic Claim Submission Utilizing AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast’s Website**

Enrolled Network Providers may submit claims directly to the Plan by utilizing the “Provider” section of our website. Submitting claims via the website is very quick and easy and is at no additional cost to Providers! It is especially easy if you have already accessed the site to check a Member’s eligibility prior to providing the service.

To submit Claims via the Web site, simply log on to [http://dentists.amerihealthcaritas.com](http://dentists.amerihealthcaritas.com)

If you have questions on submitting Claims or accessing the Web site, please contact our Systems Operations Department at: **1-855-434-9241**.

**Electronic Claim Submission via Clearinghouse**

Dentists may submit their Claims to the Plan via a clearinghouse such as DentalXChange.

You can contact your software vendor and make certain that they have the Plan listed as a payer. Your software vendor will be able to provide you with any information you may need to ensure that submitted Claims are forwarded to the Plan.

The Plan’s Payer ID is “SCION.” DentalXChange will ensure that by utilizing this unique payer ID, Claims will be submitted successfully to the Plan.

For more information on DentalXChange, please refer to their website at: [http://www.dentalxchange.com](http://www.dentalxchange.com)

**HIPAA Compliant 837D File**

For Providers who are unable to submit electronically via the Internet or a clearinghouse, the Plan will, on a case by case basis, work with the Provider to receive their claims electronically via a HIPAA Compliant 837D file from the Provider’s practice management system. Please contact Provider Services at: **1-855-434-9241** to inquire about this option for electronic claim submission.
Paper Claim Submissions
Claims must be submitted on 2012 ADA approved claim forms or other forms approved in advance by the Plan. Please reference the ADA Web site for the most current claim form and completion instructions. Forms are available through the American Dental Association at:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1-800-947-4746

Member name, identification number, and date of birth must be listed on all Claims submitted. If the Member identification number is missing or miscoded on the Claim form, the Member cannot be identified. This could result in the Claim being returned to the submitting Provider office, causing a delay in payment.

The Provider and office location information must be clearly identified on the Claim. Frequently, if only the dentist signature is used for identification, the dentist’s name cannot be clearly identified. To ensure proper Claim processing, the Claim form must include the following:
- Member name – box #12 or #20
- Member DOB – box #13 or #21
- Member ID # - box #15 or #23
- Provider name – box # 53
- Tax ID # - box #51
- NPI – box #49 and box #54
- Payee location – box #48
- Treating location – box #56
- Box number specific to ADA 2012

The date of service must be provided on the Claim form for each service line submitted.

Approved ADA dental codes as published in the current CDT book or as defined in this Manual must be used to define all services.

Providers must list all quadrants, tooth numbers, and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of Claim payment.

Affix the proper postage when mailing bulk documentation. The Plan does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment. Claims should be mailed to the following address:

AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast Health Plan– Claims
P.O. Box 651
Milwaukee, WI 53201

Reprocessed and adjusted claims should be mailed to the following address:
Claims Reprocessing and Adjustments Requests
P.O. Box 541
Milwaukee, WI 53201
The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA’s website (ADA.org).

GENERAL INSTRUCTIONS
A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard 90 window envelope (window to the left). Please fold the form using the “sidebars” printed in the margin.
B. Complete all items unless noted otherwise on the form or in the CDT manual’s instructions.
C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
D. All dates must include the four-digit year.
E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)
When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer’s Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the “Remarks” field (Item 35).

DIAGNOSIS CODING
The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient’s oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:
- Item 29a – Diagnosis Code Pointer (“A” through “D” as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (8 for ICD-9-CM, AB for ICD-10-CM)
- Item 54a – Diagnosis Code(s)/A, B, C, D (up to four, with the primary adjacent to the letter “A”)

PLACE OF TREATMENT
Enter the 2-digit Place of Service Code for Professional Claims; a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:
- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

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

PROVIDER SPECIALTY
This code is entered in Item 56 and indicates the type of dental profession who delivered the treatment. The general code listed as “Dentist” may be used instead of any of the other codes.

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>122300000X</td>
</tr>
<tr>
<td>A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.</td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>122300001X</td>
</tr>
<tr>
<td>Dental Specialty (see following list)</td>
<td>Various</td>
</tr>
<tr>
<td>Dental Public Health</td>
<td>12230001X</td>
</tr>
<tr>
<td>Endodontics</td>
<td>1223E0200X</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1223X0400X</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>1223P0221X</td>
</tr>
<tr>
<td>Periodontics</td>
<td>1223P0300X</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>1223P0700X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Pathology</td>
<td>1223P0106X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Radiology</td>
<td>1223D0008X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>1223S0112X</td>
</tr>
</tbody>
</table>

Provider taxonomy codes listed above are a subset of the full code set that is posted at “www.wpc-ed.com/codes/taxonomy”
**Timely Filing Limits**

Provider understands that failure to submit claims or failure to submit requested documentation within 180 days from the date of service may result in loss of reimbursement for services provided. Claims with EOBs from primary insurers must be submitted within 60 days of the date of the primary insurer’s EOB. Providers must submit a copy of the primary insurer’s EOB. The Plan determines whether a Claim has been filed timely by comparing the date of service to the receipt date applied to the Claim when the Claim is received. If the span between these two dates exceeds the time limitation, the Claim is considered to have not been filed timely.

**Coordination of Benefits (COB)**

When the Plan is the secondary insurance carrier, a copy of the primary carrier’s Explanation of Benefits (EOB) must be submitted with the Claim. For electronic Claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier’s payment meets or exceeds the Provider’s Plan’s contracted rate or fee schedule, the Plan will consider the Claim paid in full and no further payment will be made on the Claim, nor may the member be billed for any outstanding balance.

**Third Party Liability and Coordination of Benefits**

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than the Plan. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as the Plan, is always the **payer of last resort**. This means that all other insurance carriers (the “Primary Insurers”) must consider the Health Care Provider’s charges before a Claim is submitted to the Plan. Therefore, before billing the Plan when there is a Primary Insurer, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill the Plan for the Claim by submitting the Claim along with a copy of the Primary Insurer’s EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the section above.
Reimbursement for Members with Third Party Resources

**Medicare as a Third Party Resource**

For Medicare services that are covered by the Plan, the Plan will pay, up to the Plan’s contracted rate, the lesser of:

- The difference between the Plan’s contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment.

In any event, the total combined payment made by Medicare and the Plan, the Plan will not exceed the Plan’s contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, the Plan will pay coinsurance, deductibles and/or co-payments up to the applicable Medical Assistance (MA) Fee-For-Service rate.

For Medicare physical health services that are not covered by either the Plan or the MA Fee-For-Service Program, the Plan will pay cost-sharing amounts to the extent that the combined payment made under Medicare for the service and the payment made by the Plan does not exceed 80% of the Medicare approved amount.

The Plan’s referral and authorization requirements are applicable if the services are covered by Medicare and the Member’s Medicare benefits have been exhausted.

**Commercial Third Party Resource**

For services that have been rendered by a Network Provider, the Plan will pay, up to the Plan’s contracted rate, the lesser of:

- The difference between the Plan’s contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment.

In any event, the total combined payment made by the Primary Insurer and the Plan will not exceed the Plan’s contracted rate.

Health Care Providers must comply with all applicable the Plan and authorization requirements.

**Receipt and Audit of Claims**

In order to ensure timely, accurate remittances to each dentist, the Plan performs an edit of all Claims upon receipt. This edit validates Member eligibility, procedure codes, and Provider identifying information. A Dental Reimbursement Analyst dedicated to the Plan’s dental offices analyzes any Claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact the Plan’s Provider Services Department at: 1-855-434-9241 with any questions you may have regarding Claim submission or your remittance.

Each Enrolled Network Provider office receives an “explanation of benefit” report with their remittance. This report includes Member information and an allowable fee by date of service for each service rendered during the period.
Dentist Appeal Procedures

Providers have the opportunity to request resolution of Disputes or Formal Provider Appeals that have been submitted to the appropriate internal Plan’s department.

Providers may appeal a Plan reimbursement decision by submitting an appeal in writing, along with any necessary additional documentation within 60 days of the date of the explanation of benefit indicating claim denial:

AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast – Appeals

P.O. Box 1243

Milwaukee, WI 53201

Refer to the Provider Manual section on "Provider Dispute/Appeal Procedures" for complete and detailed information.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

As a healthcare provider, you are a “Covered Entity” under HIPAA, and you are therefore required to comply with the applicable provisions of HIPAA and its implementing regulations.

In regard to the Administrative Simplification Standards, you will note that the benefit tables included in this Provider Manual reflect the most current coding standards recognized by the ADA. Effective the date of this manual, the Plan will require Providers to submit all claims with the proper CDT codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA 2012 claim form.

Note: Copies of the Plan’s HIPAA policies are available upon request by contacting:

The Plan’s Provider Service Department at: 1-855-434-9241

For complete detailed information regarding the Plan's HIPAA policies refer to “Compliance with the HIPPA Privacy Regulations” in the Provider Manual.

Fraud, Waste & Abuse

Under the HealthChoices program, the Plan receives state and federal funding for payment of services provided to our Members. In accepting Claims payment from the Plans, Health Care Providers are receiving state and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to www.pacode.com/secure/data/055/partIItoc.html for more information regarding Fraud or abuse, including “Provider Prohibited Acts” that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

We are dedicated to eradicating Fraud and Abuse from our programs and cooperate in Fraud and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Unit of the Pennsylvania Attorney General’s Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the HHS Office of Inspector General, as well as the Bureau of Program Integrity of DHS. As part of our responsibilities, the Payment Integrity department is responsible for identifying and recovering claims overpayments. The department performs several operational activities to detect and prevent fraudulent and/or abusive activities. We expect our dental partners to share this same commitment and conduct their businesses similarly, and report suspected noncompliance, fraud, waste or abuse.
Examples of fraudulent/abusive activities:
- Billing for services not rendered or not Medically Necessary.
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients.
- Prescribing items or referring services which are not Medically Necessary.
- Misrepresenting the services rendered.
- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs.
- Retaining Medicaid funds that were improperly paid.
- Billing Medicaid recipients for covered services.
- Failure to perform services required under a capitated contractual arrangement.

If you, or any entity with which you contract to provide health care services on behalf of the Plan’s beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact us by:
- Calling the toll-free MA Provider Compliance Hotline at: **1-866-833-9718**;
- E-mailing to fraudtip@amerihealthcaritas.com; or,
- Mailing a written statement to Special Investigations Unit:
  AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast
  200 Stevens Drive, Philadelphia, PA, 19113

Below are examples of information that will assist us with an investigation:
- Contact Information (e.g. name of individual making the allegation, address, telephone number);
- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent or Abuse Activities;
- Timeframe of the Allegation(s).

Providers may also report suspected fraud, waste, and abuse to:
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast
200 Stevens Drive, Philadelphia, PA  19113
OR
Contact the Pennsylvania Department of Human Services through one of the following methods:
Phone:  **1-866-DHS-TIPS (1-866-379-8477)**
Fax:  **1-717-214-1200**, Attn: OMAP Provider
Mail:  Bureau of Program Integrity, OMAP Provider Compliance Hotline
     P.O. Box 2675
     Harrisburg, PA 17105-2675

Mandatory fraud waste and abuse provider training available on-line at
CREDENTIALING

Any DDS or DMD who is interested in participation with the Plan is invited to apply by submitting a credentialing application form for review by the Plan’s Credentialing Committee. Providers who seek participation in the Plan’s Network must be credentialed prior to participation in the network.

The Plan maintains and adheres to all applicable State and federal laws and regulations, DHS requirements, and accreditation requirements governing credentialing and re-credentialing functions. All applications reviewed by the Plan must satisfy these requirements, as they apply to dental services, in order to be admitted in the Plan’s Provider Network.

The process to be credentialed as a Plan Network Provider is fast and easy. The Plan has entered into an agreement with the Council for Affordable Quality Healthcare (CAQH) to offer our Providers the Universal Provider Data source that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, you provide credentialing information to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. The Plan’s goal is to have all of its Network Providers enrolled with CAQH. There is no charge to Providers to submit applications and participate in CAQH. Please access the credentialing page on http://dentists.amerihealthcaritas.com and follow the instructions to begin the application process for participation in the Plan’s Provider Network.

Refer to the Plan’s Provider Manual section on Credentialing and Re-credentialing Requirements for complete and detailed information.

MEDICAL RECORDKEEPING

The Plan adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations. Likewise, the Plan expects that every office will provide quality dental services in a cost effective manner in keeping with the standards of care in the community and dental profession nationwide.

The Plan’s expectation is that every Network Provider will submit claims for services in an accurate and ethical fashion reflecting the appropriate level and scope of services performed, and that Network Providers are compliant with these requirements.

The Plan will periodically conduct random chart audits in order to determine Network Providers’ compliance with these conditions and expectation, as a component of the Plan’s Quality Management Program. Network Providers are expected to supply, upon request, complete copies of Member dental records. The records are reviewed by the Plan’s Dental Director, or his/her designee, such as a Registered Dental Hygienist, to determine the rate of compliance with medical recordkeeping requirements as well as the accuracy of the dental Claims submitted for payment. All dental services performed must be recorded in the patient record, which must be made available as required by your Participating Provider Agreement.

The first part of the audit will consist of the charts being reviewed for compliance with the stated record keeping requirements, utilizing a standardized audit tool. The charts are reviewed and a composite score is determined. Offices with scores above 80% are considered as passing the audit but a corrective action letter is sent to them so that they are aware of the areas that need improvement; offices that receive a score of 95% or greater are exempt from the audit the following year. Offices with scores less than 80% will have a corrective action letter sent, and are re-reviewed for compliance within the next ninety days.
Offices that do not cooperate with improving their scores are subject to disciplinary action in accordance with the Plan’s Provider Sanctioning Policy.

The second portion of the audit consists of a billing reconciliation whereby the patient treatment notes are compared to the actual Claims submitted for payment by each dental office. The records are analyzed to determine if the patient record documents the performance of all the dental services that have been submitted for payment. Any services not documented are recouped, and the records may be subject to additional review and follow-up by the Plan’s Special Investigations Unit.

Results of both parts of the audit are entered into a tracking data base at the Plan and then reported back to each office in a summary of finding format.

The Plan recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the patient’s file for record retention and review. Patient records must be kept for a minimum of 7 years from the date of the last dental entry.

**Refer to the Quality Management, Credentialing and Utilization Management Section of the Provider Manual for more information.**

**IMPORTANT NOTICE FOR SUBMITTING PAPER AUTHORIZATIONS AND CLAIMS**

Effective September 1, 2014, the ADA 2012 form will be the only form for submission. All other forms, including ADA forms dated prior to 2006, will not be accepted and will result in a rejection of the Claim or Prior Authorization request.

Additionally, when making a correction to a previously submitted Claim, please send it clearly marked “Corrected Claims” on ADA 2012 forms to:

**Claims Reprocessing and Adjustment Request**

P.O. Box 541
Milwaukee, WI 53201

Please contact Provider Services at: **1-855-434-9241** if you have questions. If you are in need of the current forms, please visit the ADA Web site at www.ada.org for ordering information.

Claims /Authorizations with missing or invalid information may be rejected and returned to the Provider. Prior Authorization requests must include the following:

- Member name – box #12 or #20
- Member DOB – box #13 or #21
- Member ID # - box #15 or #23
- Provider name – box # 53
- Tax ID # - box #51
- NPI – box #49 and box #54
- Payee location – box #48
- Treating location – box #56
- Box number specific to ADA 2012
Authorizations with missing or invalid information may be rejected and returned to the Provider. All radiographs including digital prints, duplicates, and originals will not be returned to the dentist unless a self-addressed stamped envelope is included with the claim/authorization submission.

Authorizations should be mailed to the following address:
AmeriHealth Caritas Pennsylvania
AmeriHealth Caritas Northeast Health Plan– Authorizations
P.O. Box 654
Milwaukee, WI 53201
HEALTH GUIDELINES-AGES 0-20 YEARS
Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling.

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

Refer to the guideline below from the American Academy of Pediatric Dentistry for supporting information and references.

**RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE**
(Adapted from the American Academy of Pediatric Dentistry)
Effective May 1, 2009

<table>
<thead>
<tr>
<th>Age</th>
<th>Periodicity Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Infant 6-12 Months</td>
</tr>
<tr>
<td>Clinical Oral Examination: <strong>a</strong></td>
<td>X</td>
</tr>
<tr>
<td>Prophylaxis/Topical Fluoride Treatment Especially for children at high risk for caries and periodontal disease.</td>
<td>X</td>
</tr>
<tr>
<td>Radiographic Assessment As per the Food and Drug Administration/American Dental Association Guidelines on Prescribing Dental Radiographs</td>
<td>X</td>
</tr>
<tr>
<td>Assessment for Pit and Fissure Sealants</td>
<td>X</td>
</tr>
<tr>
<td>Treatment of Dental Disease/Caries Risk Assessment</td>
<td>X</td>
</tr>
</tbody>
</table>

**Anticipatory Guidance**
Appropriate discussion and counseling should be an integral part of each visit for care. Topics for counseling when appropriate should cover Oral Hygiene counseling (1) Injury prevention counseling (2) Dietary counseling (3) Counseling for non-nutritive habits (4) Fluoride supplementation (5,6) Assessment of oral growth and development (7) Counseling for speech/language development, assessment and treatment of developing malocclusion, counseling for interoral/periostral sucking, substance abuse counseling; assessment and/or removal of fixed molars and extraction for regular periodic dental care.

1. Initially, responsibility of parent, as child develops, joint with parents, and by age 12 responsibility of the child only.
2. Initially play objects, pacifiers, car seats, then when learning to walk; sports, continue playing and introral/periostral piercing.
3. At every appointment discuss role of refined carbohydrates, frequency of snacking.
4. At first discuss need for additional sucking; digits vs. pacifiers, then need to wean from habit before eruption of permanent incisors.
5. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
6. Up to at least 16 years.
7. By clinical examination.
AMERIHEALTH CARITAS PENNSYLVANIA AND AMERIHEALTH CARITAS NORTHEAST
MEDICAID CLINICAL CRITERIA FOR PRIOR AUTHORIZATION OF TREATMENT AND
EMERGENCY TREATMENT

A number of procedures require prior authorization before initiating treatment. When prior authorizing these procedures, please note the documentation requirements when sending in the information to the Plan. The criteria the Plan’s dental reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient’s condition. However, to receive reimbursement for the treatment, the Plan will require the same criteria/documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

Adults age 21 and older have benefit limitations. Please refer to page 17 for information on the benefit limit exception criteria, or contact Provider Services at: 1-855-434-9241 for more information.

Crowns (D2710, D2721, D2740, D2751, D2752, D2791) – prior authorization

Required documentation – Periapical x-ray showing the root and crown of the natural tooth. Current periapical x-rays of the tooth/teeth to be crowned and/or used as abutments for removable partial dentures along with a panorex or full mouth are needed for evaluation.

All criteria below must be met:
- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
  1. The tooth is filled within two millimeters of the radiographic apex
  2. The root canal is not filled beyond the radiographic apex
  3. The root canal filling is adequately condensed and/or filled
- And one of the criteria below must be met:
  1. Anterior teeth must have pathological destruction to the tooth by caries or trauma, and involve four (4) or more surfaces and at least 50% of the incisal edge.
  2. Premolar teeth must have pathological destruction to the tooth by caries or trauma, and must involve three (3) or more surfaces and at least one (1) cusp
  3. Molar teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps.
- Benefit limit exception necessary (if applicable).
Posts and cores (D2952, D2954) – prior authorization
Required documentation – Periapical x-ray showing the root and crown of the natural tooth. All criteria below must be met:

- Minimum 50% bone support.
- The patient must be free of active / advanced periodontal disease.
- No subosseous and / or furcation carious involvement.
- No periodontal furcation lesion or a furcation involvement.
- Clinically acceptable RCT if present and all the criteria below must be met:
  1. The tooth is filled within two millimeters of the radiographic apex.
  2. The root canal is not filled beyond the radiographic apex.
  3. The root canal filling is adequately condensed and/or filled.
- Benefit limit exception necessary (if applicable).

Root canals (D3310, D3320, D3330) – prior authorization
Required documentation – pre-operative x-rays (excluding bitewings)
All criteria below must be met:

- Minimum 50% bone support.
- The patient must be free of active / advanced periodontal disease.
- No subosseous and / or furcation carious involvement.
- No periodontal furcation lesion and / or a furcation involvement.
- Closed apex.
And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray:
  - Evidence of apical pathology/fistula.
  - Pain from percussion / temp.
- Benefit limit exception necessary (if applicable).

Apicoectomy / periradicular services (D3410, D3421, D3425, D3426) – prior authorization
Required documentation – pre-operative x-rays of adjacent and opposing teeth.
All criteria below must be met:

- Minimum 50% bone support.
- History of RCT.
- Apical pathology.
- The patient must be free of active / advanced periodontal disease.
- No subosseous and / or furcation carious involvement.
- No periodontal furcation lesion and / or furcation involvement.
- Benefit limit exception necessary (if applicable).

Gingivectomy or gingivoplasty (D4210) – prior authorization
Required documentation – pre-operative x-rays, perio charting, narrative of medical necessity, photo (optional)
1 of the criteria below must be met:

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects.
- Generalized 5 mm or more pocketing indicated on the perio charting.
- Benefit limit exception necessary (if applicable).
Periodontal scaling and root planning (D4341) – prior authorization
Required documentation – pre-op x-rays.
All criteria below must be met:
- No history of periodontal treatment in past 12 months.
- Extensive coronal calculus on 50% of teeth.
- Benefit limit exception necessary (if applicable).

Full mouth debridement (D4355) – prior authorization
Required documentation – pre-op x-rays
All criteria below must be met:
- No history of periodontal treatment in past 12 months.
- Extensive coronal calculus on 50% of teeth.
- Benefit limit exception necessary (if applicable).

Periodontal maintenance (D4910) – prior authorization
Required documentation – Date of previous periodontal surgical or scaling and root planning.
All criteria below must be met:
- Periodontal surgical or scaling and root planning service at least 90 days prior.
- Benefit limit exception necessary (if applicable).

Full dentures (D5110, D5120) – prior authorization
Required documentation – Full mouth or panorex x-rays.
1 of the criteria below must be met:
- Existing denture greater than 5 years old.
- Remaining teeth do not have adequate bone support or are not restorable.
- Benefit limit exception necessary (if applicable).

Immediate dentures (D5130, D5140) – prior authorization
Required documentation – Full mouth or panorex x-rays.
All criteria below must be met:
- Remaining teeth do not have adequate bone support or are not restorable.
- Benefit limit exception necessary (if applicable).

Partial dentures (D5211, D5212, D5213, D5214) – prior authorization
Required documentation – Full mouth or panorex x-rays
All criteria below must be met:
- Remaining teeth have greater than 50% bone support and are restorable.
In addition 1 of the criteria below must be met
- Replacing one or more anterior teeth.
- Replacing two or more posterior teeth unilaterally (excluding 3rd molars).
- Replacing three or more teeth bilaterally (excluding 3rd molars).
- Existing partial denture greater than 5 years old.
- Benefit limit exception necessary (if applicable).
Pediatric partial denture (D6985) – prior authorization
Required documentation – Pre-operative x-rays or diagnostic quality photos and narrative of medical necessity.

All criteria below must be met:
- Documentation describes which prematurely lost primary teeth are being replaced.
- Documentation describes reasons for prematurely lost primary teeth such as decay, accident or congenital defect.

Impacted teeth – (asymptomatic and disease free impactions will not be approved) (D7220, D7230, D7240) – prior authorization

- Documentation required – Pre-operative x-rays (excluding bitewings) and narrative of medical necessity.
- Documentation describes pain, swelling, etc. around tooth (symptomatic).
- X-rays matches type of impaction code described.
- Documentation of clinical evidence indicating impaction although asymptomatic may not be disease free.

Surgical removal of residual tooth roots (D7250) – prior authorization
Documentation required – Pre-operative x-rays (excluding bitewings) and narrative of medical necessity.

All criteria below must be met:
- Tooth root is completely covered by tissue on x-ray.
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic).

Oroantral fistula closure (D7260)– retro review
Documentation required – Narrative of medical necessity.

All criteria below must be met:
- Narrative must substantiate need due to extraction, oral infection or sinus infection.

Tooth reimplantation and/or stabilization (D7270)– retro review
Documentation required – Narrative of medical necessity.

All criteria below must be met:
- Documentation describes an accident such as playground fall or bicycle injury.
- Documentation describes which teeth were avulsed or loosened and treatment necessary to stabilize them through re-implantation and/or stabilization.

Surgical access of an unerupted tooth (D7280) – prior authorization
Documentation required – Pre-operative x-rays and narrative of medical necessity.

All criteria below must be met:
- Documentation supports impacted/unerupted tooth.

Placement of device to facilitate eruption (D7283) – prior authorization
Documentation required – Narrative of medical necessity

All criteria below must be met:
- Documentation describes condition preventing normal eruption.
- Documentation describes device type and need for placement of device.
Alveoloplasty with extractions (D7310) – prior authorization
Documentation required – Pre-operative x-rays (excluding bitewings) and narrative of medical necessity. All criteria below must be met:
   • Documentation supports medical necessity for fabrication of a prosthesis.

Alveoloplasty without extractions (D7320) – prior authorization
Documentation required – Pre-operative x-rays (excluding bitewings) and narrative of medical necessity. All criteria below must be met:
   • Documentation supports medical necessity for fabrication of a prosthesis.

Excision of lesion / tumor (D7450, D7451, D7460, D7461) – retro review
Documentation required – Copy of pathology report. All criteria below must be met:
   • Copy of pathology report indicating lesion / tumor.

Incision / drain abscess (D7510, D7511, D7520, D7521) – retro review
Documentation required – Narrative of medical necessity, x-rays or photos optional. All criteria below must be met:
For intraoral incision:
   • Documentation describes non-vital tooth or foreign body.
For extraoral incision:
   • Documentation describes periapical or periodontal abscess.

Reduction and dislocation and management of TMJ dysfunctions (D7871) – retro review
Documentation required – Narrative of medical necessity, x-rays or photos optional. All criteria below must be met:
   • Documentation describes nature and etiology of TMJ dysfunction.
   • Documentation describes treatment to manage the TMJ condition.

Frenulectomy (D7960) – prior authorization
Documentation required – Narrative of medical necessity, x-rays or photos optional. All criteria below must be met:
   • Documentation describes tongue tied, diastema or tissue pull condition.

Excision of hyperplastic tissue (D7970) – prior authorization
Documentation required – Pre-operative x-rays, narrative of medical necessity, photos optional. All criteria below must be met:
   • Documentation describes medical necessity due to ill-fitting denture.
Unspecified oral surgery procedure (D7999) – prior authorization
Documentation required – Narrative of medical necessity, name, license number and tax ID of Asst surgeon.
All criteria below must be met:
  • Documentation describes medical necessity need for Asst. surgeon.
  • Name/license number of Assistant surgeon is provided.

General anesthesia / IV sedation (Dental Office Setting) - 1 or more of the criteria below:
(D9222, D9223, D9239 and D9243)-retro review
Documentation required – Narrative of medical necessity.
1 of the criteria below must be met:
  • Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
  • 2 or more extractions in 2 or more quadrants.
  • 4 or more extractions in 1 quadrant.
  • Excision of lesions greater than 1.25 cm.
  • Surgical recovery from the maxillary antrum.
  • Documentation that patient is less than 9 years old with extensive treatment (described).
  • Documentation of failed local anesthesia.
  • Documentation of situational anxiety.
  • Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, and epilepsy, MR or other condition that would render patient noncompliant).
  • Documentation of existing clinical condition or circumstance making the use of the general anesthesia/IV sedation a reasonable inclusion as a medically necessary part of the therapeutic regimen.

Analgesia, anxiolysis, inhalation of nitrous oxide (D9230) – retro review
Documentation required – Narrative of medical necessity
  • Documentation of existing medical condition or circumstance making the use of nitrous oxide analgesia, anxiolysis a reasonable inclusion as a medically necessary part of the therapeutic regimen.
  • Documentation describes member condition such as situational anxiety or patient age supporting medical necessity for procedure.
Non-intravenous conscious sedation (Dental Office Setting) - 1 or more of the criteria below
(D9248) – retro review
Documentation required – Narrative of medical necessity
1 of the criteria below must be met:
- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids.
- 2 or more extractions in 2 or more quadrants.
- 4 or more extractions in 1 quadrant.
- Excision of lesions greater than 1.25 cm.
- Surgical recovery from the maxillary antrum.
- Documentation that patient is less than 9 years old with extensive treatment (described).
- Documentation of failed local anesthesia.
- Documentation of situational anxiety.
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant).
- Documentation of existing clinical condition or circumstance making the use or the non-intravenous conscious sedation a reasonable inclusion as a medically necessary part of the therapeutic regimen.

Treatment of complications (post-surgical) – (D9930) – retro review
Documentation required – Narrative of medical necessity
- Documentation describes post-surgical condition supporting medical necessity for procedure.
ORTHODONTICS

Fixed or removable appliance therapy (D8210, D8220) – prior authorization
Documentation required – Panorex and/or cephalometric x-rays, narrative of medical necessity
All criteria below must be met:

- Documentation describes thumb sucking or tongue thrusting habit.

Comprehensive orthodontic services (D8080, D8670) – prior authorization
Documentation requirements – Panorex and/or cephalometric x-rays, 5-7 diagnostic quality photos, completed Salzman Criteria Index Form.
1 of the criteria below must be met:

- Documentation shows deep impinging overbite that shows palatal impingement of the majority of lower incisors.
- Documentation shows true anterior open bite (not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).
- Documentation shows a large anterior – posterior discrepancy (Class II and Class III malocclusions that are virtually a full tooth class II or Class III).
- Documentation shows gingival stripping or anterior cross bite (involves more than two teeth in cross bite).
- Documentation shows posterior transverse discrepancies involving several posterior teeth (2 to 4 or more) in cross bite, not a single tooth in cross bite). Molars not required to be included.
- Documentation shows significant posterior open bites (not involving partially erupted teeth or one or two teeth slightly out of occlusion).
- Documentation shows impacted incisors or canines that will not erupt into the arch without orthodontic or surgical intervention (does not include cases where canines are going to erupt ectopically).
- Documentation supports Salzmann Criteria Index Form score of 25 points or greater when the case is evaluated using the Salzman Index.
- Documentation that supports the presence of a severe handicapping malocclusion that may not be included in the list, but whose severity is consistent with the above criteria.

Orthodontic Retention (D8680) - prior authorization
Documentation required – diagnostic quality photos
All criteria below must be met:

- Photos show completed orthodontic case.
<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
<th>Authorization Requirements</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation</td>
<td>No</td>
<td>Age Min: 0, Age Max: N/A, Reqd Docs: N/A, Age Min: 0, Age Max: 999, Age Max Count: 1, Period Length: 180, Period Type: DAYS PER DENTIST (DENTAL GROUP) EITHER D0150 or D0120</td>
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<td>Oral evaluation for a patient under three years of age and counseling with primary care giver D0150</td>
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<td>D0230</td>
<td>Add'l periapical</td>
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<td>Resin-1 surface, anterior</td>
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<td>Resin-2 surface, anterior</td>
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<td>Resin-3 surface, anterior</td>
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<td>Resin-4+ surfaces or anterior</td>
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<td>Crown - resin (laboratory)</td>
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<td>Crown-porcelain fused to metal</td>
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<td>Therapeutic pulpotomy (excluding final restoration)</td>
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<td>D7260</td>
<td>Oroantral fistula closure</td>
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<td>Comp ortho treat adolescent</td>
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<td>Deep sedation/general anesthesia-first 15 minutes</td>
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<td>D0160</td>
<td>Detailed and Extensive Oral Evaluation</td>
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Dental Benefit Limit Exception Request Form

Failure to legibly complete all fields and provide required documentation will result in this form being returned. This form must be attached to a completed ADA dental claim form.

Please Print:
Member Last Name: ___________________________  First Name: ___________________________
Member ACP/ACN ID#: ___________________________  Recipient Date of Birth: _____________
Provider Last Name: ___________________________  First Name: ___________________________
Provider ACP/ACN ID#: ___________________________  NPI #: ___________________________
Provider Telephone Number: (Area Code): ___________  Phone: ___________________________

Benefit Exception Request Type:  □ Prospective □ Retrospective - Dates of Service: ___________________________

Benefit Limit Criteria to be reviewed (Check all that apply):
□ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the recipient.
□ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid serious deterioration of the health of the recipient.
□ Granting the exception is a cost-effective alternative for the plan.
□ Granting the exception is necessary in order to comply with federal law.
□ Patient does not meet any of the benefit limit exception criteria.

Benefit Limit Exception Request for Periodontal Services Only
□ Patient is pregnant, has diabetes or has coronary artery disease and meets clinical dental criteria for periodontal services included in the Plan’s benefit program.

This request must include documentation from the patient’s primary care or specialty care physician supporting the need for the service, including but not limited to chart documentation, diagnostic study results, radiographs (if applicable), medical and dental history.

Explain below why the patient meets the criteria for a benefit limit exception. The explanation should be in narrative form and include a comprehensive justification (attach additional pages as necessary).

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

A BLE requested before the dental service begins, will receive an answer, or a request for additional information to be provided, within 21 (twenty-one) business days of receipt of the request. When additional information is required and received, the exception request will be approved or denied within 21 (twenty-one) business days after receipt of the information. BLE retrospective requests must be submitted no later than 60 days from the date the claim was rejected and will be answered within 30 days. Retrospective exception requests made on or after the 61st day from the claim rejection date will be denied.

I attest that the information provided and statements made herein are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider Signature: ___________________________  Date: ___________________________

Mail to:
Request for Benefit Limit Exception
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast, PO Box 654, Milwaukee, WI 53201

January 2018