South Carolina Department of Health and Human Services (SCDHHS) Dental Program

Dental Office Reference Manual

Updated: 08/02/2012

DentaQuest, LLC

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DentaQuest, LLC
Address and Telephone Numbers

DentaQuest's South Carolina Office
1333 Main Street, Suite 603
Columbia, SC 29201

Provider Call Center
888.307.6553

Fax: 800.461.2640
IVR: 888.307.6553

Via email -
Claims questions:
denclaims@dentaquest.com
Eligibility or Benefit Questions:
denelig.benefits@dentaquest.com

Beneficiary Call Center
888.307.6552

TDD (Hearing Impaired)
800.466.7566

Special Needs Beneficiary Services
800.660.3397

SCDHHS Fraud and Abuse Hotline
888.364.3224

Dental claims should be mailed to:
DentaQuest, LLC - Claims
PO BOX 2136
Columbia, SC 29202-2136
or e-mailed to:
eclaims@dentaquest.com

Electronic Claims should be sent:
Via the web - www.dentaquest.com
Via Clearinghouse
DentaQuest Systems Corporation
12121 N. Corporate Parkway
Mequon, WI 53092

Authorization requests should be sent to:
DentaQuest, LLC - Authorizations
PO BOX 2136
Columbia, SC 29202-2136

Prior authorizations for Hospital Operating Room Cases should be sent to:
DentaQuest, LLC - Authorizations
PO BOX 2136
Columbia, SC 29202-2136

Provider Appeals should be sent to:
DentaQuest, LLC
Utilization Management/Provider Appeals
12121 N. Corporate Parkway
Mequon, WI 53092
or faxed to:
262.834.3452

Beneficiary Grievance and Appeals
DentaQuest, LLC
Complaints and Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

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CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
8/2/12	Cover		Updated publication date
	9.00	35	Added link to electronic contact for Provider Enrollment
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
5/1/12		10	Updated Table of Contents
	1.00	13	Updated language on adult coverage
	2.01	15	Updated language on adult coverage
	2.06	18	Updated language on adult coverage
	4.06 and 4.07	24	Updated language on adult coverage
	Appendix B	41	Updated language on adult coverage
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
4/2/12	2.01	14	Updated sample member card
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
2/2/12		2	Updated email address for dental claim submission
		7	Added reference to addition of SCDHHS Provider Manual Section 1 as Appendix E
	2.01	14-15	Updated language on adult coverage
	2.06	17	Updated language on adult coverage
	2.07	18	Included information on broken appointment tracking
	4.03	23	Updated email address for dental claim submission
	4.06	24	Updated language on adult coverage
	4.07	25	Updated language on adult coverage
	4.12		Clarified language on timeframe for appeal requests
	4.14	27	Clarified language on dental charges associated with OR/ASC usage
	6.01		Clarified language on timeframe for appeal requests

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	Appendix B	42	Updated language outlining available benefits
	Appendix D	52	Included information on broken appointment tracking
	Appendix E		Added Dental Services Provider Manual Section 1
8/19/11	2.06	17	Updated beneficiary transportation information
4/14/11	2.04	16	Removed reference to copayment requirements for MR/RD Waiver members
4/7/11	1.00	12	Clarified language related to adult coverage
	1.02	12	Updated Provider Relations phone number
	2.01	14	Clarified language related to adult coverage
	2.04	16	Updated copayment requirements
	2.06	17	Updated language related to adult coverage
	3.00	19	Clarified review processes for prepayment review (PPR) and prior authorization (PA); clarified language related to adult coverage
	4.06	25	Clarified language related to adult coverage
	4.07	25	Clarified language related to adult coverage
	4.08	26	Updated copayment requirements
	4.15	28	Updated Provider Enrollment phone number
	4.16	28	Updated terminology for web portal
	6.00	31	Clarified appeal process
	9.00	36	Updated Provider Enrollment phone number
	Appendix A	38	Added definition for “medical condition”
	Appendix B	42	Clarified language related to adult coverage
	Exhibits A-C		Updated the following codes: D0140, D0240
	Exhibit B		Clarified language related to adult coverage; removed the following codes: 40700, 40701, 40702, 40720, 40761
10/21/10		2	Added fax number for submitting appeals
	3.03	20	Added instruction for submission of emergency authorization requests
	4.06	25	Clarified methods for indicating emergency services

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	Exhibit A		Updated the limitation of following codes: D0140, D0150, D0240, D0330, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2392, D2393, D2394
	Exhibit B		Updated the limitation of following codes: D0140, D0240, D7140, D7210
	Exhibit C		Updated the limitation of the following codes: D0120, D0145, D0150, D1110, D1120, D1203, D1204, D1206, D1351, D1510, D1515, D0210, D0270, D0272, D0330, D5110, D5120, D5211, D5212, D5510, D5520, D5610, D5640, D0140, D0240, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2392, D2393, D2394
7/12/10	Appendix B	42	Added instruction for tooth surface designation.
	Exhibits A - C		Revised instructions for codes requiring review and authorization requirements for planned Hospital or Ambulatory Surgical Center (ASC) usage. D9420 (hospital call) is to be included in authorization requests for planned Hospital or ASC usage.
	Exhibits A – C		Updated descriptions of the following codes: 21116, 21497, 31000, 31020, 31030, 31603, 31605, 40500, 40510, 40520, 40530, 40650, 40652, 40654, 40700, 40701, 40702, 40720, 40761, 41000, 41008, 41009, 41015, 41016, 41017, 41018, 41112, 41113, 41116, 41120, 41130, 41135, 41140, 41145, 41150, 41155, 41250, 41252, 41828, 42106, 42120, 42200, 42220, 42225, 42235, 42260, 42330, 42335, 42408, 42409, 42440, 42450, 88160
	Exhibit A		Updated descriptions of the following codes: D0120, D0145, D0150, D7280, D7550, D7671, D7771, D7910, D7911, D7912, D9420, 21210, 21215, 21240, 21242, 21243, 21340, 21356, 21360, 21365, 21385, 21423, 21433, 21436, 21454, 21461, 21462, 31040, 41874, 42205, 42210, 42215, 42550
	Exhibit B		Updated descriptions of the following codes: D0140, D0210, D0220, D0230, D0240, D0270, D0272, D0330, D7550, D7910, D7911, D7912, D9230, D9248, D9420, D7671, D7771, D9230, 20900, 20902, 21029, 21210, 21215, 21240, 21242, 21243, 21340, 21356, 21360, 21365, 21385, 21423, 21436, 21454, 21461, 21462, 31040, 42200, 42205, 42210, 42215, 42550, 88300
	Exhibit C		Updated the following codes: D7550, D7910, D7911, D7912, D9420, 21210, 21215, 21240, 21242, 21243, 21340, 21356, 21360, 21365, 21385, 21423, 21433, 21436, 21454, 21461, 21462, 31000, 31040, 41874, 42205, 42210, 42215, 42550
	Exhibit C		Changed Age Limitation from “All” to “21 and Older”
6/21/10		All	Removed references to *Healthy Connections Kids* (HCK)
	2.05	17	Clarified federal claim filing guidelines for dually eligible Medicare and Medicaid recipients.
	3.01	19	Revised definition of prior authorization.
	Appendix C	40	Clarified criteria for dental extractions do no extend to prophylactic removal of asymptomatic teeth such as third molars.
6/10/10	1.05	13	Expanded value-added service language regarding authorization coordination.
	3.01	19	Added clarification that “authorization” can be obtained via a prior authorization or pre-payment review.

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	4.02	23	Updated address for claim submission.
	4.05	24	Updated paper claim completion instructions.
	6.01	31	Clarified that complaint or appeal requests must be received within 30 calendar days.
	Appendix A	38	Revised definitions for “clean claim” and “prior authorization.”
	Appendix C	44	Updated documentation and procedure criteria to reflect what’s necessary for prepayment review as opposed to prior authorization.
	Appendix D.2	52	Dental Record recommendation language changed from “must” to “should.”

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Healthy Connections

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with Beneficiaries regarding dental treatment options.

2. Recommend a course of treatment to a Beneficiary, even if the course of treatment is not a covered benefit, or approved by the ***Healthy Connections*** program.

3. File an appeal or complaint pursuant to the procedures of ***Healthy Connections.*** Supply accurate, relevant, and factual information to any Beneficiary in connection with an appeal or complaint filed by the Beneficiary.

4. Object to policies, procedures, or decisions made by ***Healthy Connections.***

5. Charge an eligible ***Healthy Connections*** Beneficiary for dental services that are not Medicaid covered services only if the Beneficiary knowingly elects to receive the services as a private-pay patient and enters into an agreement in writing to pay for such services prior to receiving them. Non-covered services include: services not covered under the ***Healthy Connections*** plan and services for which prior authorization has been denied and deemed not medically necessary.

6. Determine to what extent they will participate in the ***Healthy Connections*** program (i.e. set patient panel size). However, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will render.

Providers have the responsibility to:

1. Protect the Beneficiaries' rights to privacy.

2. Comply with any applicable Federal and State laws that pertain to Beneficiary rights and not to discriminate against a Beneficiary on the basis of age, sex, race, physical or mental handicap, national origin, ethnicity, religion, sexual orientation, genetic information, economic status, source of payment or type, or degree of illness or condition.

   A provider may not refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability for the service(s). Reference: 42CFR447.20(b)

3. Notify Medicaid Provider Enrollment of any changes in their practice information, including: location, telephone number, limits to participation, Providers joining or leaving the practice, etc. via the Provider Update form, Attachment A-2.

4. Hold the ***Healthy Connections*** Beneficiaries harmless and shall not bill any Beneficiary for services if the services are not covered as a result of any error or omission by Provider.

5. Adhere to the ***Healthy Connections*** Provider Participation Agreement.

* * *

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DentaQuest makes every effort to maintain accurate information in this manual; however, DentaQuest will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

The Dental Services Provider Manual is composed of both the General Information and Administration section of the South Carolina ***Healthy Connections*** Manual (See Appendix E) and the South Carolina ***Healthy Connections*** Dental Office Reference Manual.

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Healthy Connections

Statement of Beneficiaries Rights and Responsibilities

Medicaid Enrolled Beneficiaries have Rights to the following regarding services received from a Medicaid provider:

1. **Civil Rights**
   The ***Healthy Connections*** enrolled providers cannot discriminate or mistreat a Medicaid eligible beneficiary because of race, sex, age, handicap, religion, national origin, political belief or limited English proficiency. If a Beneficiary feels they have not been treated fairly, they may call 1-803-898-2605 or 1-800-368-1019.

2. **Health Information Rights**
   The ***Healthy Connections*** program provides to the beneficiary a *Notice of Privacy Practices* with the beneficiary ID Card. This explains how health information about the beneficiary can be used or released. To obtain an additional copy of this notice, please call 1-888-549-0820 (toll-free).

3. **Beneficiary Appeals**
   Beneficiaries have the right to appeal to DentaQuest any adverse decision DentaQuest has made to deny, reduce or delay dental services. (Refer to Section 6.02 of this Dental ORM)

4. **Beneficiary Complaints (Grievances)**
   Beneficiaries may submit complaints to DentaQuest telephonically or in writing on any ***Healthy Connections*** dental program issues other than decisions that deny, delay, or reduce dental services. (Refer to Section 6.02 of this Dental ORM)

5. **State Fair Hearing**
   Beneficiaries have the right to request a State Fair Hearing from SCDHHS after any appeal to DentaQuest has been completed (Refer to Section 6.02 of this Dental ORM)

6. **Freedom of Choice**
   Except as otherwise specified in this manual, a ***Healthy Connections*** beneficiary has the right to choose any provider who is both enrolled in the Medicaid program and willing to accept the beneficiary as a patient.

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Dental Office Reference Manual
Table of Contents

Section		Page
1.00	What is *Healthy Connections*?	**13**
1.01	Dedicated Call Center for Providers	13
1.02	Provider Training	13
1.03	Provider Newsletters	13
1.04	DentaQuest Website	14
1.05	Other Value-Added Provider Benefits	14
2.00	Beneficiary Eligibility Criteria and Verification Processes	**15**
2.01	Eligibility and Identification Card Samples	15
2.02	DentaQuest Eligibility Systems	16
2.03	Documenting Beneficiary Eligibility	16
2.04	Beneficiary Co-Payments	17
2.05	Dual Eligibility	17
2.06	Beneficiary Transportation	18
2.07	Broken/Cancelled/Missed Appointment	18
3.00	Authorization for Treatment	**19**
3.01	Treatment Requiring Authorization – Prior Authorization and Prepayment Review	19
3.02	Authorization Requirements for Operating Room (OR) and Ambulatory Surgical Center (ASC) Cases	20
3.03	Expedited Prior Authorizations for Emergency Services	20
3.04	Payment for Non-Covered Services	21
3.05	Electronic Attachments	21
4.00	Claim Submission Procedures (claim filing options)	**22**
4.01	Electronic Claim Submission Utilizing DentaQuest's Website	22
4.02	Electronic Claim Submission via Clearinghouse	22
4.03	HIPAA Compliant 837D and 837P File	22
4.04	NPI Requirements for Submission of Electronic Claims	22
4.05	Paper Claim Submission	23
4.06	Filing Claims for the Provision of Emergency Medical (CPT) Procedures to Adults	24
4.07	Filing Claims for the Provision of Adult Services for Exceptional Medical Conditions	24
4.08	Coordination of Benefits (COB)	24
4.09	Fee Schedule and Charge Limits	25
4.10	Filing Limits	26
4.11	Claims for Retro-Eligible Beneficiaries	26
4.12	Claims Appeals	26
4.13	Receipt and Audit of Claims	26

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4.14 Claim Submission and Payment for Operating Room (OR) or Ambulatory Surgical Center (ASC) Cases 27
4.15 Electronic Funds Transfer 27
4.16 Electronic Remittance Statements 28
5.00 Health Insurance Portability and Accountability Act (HIPAA) 29
6.00 Grievances and Appeals 30
6.01 Provider Grievances and Appeals 30
6.02 Beneficiary Grievances and Appeals 30
7.00 Utilization Management Program 32
7.01 Introduction 32
7.02 Community Practice Patterns 32
7.03 Evaluation 32
7.04 Results 32
7.05 Fraud and Abuse (Policies 700 Series) 33
8.00 Quality Improvement Program (Policies 200 Series) 34
9.00 Provider Enrollment 35
9.01 Requirements for Provider Participation 35
9.02 Dental Hygienist Services in Public Health Dentistry under General Supervision 35
9.03 Out of State Providers 36
9.04 DentaQuest's General Information Form 36
APPENDIX A Definitions/Attachments
General Definitions A-1
Additional Resource Forms & Attachments (found at www.dentaquest.com) A-2
APPENDIX B Covered Benefits B-1
APPENDIX C Clinical Criteria 36
C.01 Criteria for Dental Extractions 36
C.02 Criteria for Prefabricated Stainless Steel Crowns 37
C.03 Criteria for Endodontics 38
C.04 Criteria for Authorization of Operating Room (OR) or Ambulatory Surgical Center (ASC) Cases 39
C.05 Criteria for Removable Prosthodontics (Full and Partial Dentures) 39
C.06 Criteria for Space Maintainers 41
C.07 Criteria for the Excision of Soft Tissue Lesions 41
C.08 Criteria for the Determination of a Non-Restorable Tooth 42
C.09 Criteria for General Anesthesia and Intravenous (IV) Sedation 42
APPENDIX D Recommendations/Suggestions
Reduce Broken/Canceled/Missed Appointments D-1
Dental Record D-2
Patient Recall System D-3

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APPENDIX E Section 1 of SCDHHS Dental Provide Manual……E

EXHIBITS

South Carolina Benefit Plan for Children ..... Exhibit A
South Carolina Benefit Plan for Adults (Exceptions for medically related conditions and covered CPT Procedures)…….....Exhibit B
South Carolina Benefit Plan for MR/RD Waiver Beneficiaries Only ..... Exhibit C

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1.00 What is *Healthy Connections*?

Healthy Connections is the state's Medicaid program operated by the South Carolina Department of Health and Human Services (SCDHHS).

The dental service component of ***Healthy Connections*** is administered by DentaQuest on an administrative services only (ASO) basis. DentaQuest processes claims based on SCDHHS' fee schedule and coverage policies, and SCDHHS, acting as its own fiscal agent, retains responsibility for claim payments to Providers.

Dental services are defined as any covered diagnostic, preventive, therapeutic, rehabilitative, or corrective procedure. Medical necessity or any referral information must be documented in the Beneficiary's medical record and must include a detailed description of services rendered. ***Healthy Connections*** does not cover services rendered for cosmetic purposes. Please reference Exhibits A, B, and C of this manual for detailed coverage criteria and guidelines.

Emergency adult dental (CDT) services are not covered benefits under ***Healthy Connections***. Limited exceptions are outlined in Sections 4.06 and 4.07.

DentaQuest's Value-Added Provider Benefits

1.01 Dedicated Call Center for Providers

DentaQuest offers Participating Providers access to call center representatives who specialize in areas such as:

- Eligibility, benefits and authorizations,
- Beneficiary access to care/Provider connections, and
- Claims

You can reach these representatives by calling 888.307.6553 from 8:00am-6:00pm Monday through Friday except on stated holidays.

1.02 Provider Training

DentaQuest offers free Provider training sessions periodically throughout the State of South Carolina. These sessions include important information such as: claims submission procedures, pre-payment and prior authorization criteria, how to access DentaQuest's clinical personnel, etc. In addition, Providers can contact the SC Provider Relations and Outreach Coordinator for assistance, or to request a personal, in-office visit, by calling: 803.758.0490.

1.03 Provider Newsletters

DentaQuest publishes periodic Participating Provider newsletters that include helpful information of interest to Providers. To view a copy of the DentaQuest Provider newsletter online, go to www.dentaquest.com Click on "About Us", next select "Newsletters" where a PDF version of the newsletter can be downloaded and saved or printed.

Information specifically for Healthy Connections Providers can be found through the DentaQuest website. Important announcements are placed on the homepage and resources can be found through the "Related Documents" link.

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1.04 DentaQuest Website

DentaQuest's website includes a "For Providers Only" web portal that allows Participating Providers access to several helpful options including:

- Beneficiary eligibility verification
- Claims submission
- Authorization Submission
- View claim status
- Create claim tracking reports
- Beneficiary treatment history
- Remittance Advices
- Event and training calendar
- Links to resources such as the SCDHHS fee schedule, Provider bulletins, and general oral health resources

For more information regarding DentaQuest's website, contact DentaQuest's SC Customer Service Department at 888.307.6553.

1.05 Other Value-Added Provider Benefits

Other value-added Provider benefits (detailed in other sections of this manual) include:

- Dedicated SC Project Director, Provider Relations and Outreach Coordinator, and Local Dental Consultants
- Defined Prior Authorization Requirements for Place of Service and Coordination of Approvals with Managed Care Organizations (MCOs)

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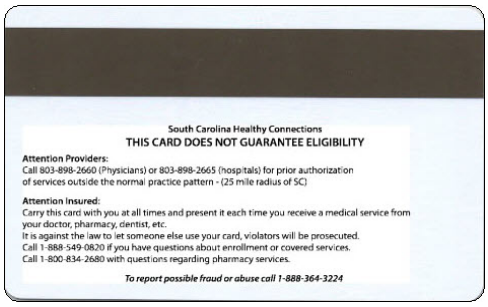
2.00 Beneficiary Eligibility Criteria and Verification Processes

2.01 Eligibility and Identification Card Samples

Medicaid Beneficiaries may receive dental services under ***Healthy Connections*** if they are eligible for Medicaid on the date of service. Dental Providers should contact DentaQuest via telephone, IVR or web portal to verify Beneficiary eligibility.

Beneficiaries will not receive a separate ***Healthy Connections*** ID card for dental services and may use their existing ***Healthy Connections*** ID card. A sample of the ID card is shown below***.***

SAMPLE ID CARD:



The ten-digit Medicaid Identification Number (Health Insurance Number) is located below the date of birth on the card. Possession of this card does not guarantee eligibility.

Comprehensive dental services available within ***Healthy Connections*** are available to Medicaid Beneficiaries from birth through the month of their 21st birthday and for Mental Retardation/Related Disabilities (MR/RD) Waiver Beneficiaries. The MR/RD Waiver program is administered by the South Carolina Department of Disabilities and Special Needs (SCDDSN). Beneficiaries applying for enrollment in the MR/RD Waiver program must meet specific guidelines based on their medical condition to be enrolled in the program. The MR/RD Waiver program has limited capacity and is not inclusive of all special needs Beneficiaries.

Dental services available to Medicaid Beneficiaries under age 21 and members of the MR/RD Waiver include:

- Diagnostic
- Preventive
- Restorative
- Surgical

Adult dental services are limited to emergency medical (CPT) procedures rendered by oral surgeons, as outlined in Section 4.06 and treatment resulting from exceptional medical conditions, as outlined in Section 4.07.*

Beneficiaries enrolled in the Family Planning Waiver or GAPS are not eligible for dental services.

* Please note that MCO plans may elect to cover adult dental procedures that are not a part of the ***Healthy Connections*** fee for service dental program benefits. Reimbursement for these non-covered procedures requires Provider enrollment in the MCO network and is paid directly by the MCO.

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2.02 DentaQuest Eligibility Systems

Participating ***Healthy Connections*** Providers must access Beneficiary eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the DentaQuest web portal, the "Providers Only" section of DentaQuest's website at www.dentaquest.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

Access to eligibility information via the Internet

DentaQuest's Web Portal currently allows Providers to verify a Beneficiary's eligibility as well as submit claims directly to DentaQuest. You can verify the Beneficiary's eligibility on-line by entering the Beneficiary's date of birth, the expected date of service and the Beneficiary's identification number or the Beneficiary's full last name and first initial.

To access the eligibility information via DentaQuest's website, simply go to our website at www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there, choose "South Carolina" and press "go." You will then be able to log in using your password and ID. . Once logged in, select "Patient" and then "Beneficiary Eligibility Search" and from there enter the applicable information for each Beneficiary you are inquiring about. You are able to check an unlimited number of Beneficiaries and can print off the summary of eligibility given by the system for your records.

First Time Users:

First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. Please contact DentaQuest's SC Customer Service Department at 888.307.6553 if you need assistance. You may contact DentaQuest's SC Customer Service between 8 AM and 6 PM Monday through Friday. Once logged in, select "eligibility look up" and enter the applicable information for each Beneficiary. You are able to check on an unlimited number of Beneficiaries and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the Interactive Voice Response IVR line:

Participating Dental Providers will use DentaQuest's Interactive Voice Response (IVR) line to verify Beneficiary eligibility.

Like the website, DentaQuest's IVR offers Participating Providers the convenience and flexibility of self service in accessing useful information such as eligibility, benefit information, and procedure history. The Provider IVR is available through our Customer Service Department at 888.307.6553. For access, Providers will need to have their NPI numbers and the last four (4) digits of their tax identification number (TIN) ready. A Participating Provider's TIN, on record as a part of Provider Enrollment, is most likely the federal employment identification number (EIN), but in select cases may be a social security number (SSN).

2.03 Documenting Beneficiary Eligibility

Beneficiaries must be eligible on the date of service for payment to be made. However, please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If a Participating Provider has documentation that a Beneficiary was verified as eligible for the date of service and yet the claim is denied due to a possible change in eligibility

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status after the date of service, the Provider will be paid for the services rendered. It is very important that Providers document the date and time that the Beneficiary eligibility was verified via IVR or by the Web Portal by printing a copy of the verification and keeping it in the beneficiaries' record. This will serve as proof that eligibility was verified.

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 888.307.6553. They will be able to assist you in utilizing either system.

2.04 Beneficiary Co-Payments

Section 1902(a)(14) of the Social Security Act permits states to require certain Beneficiaries to share some of the costs of Medicaid by imposing copayments upon them.

SCDHHS requires a copayment from Beneficiaries toward the cost of their care. Participating Providers should collect a dental copayment per date of service.

Effective for dates of service on or after April 1, 2011, the dental copayment for affected Beneficiaries has increased from $3.00 to $3.40 per date of service.

Medicaid Beneficiaries may not be denied services if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the Beneficiary of the responsibility for the copayment. It is the Provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims involving copayments.

When a beneficiary has Medicare or private insurance, the Medicaid copayment still applies per the policies outlined in this section. However, if the sum of the copayment and the Medicare/third party payment would exceed the Medicaid-allowed amount, the copayment should be adjusted or eliminated. In other words, though a Participating Provider may receive a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment should not contribute to the excess revenue.

Copayment Exclusions: Pursuant to federal regulations, the following are excluded from copayments:

- children under the age of 19;
- members of the Mental Retardation/Related Disabilities (MR/RD) Waiver;
- institutionalized individuals; and
- individuals receiving hospice care, family planning services, pregnancy-related services, and/or emergency services.

2.05 Dual Eligibility

Medicaid Beneficiaries who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Federal guidelines mandate that procedures filed on the CMS 1500 Claim Form for Beneficiaries that are dually enrolled in Medicare and Medicaid must be filed to Medicare before filing to Medicaid (even if the procedure is known to be non-covered by Medicare). Failure to file to Medicare first will result in denial of the claim. Dental procedures filed on the ADA Dental Claim Form are not subject to this federal guideline. Information regarding a Beneficiary's enrollment in Medicare will be available on the DentaQuest web portal. Providers may bill SCDHHS for Medicare cost sharing for Medicaid-covered services for dually-eligible Beneficiaries. Some dual eligibles are also Qualified Medicare Beneficiaries (QMB). If the dually eligible Beneficiary is also QMB, Providers may bill SCDHHS for Medicare cost sharing, for services that are covered by Medicare without regard to whether the service is covered

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by SCDHHS. Reimbursement for these services will be consistent with the SC State Medicaid Plan.

Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two (2) years from the date of service of discharge, or up to six (6) months following the date of Medicare payment, whichever is later.

2.06 Beneficiary Transportation

Transportation for medical and dental services is available to ***Healthy Connections*** Beneficiaries through a SCDHHS contract with transportation brokers servicing South Carolina. The guidelines for Beneficiaries or their parents/guardians to schedule transportation to a dental appointment are as follows:

- The transportation request must be made three days in advance for routine, scheduled appointment date(s).
- If the appointment is for an emergency, transportation arrangements can be made without the three day advance notice. The brokers will likely verify with Providers the nature of the visit.
- Beneficiaries will need to have their Medicaid card, the name and address of the dental Provider, and the date and time of the appointment.
- Beneficiaries over age 21 are not eligible for transportation for dental services unless the services are related to medical reasons as listed in Sections 4.06 and 4.07.
- Beneficiaries are not eligible for transportation to receive Medicaid non-covered services.
- Beneficiaries must call the broker in the county in which they reside to schedule the transportation.

Contact information for Beneficiaries to schedule transportation to a dental appointment is available at http://www.scdhhs.gov/TransportationFAQ.asp?ID=83&pType=Transportation. For assistance Beneficiaries should contact the appropriate broker based on the county where they reside. This information is also available from our Customer Service Center.

2.07 Broken/Cancelled/Missed Appointment

The Centers for Medicare and Medicaid Services (CMS) prohibit billing Medicaid Beneficiaries for broken, missed or cancelled appointments. Medicaid programs are State designed and administered with Federal policy established by CMS. Federal requirements mandate that Providers who participate in the Medicaid program must accept the payment of the agency as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. For more information, please refer to 42 USC § 1396a(a)(25)(c) (which is the United States Code) or 42 CFR § 447.15 (which is the United States regulation).

DentaQuest collects data on appointments reported as broken by ***Healthy Connections*** beneficiaries through the provider web portal. Effective January 1, 2012, providers are asked to record the incident(s) along with additional information cited with the cancellation or no-show. Providers can maintain reports of their individual broken appointment logs through the Provider Web Portal and the information can be compiled into an aggregated report for SCDHHS. Contact Customer Services at 888.307.6553 or see the Portal User Guide available in the “Related Documents” link on the Provider Web Portal for detailed instructions.

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3.00 Authorization for Treatment

3.01 Treatment Requiring Authorization – Prior Authorization and Pre-payment Review

Authorizations are a utilization tool that require Participating Providers to submit "documentation" associated with certain dental services for a Beneficiary. Participating Providers will not be paid if this "documentation" is not furnished to DentaQuest. Participating Providers must hold the Beneficiary and SCDHHS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered). Authorization can be made through prior approval or by prepayment review. Prior authorization is optional for covered procedures (see Review Requirements identified in Exhibits A-C).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest's operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria Appendix C). Please review these criteria as well as the benefits covered (see Exhibits A-C) to understand the decision making process used to determine payment for services rendered.

A. Prior Authorization – Dental services or treatment locations that require review by DentaQuest for determination of medical necessity and approval before delivery are subject to prior authorization. Proper documentation must be submitted with requests for prior authorization. A denial of authorization may be appealed if the provider feels that the request was submitted within the guidelines as stated.

After DentaQuest reviews the documentation and approves the authorization request, the submitting office shall be provided an authorization number. The authorization number will be provided within fifteen (15) calendar days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered. (For prior authorization only)

The prior authorization number is valid for the specific treatment requested, one time and will expire 6 months from the date of issue.

B. Pre-payment Review - Dental procedures that require review by DentaQuest for determination of medical necessity prior to reimbursement for the procedures. These procedures can be administered before determination of medical necessity is rendered but require submission of proper documentation for approval to process the claim.

Your submission of "documentation" should include:

1. Radiographs, narrative, or other information where requested (See Exhibits A -C for specifics by code)
2. CDT codes on the ADA dental claim form
3. CPT codes on the CMS 1500 medical claim form, when applicable

Your claims for CDT procedure codes (D codes) <u>must</u> be submitted on an ADA approved claim form (year 2006 or newer). Your claims for CPT procedure codes (medical codes) must be submitted on a CMS 1500 claim form.

The tables of Covered Services (Exhibits A-C) contain a column marked "Review Required". A "Yes" in this column indicates that the service listed requires that documentation be submitted with the claim for pre-payment review in order to be considered for reimbursement. The "Documentation Required" column will describe what information is necessary for pre-payment review.

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It is important not to submit original x-rays especially if they are the only diagnostic record for your patient. Duplicate films and x-ray copies of diagnostic quality, including paper copies of digitized images are acceptable. **DentaQuest does not generally return x-rays and other supporting documentation. However, if you wish to have your x-rays returned, they must be submitted with a self-addressed stamped envelope**.

3.02 Prior Authorization Requirement for Operating Room (OR) and Ambulatory Surgical Center (ASC) Cases

OR or ASC cases must be prior authorized. The Participating Provider should submit the prior authorization to DentaQuest. DentaQuest will review the case for medical necessity, and render an approval or denial of the planned treatment being administered in an OR or ASC setting. Once DentaQuest has approved the case, DentaQuest will coordinate authorization for non-dental services (example: facility and anesthesia) with SCDHHS and the Beneficiary's MCO as appropriate.

Please see section 4.13 for information on submitting claims for services performed in a non-dental setting.

3.03 Expedited Prior Authorizations for Emergency Services

In emergency situations, submitting a prior authorization and documentation may not be realistic if the Beneficiary's health or wellbeing is at risk. If a Provider prefers to obtain a Prior Authorization number before administering the service, the Prior Authorization request should indicate the emergency need. Prior Authorization requests made in emergency situations will be reviewed and the medical necessity determination will be made within seventy-two (72) hours of receipt. Authorization through pre-payment review may be appropriate when the need for emergency treatment does not permit an authorization to be obtained prior to treatment.

In requesting payment for emergency services, Providers should indicate the full word "EMERGENCY" in the "Notes" field on the ADA Claim Form (field #35) or field #24C on the CMS 1500 Claim Form.

To ensure a timely determination of your request for emergency authorization, we recommend the following submission methods:

Email
Scan and email your emergency request to DQSCEmergency@DentaQuest.com. Please remember to use encryption technology when sending protected health information via email. Please use the fax option if your office does not have encryption capabilities.

Fax
Fax your emergency request to 800.521.1735.

If your prior authorization request requires X-rays, please use one of the following methods to submit:

- NEA – please note the NEA number on your claim form
- Scan the diagnostic image and email it to DQSCEmergency@DentaQuest.com

If you do not have the capability to submit an NEA or image via email, you may still submit a prior authorization request. The request must include a narrative describing the emergent nature of the service. DentaQuest will verify the member's eligibility if the service is covered and determine if your narrative supports the proposed treatment. Your request will then be considered "approved – pending." This means the service is approved based on the information you provided, but does not guarantee payment. In

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order to receive payment, you must submit the claim and supporting documentation (please refer to the benefit tables in Exhibits A-C to verify required documentation for the submitted code). If the required documentation supports your initial prior authorization submission, the service will be fully approved and eligible for payment.

3.04 Payment for Non-Covered Services

Participating Providers shall hold Beneficiaries, DentaQuest, and SCDHHS harmless for the payment of Non-Covered Services except as provided in this paragraph. A Provider may charge an eligible ***Healthy Connections*** Beneficiary for dental services which are **NON-COVERED** services only if the Beneficiary knowingly elects to receive the services and enters into an agreement in writing to pay for such services prior to receiving them. Non-Covered Services include:

- Services not covered under the ***Healthy Connections*** plans
- Services for which prior authorization has been denied and deemed not medically necessary

3.05 Electronic Attachments

A. Electronic Prior Authorization Submission Utilizing Fast Attach™

DentaQuest accepts dental radiographs electronically via **FastAttach™** for prior authorization requests and pre-payment review. DentaQuest, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating ***Healthy Connections*** Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontal charts, intraoral pictures, narratives and EOBs.

FastAttach™ is inexpensive, easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for **FastAttach™** go to www.nea-fast.com or call NEA at:

800.782.5150

B. Electronic Prior Authorization Submission Utilizing DentaQuest's Website

Healthy Connections Participating Providers may submit Prior Authorizations directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting Prior Authorizations via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Beneficiary's eligibility prior to providing the service.

To submit prior authorizations via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose "South Carolina" and press "go." You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. Once logged in, select "Claims/Prior Authorizations" and then "Dental Pre-Auth Entry".

The Dentist Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the prior authorization.

If you need assistance in submitting prior authorizations through the DentaQuest web portal, please contact Customer Service at 888.307.6553.

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4.00 Claim Submission Procedures (claim filing options)

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

- Electronic claims via DentaQuest's website (www.dentaquest.com).
- Electronic submission via clearinghouses.
- HIPAA compliant 837D or 837P File.
- Paper claims (see Appendix A-2, for sample forms).

4.01 Electronic Claim Submission Utilizing DentaQuest's Website

Participating Providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Beneficiary's eligibility prior to providing the service.

To submit claims via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose "South Carolina" and press "go." You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. Once logged in, select "Claims/Prior authorizations" and then "Dental Claim Entry". The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you need assistance in submitting claims through the DentaQuest web portal, please contact Customer Service at 888.307.6553.

4.02 Electronic Claim Submission via Clearinghouse

Dentists may submit their claims to DentaQuest via Affiliated Network Services (ANS), EMDEON, Tesia, or EDI Health Group (EHG). DentaQuest's current relationship with ANS offers FREE transmission for ALL DentaQuest claims. Additional clearinghouses may be added in the future.

The DentaQuest Government Payer ID is CX014 for electronic claim filing. If your software vendor does not accommodate the Payer ID, be sure that the following address is sent on the claims:

DentaQuest Government
P.O. Box 2136
Columbia, SC 29202-2136

We recommend that you contact your software vendor to ensure DentaQuest Government is listed as a payer and confirm that the Payer ID and/or address are sent on the claims. Your software vendor will provide you with the information you need to ensure that submitted claims are forwarded to DentaQuest.

4.03 HIPAA Compliant 837D and 837P File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please contact the Systems Operations Department at 888.560.8135 or via e-mail at eclaims@dentaquest.com to inquire about this option for electronic claim submission.

4.04 NPI Requirements for Submission of Electronic Claims

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

- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately.
    - For claims with a Group NPI as the "Billing" provider, your claims must be submitted with both the Group (Type 2) NPI under "Billing Provider and Individual (Type 1) NPI under "Treating Provider." These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.

- In order to submit claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D or 837P format. This information can be found on the 837D or 837P Companion Guide located on the Provider Web Portal @ www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose "South Carolina" and press "go." You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access a copy of the most current Companion Guide.

4.05 Paper Claim Submission

- Claims with CDT procedure codes ("D" codes) must be submitted on an ADA approved dental claim form (year 2006 or newer). Claims with CPT procedure codes must be submitted on the CMS 1500 medical claim form (Appendix A-2).

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

- The paper claim must contain an acceptable Provider signature. 'Signature on File' is acceptable.

- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include a typed dentist (practice) name.

- The paper claim form must contain a valid Provider NPI (National Provider Identification) number. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.

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

- All services must be identified by either approved ADA dental or AMA professional codes as published in current CDT and CPT books, respectively, or by definition in this manual.

- 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.

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- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

- If documentation is required, please do not submit original x-rays especially if they are the only diagnostic record for your patient. Duplicate films and x-ray copies of diagnostic quality, including paper copies of digitized images are acceptable. **DentaQuest does not generally return x-rays and other supporting documentation. However, if you wish to have your x-rays returned, they must be submitted with a self-addressed stamped envelope**.

Claims should be mailed to the following address:

DentaQuest, LLC-Claims
PO BOX 2136
Columbia, SC 29202-2136

4.06 Filing Claims for the Provision of Emergency Medical (CPT) Procedures to Adults

As of January 1, 2012, adult Beneficiaries are eligible for coverage of emergency medical (CPT) procedures performed by oral surgeons. The listing of covered CPT codes is available in Exhibit B, along with review requirements and documentation that may be required for individual CPT codes.

In requesting payment for emergency services rendered to adult Beneficiaries on or after January 1, 2012, Oral Surgeons should indicate that the services were rendered as emergencies in field #24C on the CMS 1500 Claim Form. This indication can also be made by including the word “Emergency” in the “Notes” field when submitting claims through the DentaQuest Provider Web Portal.

Adult Beneficiaries are not eligible for emergency dental (CDT) procedures with the exception of qualifying treatment related to the medical conditions outlined in Section 4.07.

4.07 Filing Claims for the Provision of Adult Services for Exceptional Medical Conditions

Covered dental procedures (“D” codes listed in Exhibit B) delivered in preparation for, or during the course of treatment for one or more of the following medical reasons will be considered for payment:

- Organ Transplants
- Oncology
  - Radiation of the head and/or neck for cancer treatment
  - Chemotherapy for cancer treatment
- Total Joint Replacement
- Heart Valve Replacement
- Trauma Treatment performed in a hospital or Ambulatory Surgical Center (ASC)

Covered adult services are limited to dental procedures required for the treatment of the service exceptions listed above. The treating medical doctor or specialist must request the dental procedure(s) to be performed. The Dental Provider must determine medical necessity for the course of treatment for the requested procedure(s).

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All claims submitted for the treatment of the exceptions listed above are subject to pre-payment review. Prior authorization is optional.

Appropriate documentation from the Dental Provider **as well as the** treating medical doctor or specialist indicating treatment for one or more of the exceptions listed above must be submitted with the claim. Please refer to Exhibit B for the required documentation for each procedure code.

Claims for the treatment of the exceptions listed above must contain the words "Medical Condition" in the "Notes" field on the ADA claim form or within Field 19 on the CMS 1500 claim form.

4.08 Coordination of Benefits (COB)

Medicaid is always the payer of last resort. When other coverage is on record for a beneficiary, documentation of the primary carrier or carriers' coverage must be submitted on the claim or a copy of the primary carrier or carriers' Explanation of Benefits (EOB) can be attached to the claim. On paper ADA claims, Providers should include the South Carolina three-digit carrier code or codes in Field 9, the policy number or numbers in Field 8 and amount paid or amounts paid in Field 11. CMS 1500 claim submissions should reflect the carrier code or codes in Field 9a, the policy number or numbers in Field 9d, and amount paid or amounts paid in Field 10d. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier or carriers' payment meets or exceeds the SCDHHS dental service fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim. The Provider may not bill the Beneficiary for any difference between SCDHHS' payment and the Provider's billed amount, or request to share in the cost through a co-payment or similar charge. Providers are expected to take reasonable measures to ascertain any and all third party resource or resources available to the Beneficiary and to file a claim with that party or parties prior to filing the claim to DentaQuest.

> *A provider may not refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability for the service(s).* Reference: 42CFR447.20(b)

A provider may not require payment for a Medicaid covered service from a Beneficiary with third party coverage and repay the Beneficiary after receiving reimbursement from third party coverage and Medicaid.

Please contact Customer Service at 888.307.6553 with any questions regarding the submission of other carrier information to DentaQuest.

4.09 Fee Schedule and Charge Limits

The current SCDHHS fee schedule for covered dental services is available in the "Related Documents" section of the Provider Web Portal at www.dentaquest.com.

Providers may not charge SCDHHS any more for services to a Beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the established Medicaid reimbursement rate, determined by the program, or the Provider's charges, whichever is lower. The ***Healthy Connections*** program will not pay for services or items that are furnished gratuitously without regard to the Beneficiary's ability to pay, or where no payment from any other source is expected, such as free x-rays. Billing covered procedures prior to the date of service is prohibited. Refer to Exhibits A, B or C of this manual for covered services.

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4.10 Filing Limits

The timely filing requirement for the ***Healthy Connections*** programs is three hundred sixty-five (365) calendar days from the date of service and receipt of claim. DentaQuest 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.

Providers cannot bill the Beneficiary for claims denied for "untimely filing."

Timely Filing and Coordination of Benefits

When a Beneficiary has other health insurance coverage, the timely filing limit still begins with the date of service on the claim, regardless of the payment or claim denial date by any other company.

4.11 Claims for Retro-Eligible Beneficiaries

Claims involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Be received and entered into the claims processing system within six (6) months of the Beneficiary's eligibility being added to the Medicaid eligibility system; and
- Be received within three (3) years from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three (3) years old will not be considered for payment.
- One of two forms of documentation verifying retroactive eligibility must be included with each claim filed for retro claims processing:
    - An SCDHHS form 945 or
    - A system generated retro-eligibility letter

Both documents may be obtained by the Beneficiary from their county SCDHHS office. DentaQuest does not have authority to issue either version of documentation to prove retro-eligibility.

4.12 Claim Appeals

A Provider may appeal any adverse decision DentaQuest has made to deny, delay or suspend covered dental services. Providers may appeal in writing to DentaQuest within thirty (30) days of the date of receipt of the notice of adverse action or thirty (30) days from receipt of the remittance advice reflecting the denial, whichever is later. Upon completion of the DentaQuest appeal process, Providers may appeal to the South Carolina Department of Health and Human Services (SCDHHS). The Grievances and Appeals processes are outlined in Section 6.00.

4.13 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each Participating ***Healthy Connections*** Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Beneficiary eligibility, procedure codes and dentist identifying information. A DentaQuest Claim Resolution Specialist analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer

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Service Department at 888.307.6553 with any questions you may have regarding claim submission or your remittance.

An “explanation of benefit” statement (EOB) accompanies the remittance advice posted on the Provider Web Portal. This report includes patient information and the allowable fee for each service rendered.

4.14 Claim Submission and Payment for Operating Room (OR) or Ambulatory Surgical Center (ASC) Cases

Facility and anesthesia services for OR or ASC cases require prior authorization. Requirements to attain approval are outlined in Section 3.02.

Claims related to the facility and anesthesia services rendered in a non-dental setting will be handled as follows:

A. Facility

- All claims for facility charges, regardless of the Beneficiaries’ enrollment in a Managed Care Organization, should be submitted by the facility directly to SCDHHS for processing and reimbursement.

B. Anesthesia

- Dental Providers may not bill Medicaid for anesthesia services when performed in an OR or ASC setting. Only the anesthesia provider group associated with the hospital or ASC facility may bill Medicaid for those services.

- If a member is enrolled in a Managed Care Organization (MCO) program on the date of service, claims for anesthesia services should be filed directly to the MCO for processing.

- If a member is enrolled in the traditional Fee For Service (FFS) program on the date of service, claims for anesthesia services should be filed directly to SCDHHS for processing.

C. Dental Services

- All claims for covered dental services, regardless of the Beneficiary’s managed care enrollment, should be sent directly to DentaQuest for processing.

4.15 Electronic Funds Transfer

Electronic Funds Transfer (EFT) is a more cost effective and secure manner for providers to receive payments. SCDHHS requires providers to register for EFT in order to receive reimbursement from South Carolina Medicaid. Providers can register for EFT Medicaid payments in one of three ways:

- Go to: http://www.scdhhs.gov/dhhsnew/hipaa/index.asp and select "Electronic Funds Transfer (EFT) Agreement" for instructions.
- Contact SC Medicaid Provider Enrollment at 888.289.070.
- Complete and return an Authorization Agreement for Electronic Funds Transfer. Link to a sample form can be found in Appendix A-2 of this manual.

The EFT process takes approximately three weeks to successfully complete. During this time, the provider will continue to receive hard copy checks. On the fourth week, the reimbursement amount will be deposited directly into the provider's account.

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4.16 Electronic Remittance Statements

Healthy Connections Participating Providers are required to access their explanations of benefits (EOBs) /remittance statements electronically via DentaQuest's Provider Web Portal. Providers may access their remittance statements by following these steps:

1. Login to the Portal at www.dentaquest.com
2. Under the Documents header, select **Claim Search**.
3. Click on the **Explanation of Benefits** button to display the remittance notice.
4. Click on the **View** button at the right end of the specific remittance that you would like to view.
5. The EOB will display on the screen in a PDF format.

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5.00 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare Provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. A component of our compliance plan is working cooperatively with Providers to comply with the HIPAA regulations, including the following:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.

- Safeguarding of all information about Beneficiaries according to applicable state and federal laws and regulations. All material and information, in particular information relating to Beneficiaries or potential Beneficiaries, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.

- Neither DentaQuest nor Provider shall share confidential information with a Beneficiary's employer absent the Beneficiary's consent for such disclosure.

- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT 2010 and CPT 2010) recognized by the ADA and AMA. SCDHHS and DentaQuest require Providers to submit all claims with the proper codes listed in this manual. In addition, all paper claims with CDT procedure codes must be submitted on the current approved ADA claim form (year 2006 or later) and all CPT procedure codes must be submitted on the CMS 1500 claim form, when applicable.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 888.307.6553 or via e-mail at denelig.benefits@dentaquest.com.

Please find a link to the online ANSI Companion Guide (Appendix A-2) for Dental Healthcare Transactions.

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6.00 Grievances and Appeals

6.01 Provider Grievances and Appeals

Participating Providers that disagree with determinations made by DentaQuest Dental Directors may submit a written Notice of Appeal to DentaQuest that specifies the nature and rationale of the disagreement. Please complete the Provider Appeals Form (link found in Appendix A-2) and follow the instructions on the form. This notice *and* additional support information must be sent to DentaQuest at the address below within thirty (30) days of the date of receipt of the notice of adverse action or thirty (30) days from receipt of the remittance advice reflecting the denial, whichever is later.

DentaQuest, LLC
Attention: Utilization Management/Provider Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

Appeals can also be faxed to: 262.834.3452

DentaQuest will respond in writing with its decision to the Provider. If DentaQuest upholds the denial the Provider may appeal to the South Carolina Department of Health and Human Services (SCDHHS). The appeal must be in writing and sent within thirty (30) calendar days from the final date of appeal decision letter from DentaQuest. Appeals to SCDHHS must be sent to the following address:

Division of Hearings and Appeals
South Carolina Department of Health and Human Services
PO BOX 8206
Columbia, SC 29202-8206

6.02 Beneficiary Grievances and Appeals

Complaints (Grievances)

Beneficiaries may submit complaints to DentaQuest telephonically or in writing on any ***Healthy Connections*** dental program issues other than decisions that deny, delay, or reduce dental services. Some examples of complaints include: the quality of care or services received, access to dental care services, Provider care and treatment, or administrative issues. Beneficiary complaints should be directed to:

DentaQuest, LLC
Healthy Connections
Attention: Complaints and Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

DentaQuest will respond to Beneficiary complaints immediately, if possible, however, each complaint will be addressed no later than thirty (30) calendar days from the date the complaint (grievance) is received.

Beneficiary Appeals

Beneficiaries have the right to appeal any denial or adverse decision DentaQuest has made to deny, reduce or delay dental services. Beneficiaries may request assistance with filing an appeal by contacting DentaQuest at 888.307.6552. Beneficiaries may send appeal requests to DentaQuest at the address listed above within thirty (30) calendar days receipt of the adverse decision notice. DentaQuest will respond in writing to

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Beneficiary appeals within thirty (30) days of the date of receipt, or within three (3) days if the condition needs immediate attention.

State of South Carolina Department of Health and Human Services Fair Hearing Process

Beneficiaries also have the right to appeal to SCDHHS after a denial or adverse decision is received in the DentaQuest appeal process. Requests for a fair hearing must be sent in writing within thirty (30) calendar days receipt of DentaQuest's adverse decision to:

Division of Hearings and Appeals
South Carolina Department of Health and Human Services
PO BOX 8206
Columbia, SC 29202-8206

Note: Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 888.307.6553.

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7.00 Utilization Management Program

7.01 Introduction

Under the provisions of federal regulations, the ***Healthy Connections*** programs must provide for continuing review and evaluation of the care and services paid through Medicaid and SCDHHS, including review of utilization of the services by Providers and by Beneficiaries. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. DentaQuest conducts periodic utilization reviews on all Providers. In addition, DentaQuest conducts compliance reviews on Providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals. Participating ***Healthy Connections*** Providers are responsible for ensuring that requirements for services rendered are met in order to receive payment for services. Under the Medicaid Provider Participation Agreement the Provider also agrees to give access to records and facilities to program representatives upon reasonable request. This section provides information on utilization review and control requirement procedures conducted by program personnel.

7.02 Community Practice Patterns

In following with the requirements described in Section 7.01 above, DentaQuest has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist's treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the "community practice patterns" of local dentists and their peers. With this in mind, DentaQuest's Utilization Management Programs are designed to ensure the fair and appropriate use of Federal and State program dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

DentaQuest will monitor the quality of services delivered under SCDHHS Provider Agreements and initiate corrective action where necessary to improve quality of care, in accordance with that level of dental care which is recognized as acceptable professional practice in the respective community in which the Participating Provider practices and/or the standards established by SCDHHS for the ***Healthy Connections*** Dental Program.

7.03 Evaluation

DentaQuest's Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment;
- Patient treatment planning and sequencing;
- Types of treatment;
- Treatment outcomes; and
- Treatment cost effectiveness.

7.04 Results

With the objective of ensuring the fair and appropriate distribution of budgeted SCDHHS Dental Program dollars, DentaQuest's Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice

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patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information, Participating Providers may be asked to implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement. Providers will be required to refund payments if they are found to have billed contrary to law, regulation, or SCDHHS policy or failed to maintain adequate documentation to support their claims. Providers have the right to appeal these review findings in accordance with the procedures described in policy 6.01.

7.05 Fraud and Abuse (Policies 700 Series)

DentaQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse for the ***Healthy Connections*** are defined as:

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

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

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

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

DentaQuest will work closely with SCDHHS' Bureau of Compliance and Performance Review to ensure that Medicaid funds are used effectively, efficiently, and in compliance with applicable state and federal laws and policies.

If at any time you suspect a health care Provider or a Beneficiary is using the Medicaid program in an abusive or fraudulent manner, please call the Program Integrity Medicaid Fraud and Abuse Hotline at 888.364.3224.

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8.00 Quality Improvement Program (Policies 200 Series)

DentaQuest currently administers a Quality Improvement Program. The Quality Improvement Program includes but is not limited to:

- Beneficiary satisfaction surveys
- Provider satisfaction surveys
- Random Chart Audits
- Beneficiary Grievance Monitoring and Trending
- Peer Review Process
- Utilization Management and practice patterns
- Quarterly Quality Indicator tracking (i.e. Beneficiary complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's QI Program, is available upon request by contacting DentaQuest's Customer Service department at 888.307.6553 or via e-mail at:

denelig.benefits@dentaquest.com

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9.00 Provider Enrollment

SCDHHS maintains responsibility for the enrollment of Participating Providers. Dentists licensed by and residing in the State of South Carolina are qualified to enroll and participate in the ***Healthy Connections*** program. DentaQuest can supply interested Providers with the SCDHHS Participating Provider enrollment packet; however, Providers seeking specific information on enrollment should contact:

Medicaid Provider Enrollment
P.O. Box 8809
Columbia, SC 29202-8809
888.289.0709

Providers can also submit an online inquiry at http://scdhhs.gov/contact-us.

9.01 Requirements for Provider Participation

To participate in the Medicaid program, a provider must meet all of the following requirements:

- Be licensed by and physically located in South Carolina or within a twenty-five (25) mile radius of the state border.
- Licensure by the appropriate licensing body, certification by the standard-setting agency and/or other pre-contractual approval processes established by SCDHHS.
- Enrollment in the South Carolina Medicaid program
    - All rendering providers must be enrolled in the Medicaid program
    - Enrolled providers are prohibited from using their NPI to bill Medicaid for services rendered by a non-enrolled dentist.
- Obtain a National Provider Identifier (NPI) and share it with South Carolina Medicaid. Refer to https://nppes.cms.hhs.gov for additional information about obtaining an NPI.
- Continuously meet South Carolina licensure requirements of their respective professions or boards in order to maintain Medicaid enrollment

9.02 Dental Hygienist Services in Public Health Dentistry under General Supervision

Dental hygienists are not authorized to practice independently within the South Carolina Medicaid program. All services provided by a registered dental hygienist must be supervised by a dentist licensed by the state of South Carolina. The licensed supervising dentist is the authorizer of dental hygiene services.

General supervision means that a licensed dentist or DHEC public health dentist has authorized the procedure to be performed but does not require that a dentist be present when the procedure(s) is performed. A dentist, licensed by and located in the state of South Carolina must supervise dental hygienists participating in DHEC's public health programs. SC Medicaid requires a supervising entity (physician, dentist, or any program that has a supervising health professional component) to be physically located in SC or within the 25 mile radius of the SC border. Procedures authorized by the supervised dentist under the public health programs must be detailed in Standing Orders to the dental hygienist and must be detailed in DHEC's approved screening system, designated as "Guidelines".

For billing purposes, claims submitted by a dental hygienist must include the authorizing/supervising dentist as identified and required in the DHEC Memorandum of Agreement (MOA). The licensed dentist authorizing dental hygiene procedures performed under general supervision in a DHEC public health setting and pursuant to the DHEC MOA would be considered the provider of services for billing purposes and must be enrolled in the S. C. Medicaid program. SCDHHS requires that a copy of the signed DHEC MOA be submitted by September 30th of each year. Copies of any changes to the DHEC MOA must be submitted to SCDHHS within 10 days of approval by DHEC.

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9.03 Out of State Providers

Dentists located outside of the twenty-five (25) mile service area radius may provide **only** emergency dental services to eligible ***Healthy Connections*** beneficiaries. The dentist will be required to enroll as a Participating Provider with SCDHHS to receive reimbursement. Contact SCDHHS Provider Enrollment for further information.

9.04 DentaQuest's General Information Form

Newly enrolling ***Healthy Connections*** Providers are required to complete and submit a DentaQuest General Information Form with their registration. This supplemental form captures additional Provider and practice information that DentaQuest makes available to Providers and Beneficiaries through its Customer Service Center and Web Portal.

Currently Medicaid enrolled Providers are asked to complete the General Information Form and supply it to DentaQuest so that complete practice information is available as a resource to Beneficiaries.

A link to the South Carolina General Information Form can be found in the Appendix. The document can also be requested by contacting the Customer Service Center at 888.307.6553.

If you are currently enrolled as a Participating Provider, please submit completed forms directly to DentaQuest by,

Mail to:

DentaQuest, LLC – Provider Information
P.O. Box 2136
Columbia, SC 29202-2136

Email: provider.updates@dentaquest.com

Fascimile: 800.461.2640

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APPENDIX A
Definitions & Attachments

A-1 General Definitions

The following definitions apply to this Office Reference Manual:

A. "Agreement" or "Provider Agreement" means the contract between SCDHHS and Provider.
B. "Beneficiary" means any individual who is eligible to receive covered services provided under the ***Healthy Connections*** program.
C. "Claim" means any bill or claim made by or on behalf of a Beneficiary or the Participating Provider to DentaQuest for the provision of covered services under the ***Healthy Connections*** dental program.
D. "Clean claim" means a claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in a State's claim system. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
E. "Covered Services" means a dental health care service, including those services covered through the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program that satisfies all of the following criteria:

- Is medically necessary;
- Is covered under the ***Healthy Connections*** dental program;
- Is provided to an enrolled Beneficiary by a Participating Provider;
- Is the most appropriate supply or level of care that is consistent with professionally recognized standards of dental practice within the service area and applicable policies and procedures.

F. "DentaQuest" shall refer to DentaQuest, LLC, formerly Doral Dental USA, LLC.
G. EPSDT" means the Early and Periodic Screening, Diagnosis, and Treatment program for persons under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)43, 1396d(a) and (r) and 42 C.F.R. Part 441, Subpart B to ascertain children's individual physical and mental illness and conditions discovered by the screening services, whether or not such services are covered.
H. "***Healthy Connections***" is the name of the program provided to South Carolina Medicaid Beneficiaries under the direction of SCDHHS.
I. "Medical Condition" in relation to adult Beneficiaries means the exceptions outlined in Section 4.07 that may allow an adult Beneficiary to be eligible for necessary dental treatment under ***Healthy Connections***.
K. "Medically Necessary" means covered medical, dental, behavioral, rehabilitative or other health care services which:

- Are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitation in function, cause illness or infirmity, endanger life, or worsen a disability;
- Are provided at appropriate facilities and at the appropriate levels of care for the treatment of a Beneficiary's medical conditions;
- Are consistent with the diagnoses of the conditions;
- Are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency and independence; and
- Will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

L.. "Participating Provider" or "Provider" is a dental professional or facility that has a

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written participation agreement in effect with SCDHHS to provide dental services to Beneficiaries of the ***Healthy Connections*** programs.

M "Prior Authorization" is not required for covered procedures, but is required for planned, ordinary use of an operating room or ambulatory surgical center. Proper documentation, such as a treatment plan, narrative of medical necessity, radiographs and/or other supporting documentation must be submitted with requests for prior authorization.

N. "Pre-payment Review" is allowed for procedures that require review for medical necessity prior to payment of the claim but retrospective to administration of the services. Proper documentation of medical necessity must be submitted with services requiring pre-payment review.

O. "Service area" means the State of South Carolina and locations within a twenty-five (25) mile radius of its border.

P. "SCDDSN" means the South Carolina Department of Disabilities and Special Needs, which handles enrollment for the Mentally Retarded / Related Disabilities (MR/RD) Waiver program.

Q. "SCDHEC" means the South Carolina Department of Health and Environmental Control, which is charged with responsibility for public health programming within the state.

R. "SCDHHS" means the South Carolina Department of Health and Human Services, the state's Medicaid agency.

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A-2 Additional Resource Forms & Attachments

Welcome to the DentaQuest Provider forms and attachment resource page. The link below provides methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website (www.dentaquest.com). Once you have entered the website, click on the "Dentist" icon. From there choose "South Carolina" and press "go." You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

- Dental Office Reference Manual (ORM)
- ADA Dental Claim Form and Instructions
- CMS 1500 Health Insurance Claim Form and Instructions
- SCDHHS Form 205 (Provider Refund Form)
- SCDHHS Form 130 (Void/Adjustment Form)
- Provider Appeal Form
- Provider Update Form
- 837D and 837P Companion Guides
- ***Healthy Connections*** Fee Schedule
- SCDHHS Provider Bulletins

This link also provides sample documents that you might find helpful for use in your office.

- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment

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APPENDIX B
Covered Benefits

B-1 Covered Benefits (See Exhibits A-C)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for ***Healthy Connections*** Beneficiaries under age 21.

Healthy Connections Beneficiaries 21 and over not eligible for dental benefits unless:

- the service is a covered medical procedure (CPT) performed in an emergency situation by a participating Oral Surgeon; and/or
- the service meets the medical necessity outlined for exceptions detailed in Section 4.07.

Exhibit C shows the covered benefits available to enrollees of the MR/RD Waiver Program.

Providers with benefit questions should contact DentaQuest's Customer Service Department directly at:

888.307.6553

Tooth Numbering

DentaQuest recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review.

Tooth Surfaces

DentaQuest recognizes tooth surfaces M – Mesial, D – Distal, and L – Lingual for all primary and permanent teeth.

The appropriate restored surfaces on the following teeth must be designated either O – Occlusal or B - Buccal:

- Permanent Posterior Teeth - # 1, 2, 3, 4, 5, 12, 13, 14 to 21, 28, 29, 30, 31, and 32
- Primary Posterior Teeth - # A, B, I, J, K, L, S and T

The appropriate restored surfaces on the following teeth must be designated either I – Incisal or F – Facial:

- Permanent Anterior Teeth - # 6, 7, 8, 9, 10 11, 22, 23, 24, 25, 26, and 27
- Primary Anterior Teeth - # C, D, E, F, G, H, M, N, O, P, Q and R

These codes must be referenced in the patient's file for record retention and review.

All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.

The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT or American Medical Association CPT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. Complete copies of the code books can be purchased from the following:

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CDT Code Book
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
800.947.4746

CPT Code Book
American Medical Association
515 North State Street
Chicago, IL 60654
800.621.8335

Furthermore, DentaQuest subscribes to the definition of services performed as described in the appropriate code manual.

The benefit tables (Exhibits A-C) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. the ADA or AMA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA/CMS 1500 claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to prior authorization, pre-payment review, or any other applicable benefit limitations.

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APPENDIX C
Clinical Criteria

C. Clinical Criteria

The criteria outlined in DentaQuest's Dental Office Reference Manual are based around procedure codes as defined in the American Dental Association Current Dental Terminology (CDT) Manual and the American Medical Association Current Procedural Terminology (CPT) Manual. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives.

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

The following criteria are intended to provide a better understanding of the decision-making process for reviews. This section provides some generalized criteria, there may be additional program specific criteria outlined by SCDHHS regarding treatment. Therefore it is essential you review the "Benefits Covered" Section before providing any treatment.

C.01 Criteria for Dental Extractions

Some procedures require pre-payment review. Please refer to the benefit tables for specific requirements by code for ***Healthy Connections***.

Documentation needed for review:

- Appropriate pre- treatment radiographs clearly showing the adjacent and opposing teeth should be submitted for review: bitewings, periapicals or panorex, pathology reports to be included in the Beneficiaries' treatment record.
- Brief narrative demonstrating medical necessity or pathology report.
- Medical justification and documentation including laboratory prescription slips, and laboratory tests.

Criteria

Extractions that do not meet criteria:

- The removal of primary teeth whose exfoliation is imminent.
- The removal of multiple teeth that are non-symptomatic at the time of the service is not covered for Beneficiaries over 21.
- Multiple procedures performed, i.e. cyst removal and extraction procedures or surgical access to aid eruption and extraction codes, on the same date of service on the same site will not be reimbursed.
- Surgical Access of An Unerupted tooth (code D7280) is covered to expose the crown of an impacted permanent tooth not intended to be extracted.
- Biopsy of Oral Tissue (code D7285 & D7286) is not billable with another surgical procedure that is part of the same procedure.

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C.02 Criteria for Prefabricated Stainless Steel Crowns

Pre-payment review is not required for Stainless Steel Crowns; however treatment must meet established criteria when reviewed as part of a standard post-service audit.

Suggested documentation to retain in the patient record:

- Appropriate pre- and post-treatment radiographs clearly showing the adjacent and opposing teeth should be kept in the patient record for review: bitewings, periapicals or panorex.
- Medical justification and brief narrative demonstrating medical necessity if radiographs are not available.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.
- Stainless Steel Crowns on permanent teeth are expected to last five years.

Stainless Steel Crowns will not meet treatment criteria if:

- A more conservative means of restoration is possible
- Tooth has subosseous and/or furcation caries
- Tooth has advanced periodontal disease
- Tooth is a primary tooth with exfoliation imminent
- Crowns are being planned to alter vertical dimension

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C.03 Criteria for Endodontics

Pre-payment review is required for Endodontic treatment.

Documentation needed for review of procedure:

- Sufficient and appropriate pre- treatment radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be maintained in the patient record.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).

- The general oral condition does not justify root canal therapy due to loss of arch integrity.

- Root canal therapy is for third molars, unless they are an abutment for a partial denture.

- Tooth does not demonstrate 50% bone support.

- Root canal therapy is in anticipation of placement of an overdenture.

- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

C.04 Criteria for Authorization of Operating Room (OR) or Ambulatory Surgical Center (ASC) Cases

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Documentation needed for authorization of procedure:

- Treatment Plan
- Brief narrative describing medical necessity for OR or ASC usage

Operating Room (OR) or Ambulatory Surgical Center (ASC) Cases Must be Prior Authorized.

Criteria

In most cases, an OR or ASC location will be prior authorized (for procedures covered by ***Healthy Connections***) if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Beneficiary convenience.

- Beneficiaries requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – Beneficiaries with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, chest pain, etc. Class IV – Beneficiaries with severe systemic disease that is a constant threat to life).

- Medically compromised Beneficiaries whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.

- Beneficiaries requiring extensive dental procedures with a medical history or complex medical condition that renders in-office treatment not medically appropriate.

- Beneficiaries requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.

- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

C.05 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Pre-payment review is required for Prosthodontic treatment.

Documentation needed for review of procedure:

- Appropriate pre-treatment radiographs clearly showing the adjacent and opposing teeth must be submitted for review: bitewings, periapicals or panorex.

- Adjustments, relines, and/or rebases are non covered services.

Criteria

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

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- A denture is determined to be an initial placement if the Beneficiary has never worn a prosthesis. Initial placement does not refer to the first time a Beneficiary is seen and treated by a given Provider.

- Partial dentures are covered only for beneficiaries with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.

- As part of any removable prosthetic service, dentists are expected to instruct the Beneficiary in the proper care of the prosthesis.

- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures); it must be at least 3 years old and unserviceable to qualify for replacement.

- In general, a partial denture will be approved for benefits if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full sized teeth.

Reviews for Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 3 years old and unserviceable.

- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.

- If there are untreated cavities or active periodontal disease in the abutment teeth.

- If abutment teeth are less than 50% supported in bone.

- If the Beneficiary cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped).

- If the Beneficiary has a history or an inability to wear a prosthesis due to psychological or physiological reasons.

- If a partial denture, less than three years old, is converted to a temporary or permanent complete denture.

- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the Beneficiary. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the partial denture meet functional criteria.

- If there is a pre-existing prosthesis, it must be at least 3 years old and unserviceable to qualify for replacement.

- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

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- All prosthetic appliances shall be seated in the mouth before a claim is submitted for payment.

- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Beneficiaries must be eligible on that date in order for the denture service to be covered. In addition, there may be coverage for dentures in cases where extractions are performed in conjunction with an authorized denture or final impression while the Beneficiary is still eligible.

C.06 Criteria for Space Maintainers

- Space maintainers are performed to prevent tooth movement and maintain the space for eruption of a permanent tooth when the deciduous tooth has been lost prematurely.

- The procedure is reimbursable once per lifetime and includes any follow-up care and/or re-cementing, if necessary.

- The space maintainer must be cemented prior to submitting a claim for reimbursement.

- Space maintainers are not reimbursable when the eruption of the permanent tooth is imminent.

C.07 Criteria for the Excision of Soft Tissue Lesions

To ensure the proper seating of a removable prosthesis (partial or full denture) some treatment plans may require the removal of excess tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal is an appropriate course of treatment prior to fabrication of the prosthesis.

Pre-payment review is required for Surgical Excision of Soft Tissue Lesions.

Documentation needed for review of procedure:

- Appropriate radiographs and/or intraoral photographs which clearly identify the must be submitted for review; bitewings, periapicals or panorex

- Brief narrative of medical necessity, if appropriate

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C.08 Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the Beneficiary is such that an alternative treatment plan would be better suited to meet the Beneficiary's needs.

C.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Pre-payment review is required for adjunctive services; services must meet the following criteria for approval.

Documentation needed for review of procedure:

- Treatment plan
- Brief narrative describing medical necessity for General Anesthesia or IV Sedation

Criteria

Use of for general anesthesia or IV sedation will be authorized if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth
- Surgical root recovery from maxillary antrum
- Surgical exposure of impacted or unerupted cuspids
- Radical excision of lesions in excess of 1.25 cm

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension)
- Underlying hazardous medical condition which would render the Beneficiary non-compliant

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- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective

- Younger Beneficiaries with extensive procedures to be accomplished

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APPENDIX D
Recommendations/ Suggestions

D-1 Reducing Broken/Canceled/Missed Appointments

Broken appointments are a major concern for SCDHHS and DentaQuest. We recognize that broken appointments are a costly and unnecessary expense for Providers. Our goal is to remove any barriers that prevent dentists from participating in the ***Healthy Connections*** program as well as barriers that prevent our Beneficiaries from utilizing their benefits.

We encourage you to utilize the Broken Appointment Log available in the Provider Web Portal to document the incident(s) among your ***Healthy Connections*** patients. Providers can maintain reports of their individual broken appointment logs through the Provider Web Portal and the information can be compiled into an aggregated report for SCDHHS.

As a result of your feedback, we have developed several Broken Appointment Best Practice guidelines. We encourage you to implement these practices in your office.

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

- Develop a Broken Appointment policy that is for ALL patients.
- Have a contract that patients sign that spells out their rights and responsibilities.
- Confirm appointments after hours when the patient is likely to be home to answer the call.
- Confirm all appointments, including recall and hygiene appointments, the day before the appointment.
- Consider telling patients they must confirm their own appointment the day before the visit, or their appointment slot will be lost.
- If a patient has a broken appointment history or is a new patient, it is recommended that you attempt to speak directly with the patient for the appointment confirmation.
- Continuing care appointments made for three to six months ahead should be reserved for patients of record with no history of broken appointments.
- Patients with a history of broken appointments or that did not schedule a continuing care appointment, should receive a postcard asking them to call to schedule an appointment.
- Many emergency patients will not keep future appointments if scheduled on the day of emergency treatment. These patients should be called later during the week to schedule follow-up treatment.
- When a procedure needs to be completed at a subsequent appointment, send information home with patients about that next appointment. The information should stress the importance of such a procedure and indicate possible outcomes if it is not completed within the designated timeframe.
- Maintain a list of patients that can be contacted to come in on short notice; this will allow you to fill gaps when late notice cancellations occur.
- Many patients cite daytime obligations such as work or childcare as significant contributing factors to missing appointments. Having extended hours on selected days of the week or occasional weekend hours can alleviate this barrier to accessing dental care.

D-2 The Dental Record

DentaQuest recommends that participating ***Healthy Connections*** Provider offices maintain a formal dental record for every Beneficiary seen. The dental record, also

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known as the chart, is the official office document that records all diagnostic information, clinical notes, treatment preformed and communications that occur in the dental office, including instruction for home care and consent to treatment. The following guidelines have been established to assist Provider offices with keeping diligent and complete dental records.

A. Organization

1. The dental record should have areas for documentation of the following information:

   a. Registration data including a complete health history
   b. Medical alert predominantly displayed inside chart jacket
   c. Initial examination data
   d. Radiographs
   e. Periodontal and Occlusion status
   f. Treatment plan/Alternative treatment plan
   g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations
   h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports)

2. The design of the dental record should provide the capability or periodic update, without the loss of documentation of the previous status, of the following information.

   a. Health history
   b. Medical alert
   c. Examination/Recall data
   d. Periodontal status
   e. Treatment plan

3. The design of the dental record should ensure that all permanent components are attached or secured within the record.

4. The design of the dental record should ensure that all components are readily identifiable to the Beneficiary, i.e., first and last name, and identification number on each page.

5. The organization of the dental record system should require that unique records are assigned to each patient.

B. Content-The dental record should contain the following:

1. Adequate documentation of registration information which requires entry of these items:

   a. Beneficiaries' first and last name
   b. Date of birth
   c. Sex
   d. Address
   e. Telephone number
   f. Name and telephone number of the person to contact in case of emergency

2. An adequate health history that requires documentation of these items:

   a. Current medical treatment
   b. Significant past illnesses

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c. Current medications
d. Drug allergies
e. Hematologic disorders
f. Cardiovascular disorders
g. Respiratory disorders
h. Endocrine disorders
i. Communicable diseases
j. Neurologic disorders
k. Signature and date by patient
l. Signature and date by reviewing dentist
m. History of alcohol and/or tobacco usage including smokeless tobacco

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

   a. Significant changes in health status
   b. Current medical treatment
   c. Current medications
   d. Dental problems/concerns
   e. Signature and date by reviewing dentist

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

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

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

   a. Blood pressure (Recommended)
   b. Head/neck examination
   c. Soft tissue examination
   d. Periodontal assessment
   e. Occlusion classification
   f. Dentition charting

6. Adequate documentation of the Beneficiaries' status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:

   a. Blood pressure (Recommended)
   b. Head/neck examination
   c. Soft tissue examination
   d. Periodontal assessment
   e. Dentition charting

7. Radiographs which are:

   a. Identified by first and last name
   b. Dated
   c. Designated by left and right side
   d. Mounted (if intraoral films)

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8. An indication of the Beneficiaries' clinical problems/diagnosis

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

    a. Procedure
    b. Localization (area of mouth, tooth number, surface)

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

    a. Periodontal pocket depth
    b. Furcation involvement
    c. Mobility
    d. Recession
    e. Adequacy of attached gingiva
    f. Missing teeth

11. An adequate documentation of the Beneficiaries' oral hygiene status and preventive efforts which requires entry of these items:

    a. Gingival status
    b. Amount of plaque
    c. Amount of calculus
    d. Education provided to the Beneficiary
    e. Beneficiary receptiveness/compliance
    f. Recall interval
    g. Date

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

    a. Provider to whom consultation is directed
    b. Information/services requested
    c. Consultant's response

13. Adequate documentation of treatment rendered which requires entry of these items:

    a. Date of service/procedure
    b. Description of service, procedure and observation
    c. Type and dosage of anesthetics and medications given or prescribed
    d. Localization of procedure/observation, (tooth #, quadrant etc.)
    e. Signature of the Provider who rendered the service

14. Adequate documentation of the specialty care performed by another dentist that includes:

    a. Examination
    b. Treatment plan
    c. Treatment status

C. Compliance

1. The dental record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the dental record by all staff.

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3. The components of the dental record that are required for complete documentation of each Beneficiary's status and care are present.
4. Entries in the dental records are legible.
5. Entries of symbols and abbreviations in the dental records are uniform, easily interpreted and are commonly understood in the practice.

D-3 Dental Recall System

DentaQuest strongly encourages Participating Provider offices to maintain a formal system for Beneficiaries' dental recall. The system can utilize either written or phone contact. Any system should encompass routine check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any ***Healthy Connections*** Beneficiary that has sought dental treatment.

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

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."

- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

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

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

B. DentaQuest Appointment Assistance

DentaQuest's Customer Service Department uses technology to link ***Healthy Connection*** Beneficiaries to the closest and most appropriate dental Provider. On occasion, Beneficiaries require special assistance making appointments due to geographic or special physical needs. In emergency or difficult situations, DentaQuest's Customer Service department will assist Beneficiaries in making appointments with Participating Providers.

C. Non-Compliant Beneficiaries

Providers and dental offices are not allowed to charge Beneficiaries for missed appointments.

D. Office Compliance Verification Procedures

Per SCDHHS regulations, Participating Providers are expected to meet minimum standards with regards to appointment availability. The standards are:

- **Emergency care –** As quickly as the situation warrants
- **Urgent care –** Within forty-eight (48) hours
- **Routine care** – Not to exceed six (6) weeks

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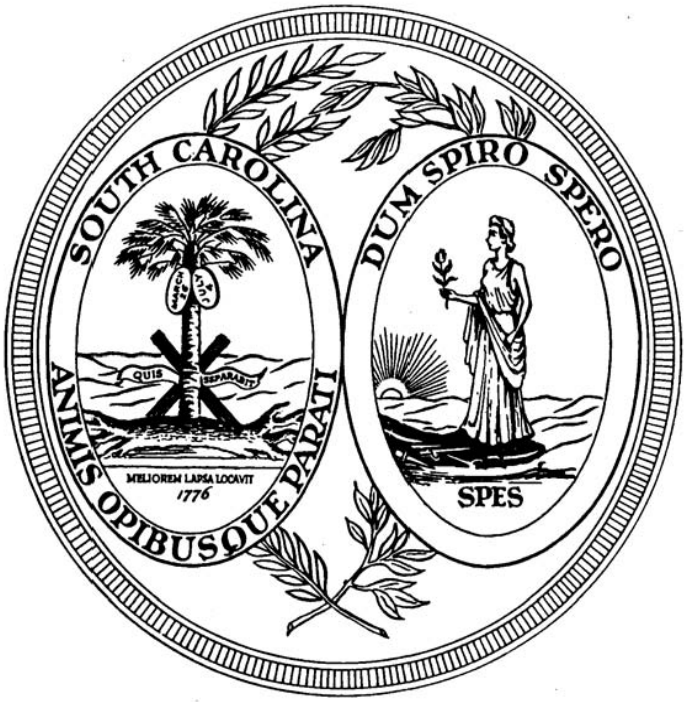


SOUTH CAROLINA HEALTHY CONNECTIONS (MEDICAID) PROVIDER MANUAL

DENTAL SERVICES

March 15, 2008
Updated August 1, 2012

Effective August 2, 2010, SCDHHS has transferred the administration of the Dental Services program to DentaQuest. All dental providers are required to comply with SCDHHS Section 1 included in this document and the DentaQuest Office Reference Manual (ORM) located on the DentaQuest Web site. Please refer to www.dentaquest.com for the DentaQuest ORM.

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-12	1	2, 8, 9, 12, 13, 15, 25, 34	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
04-01-12	1	4	Replaced South Carolina Healthy Connections card
01-01-12	1	2-5, 20, 24	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
11-01-11	1	24	Updated TPL contact information
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
03-01-11	1	7, 9	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
01-01-11	1	7 19-20	• Updated the South Carolina Medicaid Web-based Claims Submission Tool section • Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits
12-01-10	Cover	-	Replaced "Medicaid Provider Manual" with "South Carolina Healthy Connections (Medicaid)"
10-01-10	1	1 7 10	• Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Program Description section • Updated the SC Medicaid Web-Based Claims Submission Tool section to reflect Medicaid Bulletin dated July 8, 2010-Transfer of the Dental Program Administration to DentaQuest • Updated Freedom of Choice section
10-01-10	5		Correct McCormick county office street address
10-01-10	Managed Care Supplement	1 2	• Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Managed Care Overview • Updated Managed Care Organizations and Core Benefits paragraphs

CHANGE CONTROL RECORD

		3 4 5 6 13 17	• Updated MCO Program ID card paragraph • Updated MHN Program ID card paragraph • Updated Core Benefits • Updated Exempt Services • Updated Overview • Deleted "Medicaid Managed" from "Current Medicaid Managed Care Organizations" heading and following paragraph
08-19-10	Cover	-	Added statement to refer providers to the DentaQuest Office Reference Manual (ORM) for additional policies and procedures
08-02-10	-	-	Deleted the following: Sections 2-5, Forms, Appendices 1-3, Managed Care supplement and Third Party Liability supplement
07-01-10	5	-	Updated telephone numbers and zip codes for multiple county offices
07-01-10	Appendix 1	32 35	• Updated edit code 714 • Updated edit code 738
07-01-10	Appendix 2	21, 22, 25, 63, 89	Changed First Health to Magellan Medicaid Administration
06-01-10	Managed Care Supplement	1 3 17 20, 23, 25	• Updated Managed Care Overview section • Updated Manage Care Organization (MCO), Core Benefits section • Updated the Managed Care Disenrollment Process, Overview section • Updated to reflect Medicaid Bulletin dated March 18, 2010 — Managed Care Organizational Change
03-01-10	Cover	-	Replaced the manual cover
03-01-10	Change Control Record	2	Added Time Limit for Submitting Claims Medicaid Bulletin date to section 1 and section 3 entries dated 12-01-09
03-01-10	3	9, 12	Removed modem as an electronic claims transmission method
02-01-10	Appendix 1	13 36	• Added New Edit Codes 356,357 and 358 • Updated Edit Code 738
02-01-10	Appendix 2	All	Updated Carrier Code List
01-01-10	2	1-3	• Updated the following sections: o Dental Services for Adults Age 21 and Over

CHANGE CONTROL RECORD

		6 13 17 18 12 18	(Optional Coverage Group) o Notification of Policy and Procedure Changes (Medicaid Bulletins) o Dental Hygienist Services, General Supervision o Orthodontic Services o Prior Authorization o Beneficiary Eligibility section (unlimited number of calls for the IVRS and unlimited number transactions per call) o Managed Care Entities • Changed Hospital Services heading to Hospital or Ambulatory Surgical Center (ASC) Facility Services and updated the policy • Deleted Preventive/Rehabilitative Services Primary Care Enhancement (P/RSPCE), Formerly Known as Family Support Services (FSS) section
01-01-10	4	1, 3-5, 14, 19 5 7-8, 10-12, 15,19, 20	• Updated the following sections: o Medical Justification and Documentation o Updated the Procedure Code Table o Updated the Procedure Codes Not Listed o Oral and Maxillofacial Surgery o Anesthesia • Moved Dental Fee Schedule section • Updated the MR/RD procedural key definition • Updated the following codes: D0330, D1206, D1351, D1510, D1515, D2391, D2950, D2954, D3220, D3310, D3330, D7280, D9220, D9920
01-01-10	5	5 10 12	• Updated Physical Address for Allendale County Office • Replaced Jasper County DSS with Jasper County DHHS • Replaced Orangeburg County DSS with Orangeburg County DHHS
01-01-10	Appendix 1	49	Updated Edit Code 932
12-01-09	1	8 25	• Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package • Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated November 24, 2009
12-01-09	3	1-3 10-11, 13,37-39, 42	• Updated Claim Filing Timeliness section to reflect Medicaid Bulletin dated November 24, 2009 • Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package
12-01-09	5	8	Updated the Dorchester County office street address
12-01-09	Appendix 1	- - 18, 19	• Replaced CARC 17 with CARC 16 • Updated CARC A1 • Updated codes 509 and 510

CHANGE CONTROL RECORD

		20	• Added code 533
11-01-09	Appendix 2	All	Updated carrier code list
10-01-09	1	3-4 4-6 26	• Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs) • Updated SC Medicaid Healthy Connections language throughout section • Updated South Carolina Medicaid Bulletins and Newsletters • Changed heading to Medicare Cost Sharing
10-01-09	5	10 11 12	• Updated physical address for Jasper County office • Updated telephone number for Lexington County office • Updated zip codes for Orangeburg County office
10-01-09	Appendix 1	3 60	• Updated edit code 065 • Updated edit code 852
09-08-09	Managed Care Supplement	20	Replaced the Absolute Total Care Medicaid beneficiary card sample
09-01-09	Managed Care Supplement	21 20, 25	• Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009 • Updated Absolute Total Care entries as following: o Changed the company's name to Absolute Total Care o Replaced the beneficiary card samples o Corrected contact information
08-01-09	5	14	Updated telephone number for York County office
08-01-09	Appendix 1	3	Updated edit code 062
08-01-09	Appendix 2	-	Updated carrier code list
07-01-09	5	6, 12 8 9	• Updated address for Bamberg and Orangeburg County offices • Updated office zip code for Darlington County • Updated telephone number for Fairfield County office
06-01-09	TPL Supplement	19	Updated Department of Insurance Web site address
05-01-09	1	1-6, 11 2 3	• Updated to reflect managed care policies and procedures effective May 1, 2009 • Updated the Eligibility subsection • Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card

CHANGE CONTROL RECORD

		5 28-33	subsection • Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection • Updated the Medicaid Program Integrity subsection
05-01-09	5	13	Updated telephone number for Union County office
05-01-09	Appendix 1	43	Deleted edit code 694
05-01-09	Appendix 2	-	Updated list of carrier codes
05-01-09	Managed Care Supplement	-	Updated supplement to include general policies and procedures effective May 1, 2009
04-01-09	1	2, 3, 8	Updated hyperlinks
04-01-09	3	5, 7, 11, 17, 19, 30, 32, 39	Updated hyperlinks
04-01-09	5	11	Updated telephone number for Lexington County office
03-01-09	2	2, 4, 8, 12, 22	Updated hyperlinks
03-01-09	5	3-4 8 5, 11-13	• Updated hyperlinks • Corrected Dorchester County's Orangeburg Road telephone number • Change DSS to DHHS in addresses for Abbeville, McCormick, Newberry, and Saluda counties
03-01-09	Appendix 1	43 72	• Added new edit codes 693 and 694 • Changed edit code 945 Resolution to input "26"modifier in field 18
03-01-09	Managed Care Supplement	1, 7, 10, 17, 23, 25-30, 35	Updated hyperlinks
03-01-09	TPL Supplement	8, 9, 19	Updated hyperlinks
02-01-09	5	5	Updated Allendale County office PO Box zip code
02-01-09	Forms	-	Updated Authorization Agreement for Electronic Funds Transfer (EFT) form

CHANGE CONTROL RECORD

02-01-09	Appendix 2	-	Updated list of carrier codes
01-01-09	1	8	Updated hyperlink for bulletin.scdhhs.gov
01-01-09	5	11	Update Lee County office address
11-01-08	1	8	Added e-bulletin information to reflect Medicaid Bulletin dated August 26, 2008
11-01-08	3	37, 38	Added EFT information to reflect Medicaid Bulletin dated August 26, 2008
11-01-08	4	3 3, 5 -	• Changed Column Four to Column Three • Added Dental Fee Schedule section • Removed Column Three – Fee
10-01-08	3	43 44 47	• Changed ADA 2006 field 1 to Prov/Xwalk ID • Changed ADA 2006 field 13 to Individual Prov/Xwalk ID • Changed CMS-1500 ECF field 1 to Prov/Xwalk ID
10-01-08	4	-	Updated section from bulletin dated September 10, 2008
10-01-08	5	9, 13	• Updated address for Lake City • Updated phone number for Sumter County office
10-01-08	Forms	-	• Revised ADA 2006 ECF example to show update for fields 1 and 13 • Revised CMS-1500 ECF example to chow update for field 1
10-01-08	Appendix 1	-	Updated edit codes 007, 059, 112, 219, 308, 339, 386, 403, 710, 722, 786, 798, 799, 843, 844, 845, 912, 914, 928, 941, 942, 943, 945, 952
09-01-08	5	6	Updated phone number for Berkeley County office
09-01-08	5	10	Updated phone number for Kershaw County office
09-01-08	Appendix 1	17	Added Edit Code 318
08-01-08	Appendix 1	3	Updated Edit Code 062
08-01-08	5	7	Deleted PO Box for Chester County
07-01-08	5	11	Deleted PO Box for Lancaster County
07-01-08	Managed Care	27	Replaced Web site address for BlueChoice

CHANGE CONTROL RECORD

	Supplement		
06-12-08	Forms	-	Replaced DHEC Form 0782
06-10-08	2	1 3 5 12 13	• Added restriction for full mouth extractions • Added additional guidelines for provider enrollment • Updated NPI policy to reflect May 23, 2008, deadline requiring NPI only on claims • Updated Prior Authorization submittal requirement • Replaced dental program manager with dental program coordinator
06-10-08	3	27, 33, 34 - 16, 17, 18 , 23, 28, 30, 31, 32	• Updated NPI policy and form instructions to reflect May 23, 2008, deadline requiring NPI only on claims for typical providers • Standardized field and zip code + 4 references throughout section • Updated all field instruction to clarify which fields do not required data entry
06-10-08	5	12	Updated telephone number for Orangeburg county office
06-10-08	Forms	-	Updated the following forms to reflect the May, 23, 2008, deadline requiring NPI only: • Example Dental Claim Form • Example Dental Claim Form Reporting Third-Party or Medicare Information • Example Dental Claim Form Oral and Maxillofacial Surgeons Only • Example Dental Claim Form Reporting Third Party and/or Medicare Payments or Denials Oral and Maxillofacial Surgeons Only For example dental claim forms: • Change/removed sample entries for fields 8, 15, 23, and 49 • Added a tooth number to line 4
06-01-08	Appendix 1	30, 39, 42	• Added new edit code 529 • Deleted NPI warning edits 578, 579, 580, 581, 582, 583, 692
06-01-08	TPL Supplement	-	Updated Example Dental Claim Form Reporting Third-Party for Medicare Information to show NPI only; change/removed sample entries for fields 8, 15, 23, and 49; and added a tooth number to line 4
04-01-08	5	8	Updated address and phone number for Dorchester County office

CHANGE CONTROL RECORD

04-01-08	Appendix 1	4, 13, 20, 33	Added new edit codes 062, 219, 339, 528
04-01-08	TPL Supplement	2 3, 8, 15 12 29	• Updated reference to Medicaid card name • Changed references to location of form from Section 5 to Forms section • Updated field numbers for occurrence codes on UB-04 • Replaced sample ADA form with more attractive version

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

TABLE OF CONTENTS

South Carolina Medicaid Program 1
Program Description 2
Eligibility Determination 2
Enrollment Counseling Services 4
Medicare / Medicaid Eligibility 4
South Carolina Healthy Connections Medicaid Card 4
SC Healthy Connections Health Opportunity Account 6
South Carolina Medicaid Web-based Claims Submission Tool 8
South Carolina Medicaid Bulletins and Newsletters 8
Requirements for Provider Participation 8
Enrollment 10
Extent of Provider Participation 10
Non-Discrimination 12
Service Delivery 12
Freedom of Choice 12
Medical Necessity 12
Records/ Documentation Requirements 13
General Information 14
Disclosure of Information by Provider 16
Safeguarding Beneficiary Information 16
Confidentiality of Alcohol and Drug Abuse Case Records 18
Special / Prior Authorization 18
Reimbursement 20
Charge Limits 21
Broken, Missed, or Cancelled Appointments 21
National Correct Coding Initiative (NCCI) 22
Medicaid as Payment in Full 24
Payment Limitation 24
Reassignment of Claims 24
Third-Party Liability 26
Health Insurance 26
Premium Payment Project 28

SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

TABLE OF CONTENTS

Casualty Insurance 28
Provider Responsibilities – TPL 28
Time Limit for Submitting Claims 30
Medicare Cost Sharing Claims 30
Retroactive Eligibility 30
Payment Information 30
Medicaid Program Integrity 33
Program Integrity 34
Beneficiary Explanation of Medical Benefits Program 36
Beneficiary Oversight 36
Medicaid Beneficiary Lock-In Program 36
MEDICAID ANTI-FRAUD PROVISIONS / PROVIDER EXCLUSIONS / SUSPENSIONS 38
Fraud 39
Provider Exclusions / Suspensions 39
Administrative Sanctions 40
Other Financial Penalties 41
Fair Hearings 41
Reinstatement 41
Appeals 41
Division of Audits 43
Payment Error Rate Measurement 43

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA
MEDICAID
PROGRAM

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROGRAM DESCRIPTION

The Medicaid program, as established by Title XIX of the Social Security Act, as amended, provides quality health care to low income, disabled, and elderly individuals by utilizing state and federal funds to reimburse providers for approved medical services. This care includes the diagnosis, treatment, and management of illnesses and disabilities.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan.

SCDHHS offers two Medicaid Managed Care Programs:

- Medicaid Managed Care Organization (MCO) Program
- Primary Care Case Management/Medical Homes Networks (PCCM or PCCM/MHN)

The Medicaid Managed Care Organization (MCO) program consists of contracted MCOs that, through a developed network of providers, provide, at a minimum, all services outlined in the core benefit package described in the MCO contract, for certain eligibility categories. SCDHHS pays a capitated rate per member per month, according to age, gender, and category of eligibility to MCOs. Payments for core services provided to MCO members are the responsibility of MCOs, not the fee-for-service Medicaid program.

The Medical Homes Network (MHN) Program is a Primary Care Case Management (PCCM) program. An MHN is composed of a Care Coordination Services Organization (CSO) and the primary care providers (PCPs) enrolled in that network. The CSO supports the member physicians by providing care coordination, disease management, and data management. The PCPs manage the health care of their patient members either by directly providing medically necessary health care services or authorizing another provider to treat the beneficiary. The Network receives a per-member-per-month (PMPM) care coordination fee. Reimbursement for medical services provided is made on a fee-for-service basis.

PROGRAM DESCRIPTION (CONT'D.)

Both MHNs and MCOs may elect to provide their members enhanced services beyond what is offered under traditional fee-for-service Medicaid.

ELIGIBILITY DETERMINATION

Applications for Medicaid eligibility may be filed in person or by mail. Applications may be obtained and completed at outstationed locations such as county health departments, some federally qualified health centers, most hospitals, and SCDHHS county eligibility offices. Applications are also available at the SCDHHS Web site: http://www.scdhhs.gov.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

Individuals who apply for SSI through the Social Security Administration and are determined eligible are automatically eligible for Medicaid.

For certain programs, Medicaid eligibility may be retroactive for a maximum of three months prior to the month of application when the applicant received medical services of the type covered by Medicaid and the applicant would have met all eligibility criteria had the application been filed at the time. A child born to a woman eligible for Medicaid due to pregnancy is automatically entitled to Medicaid benefits for one year provided that the child continues to reside in South Carolina.

Not all Medicaid beneficiaries receive full coverage. Some beneficiaries may qualify under the categories of limited benefits or emergency services only. Questions regarding coverage for these categories should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://scdhhs.gov/contact-us. A provider service representative will then respond to you directly with additional information about these categories.

Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing a Point of Sale (POS) device, the South Carolina Medicaid Web-based Claims Submission Tool, or an eligibility verification vendor. Additional information on these options is detailed later in this section.

ELIGIBILITY DETERMINATION (CONT'D.)

If the beneficiary is enrolled in a MCO or MHN/PCCM, certain services will require prior approval and/or coordination through the MCO or MHN/PCCM providers. For questions regarding MCO or MHN/PCCM programs, please refer to the MCO or MHN Policy and Procedure Guide available on the SCDHHS Web site: http://www.scdhhs.gov.

More information about managed care can also be found in the Managed Care Supplement attached to all provider manuals.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ENROLLMENT COUNSELING SERVICES

SCDHHS provides enrollment counseling services to Medicaid beneficiaries through a contract with a private vendor, Maximus, Incorporated. Services are provided under the program name "South Carolina Healthy Connections Choices." The function of the enrollment counselor is to assist Medicaid-eligible members in the selection of the best Medicaid health plan to suit individual/family needs. For additional information, contact South Carolina Healthy Connections Choices at (877) 552-4642 or visit http://www.SCchoices.com.

MEDICARE / MEDICAID ELIGIBILITY

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Providers may bill SC Medicaid for Medicare cost sharing for Medicaid-covered services for dually eligible beneficiaries. Some dual eligibles are also Qualified Medicare Beneficiaries (QMB). If the dually eligible beneficiary is also a QMB, providers may bill SC Medicaid for Medicare cost sharing, for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan.

MEDICARE / MEDICAID ELIGIBILITY (CONT'D.)

Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries. For instructions on how to access beneficiary information, including QMB status, refer to the Medicaid Web-Based Claims Submission Tool (the Web Tool), explained later in this section.

In the Web Tool, the Eligibility or Beneficiary Information section will indicate "Yes" if the beneficiary is a Qualified Medicare Beneficiary.

Note: Pharmacy providers should refer to Section 2 of the Pharmacy Services Provider Manual for more information on coverage for dually eligible beneficiaries.

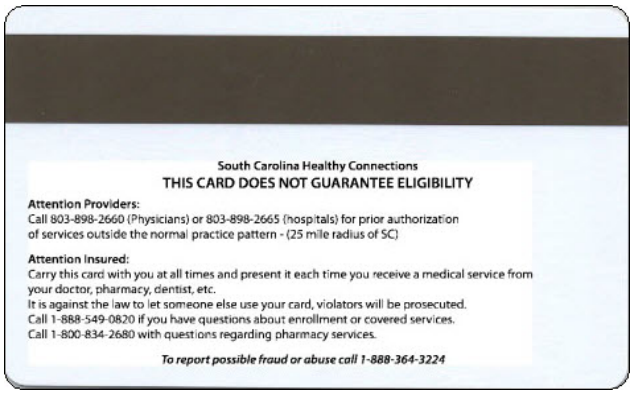
SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD

Medicaid beneficiaries are issued a plastic South Carolina Healthy Connections Medicaid card. Only one person's name appears on each card. If more than one family member is eligible for Medicaid, the family receives a card for each eligible member. In addition to the member's name, the front of the card includes the member's date of birth and Medicaid Member Number. Possession of the plastic card does not guarantee Medicaid coverage. Failure to verify eligibility prior to providing a service leaves the provider at risk of providing services to an ineligible individual.

The following is an example of a South Carolina Healthy Connections card:

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM



SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD (CONT'D.)

The back of the Healthy Connections Medicaid card includes:

- A number that providers may call for prior authorization of services outside the normal practice pattern or outside a 25-mile radius of South Carolina
- A magnetic strip that may be used in POS devices to access information regarding Medicaid eligibility, third-party insurance coverage, beneficiary special programs, and service limitations 24 hours a day, seven days a week in a real time environment. There is a fee to providers for such POS services.
- A toll-free number for the beneficiary if he or she has questions about enrollment or Medicaid-covered services
- A toll-free number for the beneficiary if he or she has questions regarding pharmacy services

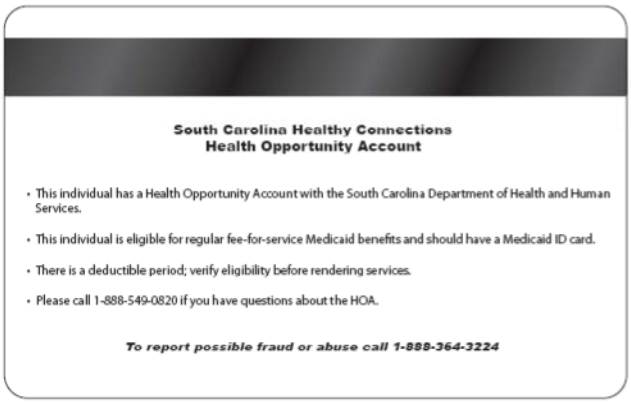
Providers are urged to report inappropriate use of a Medicaid card by a beneficiary (such as abuse, card-sharing, etc.) to the Division of Program Integrity's toll-free Fraud and Abuse Hotline at 1-888-364-3224.

Beneficiaries who choose to enroll with a Medicaid Managed Care Organization (MCO) will also be issued an identification card by the MCO. This MCO-issued card contains phone numbers for member services and provider billing issues specific to the managed care plan. Please see the Managed Care Supplement for samples of cards from the various managed care plans.

SC HEALTHY CONNECTIONS HEALTH OPPORTUNITY ACCOUNT

The South Carolina Healthy Connections Health Opportunity Account (HOA) was implemented by SCDHHS in May 2008. It is a Medicaid option that allows beneficiaries to manage their own health care spending and set aside money to be used when they no longer need Medicaid. Routine claims filing procedures apply to HOA participants.

The following is an example of a South Carolina Healthy Connections Health Opportunity Account card:



SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SC HEALTHY CONNECTIONS HEALTH OPPORTUNITY ACCOUNT (CONT'D.)

The back of the South Carolina Healthy Connections Health Opportunity Account card includes a toll-free number for questions about enrollment, Medicaid-covered services, or eligibility.

SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL

SCDHHS provides a free tool, accessible through an Internet browser, which allows providers to submit claims (UB and CMS-1500), query Medicaid eligibility, check claim status, offers providers electronic access to their remittance packages and the ability to change their own passwords.

Note: Dental claims can no longer be submitted on the Web Tool. Please contact the DentaQuest Call Center at 1-888-307-6553 for billing instructions.

Providers interested in using this tool must complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS and return the signed SC Medicaid TPA Enrollment Form. Once received, the provider will be contacted with the Web site address and Web Tool User ID(s). If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance package, both the provider and the billing agent must have a TPA on file. The provider's TPA must name their billing agent. The billing agent's TPA must include the provider's name and Medicaid number. For more information regarding the TPA, refer to Section 3 of this manual.

To learn more about this tool and how to access it, visit the SC Medicaid provider Web site at: http://www.scmedicaidprovider.org or contact the SC Medicaid EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709. A list of training opportunities is also located on the Web site. For Web Tool training dates, click on "Training Options."

SOUTH CAROLINA MEDICAID BULLETINS AND NEWSLETTERS

SCDHHS Medicaid bulletins and newsletters are distributed electronically through e-mail and are available online at http://www.scdhhs.gov/.

To ensure that you receive important SC Medicaid information, visit the Web site or enroll to receive bulletins and newsletters via e-mail, go to bulletin.scdhhs.gov to subscribe.

REQUIREMENTS FOR PROVIDER PARTICIPATION

In order to participate in the Medicaid program, a provider must meet all of the following requirements:

- Licensure by the appropriate licensing body, certification by the standard-setting agency, and /or other pre-contractual approval processes established by SCDHHS
- Enrollment in the South Carolina Medicaid program

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

- If required, obtain a National Provider Identifier (NPI) and share it with South Carolina Medicaid. Refer to https://nppes.cms.hhs.gov for additional information about obtaining an NPI
- Continuously meet South Carolina licensure requirements of their respective professions or boards in order to maintain Medicaid enrollment

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

Enrollment

In order to become eligible to participate in the Medicaid program, providers are required to either complete a provider enrollment agreement form or sign a contract with SCDHHS, depending on what type of service they provide. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

By signing the provider enrollment agreement or contract, the provider agrees to comply with all federal and state laws and regulations currently in effect as well as all policies, procedures, and standards required by the Medicaid program. Official notification of enrollment is sent to the provider.

All rendering providers must be enrolled in the Medicaid program. Enrolled providers are prohibited from allowing non-enrolled providers use of their Medicaid ID number/NPI number in order for non-participating providers to be reimbursed for services. Please refer to Section 3 of this manual for instructions regarding billing procedures.

MCO network providers/subcontractors do not have to be Medicaid-enrolled providers. Fee-for-service reimburse-ment from SCDHHS may only be made to Medicaid-enrolled providers.

Enrollment (Cont'd.)

A provider must immediately report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to the appropriate area within SCDHHS. Not reporting this change of information promptly could result in a delay of payment to the provider. Contact information for these areas is listed below:

Contracted Providers	**Non-Contracted Providers**
Division of Contracts SCDHHS Post Office Box 8206 Columbia, SC 29202-8206 (803) 898-2605	Medicaid Provider Enrollment Post Office Box 8809 Columbia, SC 29202-8809 1-888-289-0709 Fax: (803) 870-9022

The Medicaid program administered by SCDHHS is considered to be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will render. A provider may not refuse to furnish services covered under Medicaid to an eligible individual because of a third party's potential liability for the

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

service(s). A provider who is not a part of a Managed Care Organization's network may refuse service to a Medicaid MCO member.

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine before treatment is rendered whether the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency, or if a provider cannot determine that a patient is Medicaid- eligible at the time service is rendered, the provider should meet with the beneficiary (or the beneficiary's legal guardian or representative) at the earliest possible date to determine whether the provider is willing to accept the beneficiary as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

Extent of Provider Participation (Cont'd.)

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly to the managed care provider or the Bureau of Managed Care at (803) 898-4614.

Once a provider has accepted a beneficiary as a Medicaid patient, it is the responsibility of the provider to deliver all Medicaid-covered services throughout the course of treatment. The policy section of this manual may include clarification of specific program policies.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

Non-Discrimination

All Medicaid providers are required to comply with the following laws and regulations:

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)
- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)
- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)

Service Delivery

Freedom of Choice

Except as otherwise specified in this manual, a Medicaid beneficiary has the right to choose any provider who is both a participant in the Medicaid program and willing to accept the beneficiary as a patient.

However, once a beneficiary exercises his or her freedom of choice by enrolling in a Medicaid managed care option, the beneficiary is required to follow that plan's requirements (*e.g.*, use of designated primary and specialist providers, precertification of services, etc.) for the time period during which the beneficiary is enrolled in the managed care option.

Medical Necessity

Medicaid will pay for a service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service (the provision of which may be limited by specific manual provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records or other appropriate documentation for each beneficiary must substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS/ DOCUMENTATION REQUIREMENTS

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide access to records. These records should fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries. Unless program policy otherwise allows, this documentation must be present in the beneficiaries' records before the provider files claims for reimbursement. For the purpose of reviewing and reproducing documents, providers shall grant to staff of SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Government Accountability Office (GAO), and the U.S. Department of Health and Human Services (USDHHS) and/or any of their designees access to all records concerning Medicaid services and payment. These records may be reviewed during normal business hours, with or without notice.

A provider record or any part thereof will be considered illegible if at least three medical or other professional staff members who regularly perform post-payment reviews are unable to read the records or determine the extent of services provided. If this situation should occur, a written request for a translation may be made. In the event of a negative response or no response, the reimbursed amount will be subject to recoupment.

Assuming that the information is in a reasonably accessible format, the South Carolina Medicaid Program will accept records and clinical service notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §26-6-10 *et seq.*). Reviewers and auditors will accept electronic documentation as long as they can access them and the integrity of the document is ensured. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

The minimum retention period for Medicaid records is five years. Exceptions include providers of hospital and nursing home services, who are required to maintain records pertaining to Medicaid beneficiaries for a period of six years. Other Medicaid provider agreements/contracts may require differing periods of time for records retention.

GENERAL INFORMATION (CONT'D.)

Providers should contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for specific information regarding the documentation requirements for the services provided. In all cases, records must be retained until any audit, investigation, or litigation is resolved, even if the records must be maintained longer than normally required. Medicaid providers generally maintain on-site all medical and fiscal records pertaining to Medicaid beneficiaries.

Medical and fiscal records pertaining to Medicaid beneficiaries that a provider may maintain at an off-site location/storage facility are subject to the same retention policies, and the

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

records must be made available to SCDHHS within five business days of the request. For reviews by the SCDHHS Division of Program Integrity, requested Medicaid records should be provided within two business days.

Note: These requirements pertain to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

DISCLOSURE OF INFORMATION BY PROVIDER

As of April 14, 2003, for most covered entities, health care providers are required to comply with privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, which includes providing all patients and/or clients with a Notice of Privacy Practices. The Notice should include sufficient information to disclose to each Medicaid patient/client the provider's intent to release any medical information necessary for processing claims, including Medicaid claims. Providers who have not issued their patients/clients a Notice of Privacy Practices should obtain authorization to release such information to SCDHHS. The authorization must be signed and dated by the beneficiary and must be maintained in the patient's/client's record.

DISCLOSURE OF INFORMATION BY PROVIDER (CONT'D.)

Once a Notice of Privacy Practices is acknowledged by the Medicaid beneficiary, or the beneficiary's authorization to release information is obtained, a provider who uses hard-copy claim forms that require the patient's signature is no longer required to have each claim form signed by the beneficiary. Providers who file claims electronically are required under their Trading Partner Agreement (TPA) to ensure ready association of electronic claims with an acknowledged Notice of Privacy Practices or a signed statement from the beneficiary consenting to the release of information necessary to process claims.

Certain medical services may be subject to more stringent rules or regulations governing the disclosure of information than others. However, if a provider is unable to release information necessary for Medicaid claims processing due to the lack of proper Notice or authorization from the beneficiary, payment may be denied and/or previous payments may be recouped. Consequently, providers who are concerned about releasing patient information to SCDHHS are advised to obtain specific written authorization from the Medicaid patient/client.

SAFEGUARDING BENEFICIARY INFORMATION

Federal regulations at 42 CFR Part 431, Subpart F, and South Carolina Regulations at Chapter 126, Article 1, Subarticle 4, require that certain information concerning Medicaid applicants and beneficiaries be protected. As a condition of participation in the Medicaid program, all providers must agree to comply with the federal laws and regulations regarding this protection, by execution of either a contract or a provider enrollment agreement. Questions regarding access to protected information should be referred to the PSC. Provider can also submit an online inquiry at http://scdhhs.gov/contact-us to request additional information.

Beneficiary information that must be protected includes but is not limited to the following:

- Name and address
- Medical services provided

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION (CONT'D.)

- Social and economic circumstances
- Medical data, including diagnosis and past history of disease or disability
- Any information involving the identification of legally liable third-party resources
- Any information verifying income eligibility and the amount of medical assistance payments

This information may generally be used or disclosed only for the following purposes:

- Establishing eligibility
- Determining the amount of medical assistance
- Providing services for beneficiaries
- Assisting in a Medicaid-related investigation, prosecution, or civil or criminal proceeding

Regarding the release of beneficiary information to billing/collection agencies, the Centers for Medicare and Medicaid Services (CMS) has instructed the states that the requirements for the release of beneficiary information should parallel the limitations on payments. Agents to whom payments could be made are allowed to obtain relevant beneficiary information, since the sharing of that information is for a purpose directly connected with Medicaid administration. However, if no payment could be made to the agent because the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent.

Note: The manner in which the Medicaid program deals with the agent is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider. Agents or providers who furnish inaccurate, incomplete, or misleading information to SCDHHS regarding agent compensation issues may face sanctions.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

Confidentiality of Alcohol and Drug Abuse Case Records

Federal law requires providers to observe more stringent rules when disclosing medical information from the records of alcohol and drug abuse patients than when disclosing information concerning other Medicaid beneficiaries. Federal regulations govern the information that must be protected in such cases and the circumstances under which this information may be disclosed. These regulations may be found at 42 CFR Part 2.

SPECIAL / PRIOR AUTHORIZATION
SPECIAL / PRIOR AUTHORIZATION (CONT'D.)

Certain medical services must be authorized by SCDHHS (or its designee) prior to delivery in order to be reimbursable by Medicaid. Some of the services that are specifically subject to prior authorization and approval are as follows:

- Services provided outside of the South Carolina Medicaid Service Area (SCMSA). The SCMSA is South Carolina and adjacent areas within 25 miles of its borders. Providers should contact the PSC or submit an online inquiry for prior authorization guidelines.
- Services not routinely covered by Medicaid, or other services that require prior approval before payment or before service delivery as a matter of policy. Please refer to the appropriate section of this manual, contact the PSC, or submit an online inquiry for prior authorization guidelines.
- Services for which prepayment review is required.

Refer to program-specific sections of this manual for other services that must be authorized prior to delivery.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

CHARGE LIMITS

Providers may not charge Medicaid any more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate, determined by the program, or the provider's charges. The Medicaid program will not pay for services or items that are furnished gratuitously without regard to the beneficiary's ability to pay, or where no payment from any other source is expected, such as free x-rays or immunizations provided by health organizations.

BROKEN, MISSED, OR CANCELLED APPOINTMENTS

CMS prohibits billing Medicaid beneficiaries for broken, missed, or cancelled appointments. Medicaid programs are state-designed and administered with federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency's payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The South Carolina Medicaid program utilizes NCCI edits and its related coding policy to control improper coding.

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations or units of service are reported exceeding what is normally considered to be medically necessary. NCCI edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service.

NCCI consist of two types of edits:

1) NCCI Procedure to Procedure (PTP) edits: These edits define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons. These edits consist of a column one code and a column two code. If both codes are reported, the column one code is eligible for payment and the column two code is denied. In some instances an appropriate modifier may be added to one or both codes of an edit pair to make the code combination eligible for payment.

2) Medically Unlikely Edits (MUE): These edits define for each HCPCS/CPT code the number of units of service that is unlikely to be correct. The units of service that exceed what is

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

considered medically necessary will be denied.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

Services denied based on NCCI code pair edits or MUEs may not be billed to patients.

The following CMS web page provides overview information to providers on Medicare's NCCI edits and links for additional information:

http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

MEDICAID AS PAYMENT IN FULL

Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition to not charging the patient for any coinsurance or deductible amounts, providers may not charge the patient for the primary insurance carrier's copayment. Only applicable Medicaid copayments and services not covered by Medicaid may be billed to the beneficiary.

For beneficiaries enrolled in a Medicaid managed care option, the managed care entity must accept SCDHHS' capitated payment as payment in full for all services covered by the capitation arrangement. Managed care network providers must accept their reimbursement from the managed care entity as payment in full. Only services not included in the specified benefits package or not otherwise covered by Medicaid may be billed to a beneficiary enrolled in a managed care option.

PAYMENT LIMITATION

Medicaid payments may be made only to a provider, to a provider's employer, or to an authorized billing entity. **There is no option for reimbursement to a beneficiary.** Likewise, seeking or receiving payment from a beneficiary pending receipt of payment from the Medicaid program is not allowed, except where a copayment is applicable. By virtue of submitting a claim to Medicaid, a provider is agreeing to accept Medicaid as the payer.

REASSIGNMENT OF CLAIMS

In general, Medicaid payments are to be made only to the enrolled practitioner. However, in certain circumstances payment may be made to the following:

1. The employer of the practitioner, if the practitioner is required as a condition of employment to turn over fees to the employer

REASSIGNMENT OF CLAIMS (CONT'D.)

2. The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim
3. A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim
4. A business agent. Regulations found at 42 CFR Part 447, Subpart A, allow Medicaid to make payment for services to a provider's "business agent" such as a billing service or an accounting firm, only if the agent's compensation is:

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

a) Related to the cost of processing the billing

b) Not related on a percentage or other basis to the amount that is billed or collected

c) Not dependent upon the collection of the payment

If the agent's compensation is tied to the amount billed or collected or is dependent upon the collection of the payment, Medicaid is not allowed to make payment to the agent. Furthermore, providers are urged to seek advice regarding the HIPAA (Public Law 104-191) provisions when entering into such an agreement.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

THIRD-PARTY LIABILITY

As a condition of eligibility for Medicaid, federal regulations at 42 CFR Part 433, Subpart D, require individuals to assign any rights to medical support or other third-party payment to the Medicaid agency (SCDHHS) and cooperate with the agency in obtaining such payments. The South Carolina Code §43-7-420 makes this assignment effective automatically upon application for Medicaid.

THIRD-PARTY LIABILITY (CONT'D.)

Medicaid providers may obtain information regarding third-party resources that are known to SCDHHS by utilizing the South Carolina Healthy Connections Medicaid Insurance card with a Point of Sale (POS) device or by using the South Carolina Medicaid Web-based Claims Submission Tool. Third-party resources include but are not limited to health benefits under commercial health insurance plans, indemnity contracts, school insurance, Workers' Compensation, and other casualty plans that may provide health insurance benefits under automobile or homeowner's coverages.

For Medicaid purposes, third-party resources are divided into two general categories: Health Insurance and Casualty Insurance.

Health Insurance

In general, health insurance may include any individual accident and health policy or group policy that provides payment for health care costs. Unless otherwise permitted, a provider who accepts a Medicaid beneficiary as a patient is required to request payment from all available third-party resources prior to billing Medicaid. All third-party claims filed must be assigned to the provider.

Should the third-party carrier deny payment or reduce payment to less than the Medicaid approved amount, the provider may then submit the claim to Medicaid. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see Section 3 or other appropriate materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139, claims for certain services to beneficiaries who have health insurance coverage may automatically reject if the third-party carrier has not been billed first. If a claim is rejected for failure to bill third-party coverage, the resulting Edit Correction Form (ECF) for the rejected claim will contain the carrier code, policy number, and name of the policyholder for each third-party carrier. SCDHHS will not reprocess the claim unless the provider returns a correctly coded ECF that documents payment or denial of payment by the third-party carrier.

While most claims are subject to coordination of benefits to ensure Medicaid is the payer of last resort, federal regulations exempt claims submitted for physicians' services under the Early

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

& Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Maternal Health, Title IV – Child Support Enforcement, and certain Department of Health and Environmental Control (DHEC) services under Title V. While providers are encouraged to file with any liable third party for these claim types, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Premium Payment Project

Through the Premium Payment Project, SCDHHS is able to pay private health insurance premiums for Medicaid beneficiaries who are subject to losing coverage due to non-payment. SCDHHS will pay these premiums when said payment is determined to be cost effective.

Premium payment is usually cost effective for Medicaid beneficiaries with chronic medical conditions requiring long-term treatment such as cancer, end stage renal disease, chronic heart problems, congenital birth defects, and AIDS. Depending on the amount of the premium, the program may also be appropriate for beneficiaries with short-term costly health needs, such as pregnancy.

Providers of services to participating beneficiaries should consider Medicaid the payer of last resort and bill any liable third-party insurance plan prior to billing Medicaid.

Questions regarding the Premium Payment Project or referrals for beneficiary participation in this project should be directed to the Third Party Liability - Medicaid Insurance Verification Services (MIVS) department by calling (803) 264-6847.

Casualty Insurance

Casualty insurance includes policies that provide payment for treatment related to an accident or injury. This type of coverage is most commonly related to incidents such as auto accidents, and in these cases the injured party is frequently represented by an attorney.

Unlike health insurance claims, claims involving casualty insurance are not subject to review under the Cost Avoidance program. The accident questionnaire is the primary referral source and is generated by the Medicaid claims processing system. At times, it is the provider who identifies a potentially liable third party. If there is casualty insurance coverage, the provider may pursue the claim directly with either the beneficiary's attorney or the casualty insurance carrier, or file a claim with Medicaid (provided that the one-year time limit for submission of claims has not been exceeded).

If the provider files a claim with Medicaid and the claim is paid, then SCDHHS will pursue reimbursement from any liable third party.

Provider Responsibilities – TPL

A provider who has been paid by Medicaid and **subsequently** receives reimbursement from a third party must repay to SCDHHS either the full amount paid by Medicaid or the full amount paid by the third party, whichever is less. Some providers may choose to submit a repayment check accompanied by a completed Form for Medicaid Refunds (DHHS Form 205) identifying the third-party payer. Others providers may decide to submit a Claim Adjustment Form 130, which will allow them to void and/or replace a claim that resulted

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

in under or overpayment. Examples of these forms can be found in the Forms section of this manual. For detailed information regarding both of these adjustment processes, please refer to Section 3 of this manual.

The Medicaid program makes payments to providers on behalf of beneficiaries for medical services rendered, but only to the extent that the beneficiary has a legal obligation to pay. If the beneficiary does not have a legal obligation to pay, then Medicaid will not make a payment. This means that if a beneficiary has third party insurance, including Medicare, SCDHHS's payment will be limited to the patient's responsibility (usually the deductible, co-pay and/or co-insurance.) The Medicaid reimbursement and third party payment cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer. A provider must not bill Medicaid for the difference between the payment received from a third party and the actual charges if the provider's third-party payment was determined under a "preferred provider" agreement. A "preferred provider" agreement is an agreement between the provider and the third party payer that establishes an amount that the provider is agreeing to accept as payment in full on its claims. Where such an agreement exists, Medicaid may only coordinate payment up to the lesser of the Medicaid allowed amount or the amount the provider has agreed to accept as payment in full from the third party payer.

Provider Responsibilities – TPL (Cont'd.)

The South Carolina Code §43-7-440(B) requires Medicaid providers to cooperate with SCDHHS in the identification of any third-party resource that may be responsible for payment of all or part of the cost of medical services provided to a Medicaid beneficiary. Upon receiving knowledge of third-party coverage that is not verified via a POS system or SCDHHS Web Tool, a provider is encouraged to notify SCDHHS's Division of Third-Party Liability of said coverage. The Health Insurance Information Referral Form may be used for this purpose. This form can be found in the Forms section of this manual.

The Division of Third-Party Liability must also be notified in writing if copies of claims submitted to Medicaid are released to anyone, including the beneficiary or the beneficiary's attorney. Before being released, the documents must clearly indicate that third-party benefits are assigned to SCDHHS pursuant to state law.

Providers should be aware that in no instance will SCDHHS pay any amount that is the responsibility of a third-party resource. If a provider releases copies of claims submitted to Medicaid and the release of those documents results in third-party payment being made to the beneficiary rather than to the provider, SCDHHS will not reimburse the provider for the amount of the third-party payment made to the beneficiary.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

TIME LIMIT FOR SUBMITTING CLAIMS

SCDHHS requires that only "clean" claims and related ECFs received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) be considered for payment. A "clean" claim is error-free and can be processed without obtaining additional information from the provider or from another third party. This time limit will not be extended on the basis of third-party liability requirements. However, the one-year time limit does not apply to Medicare cost sharing claims or to claims involving retroactive eligibility.

Medicare Cost Sharing Claims

Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later.

Retroactive Eligibility

Effective December 1, 2009, claims and related ECFs involving retroactive eligibility must meet both of the following criteria to be considered for payment:

Retroactive Eligibility (Cont'd.)

- Be received and entered into the claims processing system within **six months** of the beneficiary's eligibility being added to the Medicaid eligibility system **AND**
- Be received within **three years** from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three years old will not be considered for payment.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim or ECF within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
- The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

Payment Information

SCDHHS establishes reimbursement rates for each Medicaid-covered service. Specific service rates for covered services can be found in the appropriate section of this provider manual. Providers should contact the PSC or submit an online inquiry for additional information.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

The South Carolina Department of Health and Human Services ensures the integrity of the Medicaid Program and seeks to reduce waste, fraud, and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity and the Division of Audits. The purposes of program oversight are to safeguard against unnecessary or inappropriate use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY

The Division of Program Integrity conducts post-payment reviews of health care providers including but not limited to outpatient hospitals, clinics, pharmacies, therapeutic group homes, physicians, dentists, other health care professionals, CLTC providers, durable medical equipment providers, transportation providers, and behavioral and mental health care providers. Program Integrity uses several methods to identify areas for review:

- The toll-free Fraud and Abuse Hotline for complaints of provider and beneficiary abuse. The number is 1-888-364-3224.
- Complaints of provider or beneficiary abuse reported using the Fraud and Abuse email address: fraudres@scdhhs.gov. Each complaint received from the hotline or email is reviewed, and if the complaint is determined to involve either a Medicaid beneficiary or provider, a preliminary investigation is conducted to identify any indications of fraud and abuse.
- Referrals from other sources as well as ongoing provider monitoring that identify aberrant or excessive billing practices.
- The automated Surveillance and Utilization Review System (SURS) to create provider profiles and exception reports that identify excessive or aberrant billing practices.

PROGRAM INTEGRITY (CONT'D.)

A Program Integrity review can cover several years' worth of paid claims data. (See "Records/Documentation Requirements" in this section for the policy on Medicaid record retention.) The Division conducts payment reviews, analysis of provider payments, and review of provider records, using statistical sampling and overpayment estimation when feasible, to determine the following:

- Medical reasonableness and necessity of the service provided
- Compliance with Medicaid program coverage and payment policies
- Compliance with state and federal Medicaid laws and regulations
- Compliance with accepted medical coding conventions, procedures, and standards
- Whether the amount, scope, and duration of the services billed to Medicaid are fully documented in the provider's records

Most Program Integrity on-site reviews are unannounced. The medical records and all other necessary documents

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

obtained/received from the provider must contain documentation sufficient to disclose the extent of services delivered, medical necessity, appropriateness of treatment, and quality of care. Program Integrity staff thoroughly review all the documentation and notify the provider of the post-payment review results. If the Program Integrity review finds that excessive or improper payments have been made to a provider, the provider will be required to refund the overpayment or have it taken from subsequent Medicaid reimbursement. Even if a provider terminates his or her agreement with Medicaid, the provider is still liable for any penalties or refunds identified by a Program Integrity review or audit. Failure to repay an identified overpayment may result in exclusion from the Medicaid program and other sanctions, which will be reported to the Federal Office of Inspector General (OIG).

For claims selected for a Program Integrity review, the provider cannot void, replace, or tamper with any claim records and documentation until the review is finalized.

PROGRAM INTEGRITY (CONT'D.)

Providers who disagree with the review findings are instructed to follow the process outlined in the certified letter of notification. The process affords providers the opportunity to discuss and/or present evidence to support their Medicaid claims.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM

The Beneficiary Explanation of Medical Benefits Program allows Medicaid beneficiaries the opportunity to participate in the detection of fraud and abuse. Each month the Division of Program Integrity randomly selects four hundred beneficiaries for whom claims for services were paid. These beneficiaries are provided with an Explanation of Medical Benefits that lists all non-confidential services that were billed as having been delivered to them and which were paid during the previous 45-day period. Beneficiaries are requested to verify that they received the services listed. The Division of Program Integrity investigates services that beneficiaries deny having received.

BENEFICIARY OVERSIGHT

The Division of Program Integrity identifies beneficiaries who may be misusing or overusing Medicaid services. Claims of identified persons are analyzed for patterns of possible fraudulent or abusive use of services. Referral to the State Attorney General's Office or other law enforcement agencies for investigation will be made based on the severity of the misuse. When an investigation is not warranted, an educational letter may be sent to the beneficiary encouraging them to select a primary care physician and one pharmacy to ensure they receive quality care from a health care provider of their choice.

Complaints pertaining to beneficiaries' misuse of Medicaid services can be reported using the Fraud and Abuse Hotline (1-888-364-3224) or fraud email at fraudres@scdhhs.gov.

MEDICAID BENEFICIARY LOCK-IN PROGRAM

SCDHHS implemented a Medicaid Beneficiary Lock-In Program in December 2008. The purpose of the Beneficiary Lock-In Program is to address issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary profiles in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services, such as using four or more pharmacies in a six-month period. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program for one year to monitor their drug utilization and to require them to utilize one designated pharmacy. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The pharmacy provider selected is also notified of the lock-in, so that adequate time is allowed for selection of another provider should the first provider find he or she cannot provide the needed services.

MEDICAID BENEFICIARY LOCK-IN PROGRAM (CONT'D.)

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PROVIDER EXCLUSIONS / SUSPENSIONS

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS/PROVIDER EXCLUSIONS/SUSPENSIONS

FRAUD

The South Carolina Medicaid program operates under the anti-fraud provisions of 42 US Code §1320a-7b. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations, and the individuals and/or entities liable under this section.

The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A. Program Integrity must conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit of the State Attorney General's Office for investigation and possible prosecution. Medicaid payments to a provider may be withheld upon credible allegations of fraud. Suspected Medicaid fraud on the part of a beneficiary is also referred to a Medicaid Recipient Fraud Unit in the State Attorney General's Office for investigation.

PROVIDER EXCLUSIONS / SUSPENSIONS

Federal regulations that give States the authority to exclude providers for fraud and abuse in the Medicaid program are found at 42 CFR Part 1002, Subparts A and B. Exclusion means that a health care provider, either an individual practitioner or facility, organization, institution, business, or other type of entity, cannot receive Medicaid payment for any health care services rendered. Exclusions from Medicaid, as well as the State Children's Health Insurance Program (SCHIP), may be the result of:

PROVIDER EXCLUSIONS / SUSPENSIONS (CONT'D.)

- Conviction of a criminal offense related to delivery of services in a health care program
- Conviction of health care fraud under either Federal or State laws
- Conviction of the patient neglect or abuse in connection with delivery of health care
- Excessive claims or furnishing of unnecessary or substandard items and services
- Failure to comply with financial responsibilities and obligations
- Adverse action by a licensing board

Exclusions can be initiated by either federal authorities such as the US Department of Health and Human Services, Office of Inspector General (OIG) or by the State Medicaid agency. An excluded individual may be a licensed medical professional, such as a physician, dentist, or nurse, but exclusion is not limited to these types of individuals. The ban on Medicaid funding can extend to any individual or entity providing services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS/PROVIDER EXCLUSIONS/SUSPENSIONS

that are related to and reimbursed, directly or indirectly, by a Medicaid program.

In addition, the OIG and/or SCDHHS may exclude an entity, including managed care organizations, if someone who is an owner, an officer, an agent, a director, a partner, or a managing employee of the entity has been excluded.

PROVIDER EXCLUSIONS / SUSPENSIONS (CONT'D.)

Any medical provider, organization, or entity that accepts Medicaid funding, or that is involved in administering the Medicaid program, should screen all employees and contractors to determine whether any of them have been excluded. Any individual or entity which employs or contracts with an excluded provider cannot claim Medicaid reimbursement for any items or services furnished, authorized, or prescribed by the excluded provider.

Federal regulations further require that any party who is excluded, suspended, or terminated from participation in Medicare under 42 CFR Part 1001 must also be suspended from the Medicaid program. Medicaid payment is not available for services furnished directly by, or under the supervision of, an excluded or suspended party.

The OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE Web site is located at http://www.oig.hhs.gov/fraud/exclusions.asp.

SCDHHS also maintains its own list of excluded, South Carolina-only Medicaid providers (or those with a South Carolina connection) that is on our Web site at http://www.scdhhs.gov/.

ADMINISTRATIVE SANCTIONS

State regulations concerning administrative sanctions in the Medicaid program are found in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1. SCDHHS may impose one or more of the following sanctions against a provider who has been determined to have abused the program:

- Educational intervention
- Postpayment review
- Prepayment review
- Peer review
- Financial sanctions, including recoupment of overpayment or inappropriate payment
- Suspension
- Termination or exclusion
- Referral to licensing/certifying boards or agencies

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS/PROVIDER EXCLUSIONS/SUSPENSIONS

OTHER FINANCIAL PENALTIES

The State Attorney General's Office may also impose financial penalties and damages against a provider who has been determined to be guilty of fraud or convicted of a crime related to participation in the Medicaid or Medicare programs.

The United States Department of Health and Human Services (USDHHS), Office of Inspector General (OIG), may also impose civil money penalties and assessments under the provisions of 42 CFR Part 1003.

FAIR HEARINGS

Proposed South Carolina initiated exclusion, suspension, or termination from the Medicaid program, as well as recoupment of an overpayment identified by Program Integrity, may be appealed within 30 days of imposition of the sanction. (See "Appeals Procedures" elsewhere in this section.)

FAIR HEARINGS (CONT'D.)

Any party who has been suspended, excluded, or terminated from the Medicaid program as a result of a similar action by Medicare may exercise appeal rights as set forth in the written notice from the USDHHS OIG. Appeals to the OIG shall be processed in accordance with 42 CFR 1001.2007. A party so excluded shall have no right to separate appeal before SCDHHS.

REINSTATEMENT

Re-enrollment in Medicaid by formerly excluded providers is not automatic. The CFR [42 CFR 1002.215(a)] gives states the right to review requests for reinstatement and to grant or deny the requests.

Before a request for re-enrollment in Medicaid will be considered, the provider must have an active, valid license to practice and must not be excluded from Medicaid by the federal government (USDHHS OIG). It is the provider's responsibility to satisfy these requirements.

All requests for re-enrollment in Medicaid will be considered by SCDHHS on an individual basis and on their own merit.

APPEALS

SCDHHS maintains procedures ensuring that all Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in South Carolina Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

The South Carolina Medicaid appeals process is not a reconsideration or claims review process. It is a formal process that should be considered as an avenue of last resort to be used in attempting to resolve or settle a dispute(s). Providers should contact the PSC or submit an online inquiry for assistance to resolve or settle a dispute(s) before requesting an administrative hearing.

In accordance with regulations of SCDHHS, a provider wishing

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS/PROVIDER EXCLUSIONS/SUSPENSIONS

to file an appeal must send a letter requesting a hearing along with a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Letters requesting an appeal hearing should be sent to the following address:

Division of Appeals and Hearings
Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

APPEALS (CONT'D.)

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 days from receipt of the remittance advice reflecting the denial, whichever is later. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS/PROVIDER EXCLUSIONS/SUSPENSIONS

DIVISION OF AUDITS

Medicaid providers who contract with SCDHHS for services, including state agencies, may be audited by the SCDHHS Division of Audits. The SCDHHS Division of Audits was formed to assist the agency in the management, assessment, and improvement of agency programs, services, and operations. The Division of Audits accomplishes these goals by continuously reviewing and evaluating programs administered by SCDHHS to determine the extent to which fiscal, administrative, and programmatic objectives are met in a cost-effective manner.

In performing its audits, the Division of Audits follows generally accepted auditing standards (GAGAS). The Division of Audits performs different types of audits of Medicaid providers and programs, including:

- Performance audits that provide an independent assessment of the program outcomes and the management of resources. These audits address the effectiveness, efficiency, and adequacy of program results.
- Audits of contracts with health care providers and other state agencies to ensure compliance with contract terms and conditions for Medicaid service delivery and administration
- Audits to confirm the accuracy and allowability of costs and other financial information reported to SCDHHS

PAYMENT ERROR RATE MEASUREMENT

PAYMENT ERROR RATE MEASUREMENT (CONT'D.)

The South Carolina Medicaid program, along with the Medicaid programs in other states, will be required to comply with the CMS Payment Error Rate Measurement (PERM) program, beginning in federal fiscal year 2007. PERM requires states to submit a statistically valid sample of paid Medicaid claims to a federal contractor, which will review for compliance with payment rates and state Medicaid policies, and will determine whether medical necessity for the service is adequately documented in the medical record. Providers who are chosen for the sample will be required to submit all applicable medical records for review; however, for most providers only one claim will be chosen for the sample. Providers who fail to send in the requested documentation will face recoupment of the Medicaid payment for the claim in question. In addition, if the CMS PERM contractor determines that a Medicaid claim was paid in error, SCDHHS will be required to recoup the payment for that claim. PERM will combine the errors found in each state in order to establish a national Medicaid error rate.

Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series. When individual radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

OPERATING ROOM (OR) OR AMBULATORY SURGICAL CENTER (ASC) USAGE FOR PLANNED, NON-EMERGENT TREATMENT MUST BE PRIOR AUTHORIZED. AUTHORIZATION REQUESTS MUST BE SUMITTED WITH APPROPRIATE DOCUMENTATION NO LESS THAN 15 DAYS PRIOR TO THE DATE OF TREATMENT. REFER TO SECTION 3.02 OF THE DENTAL ORM.

Child members of Healthy Connections are covered through the month of their 21st birthday.

Diagnostic						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation	0-20		No	One of (D0120, D0145) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	0-20		No	Two of (D0140) per 12 Month(s) Per Provider.	
D0145	oral evaluation under 3 years of age	0-2		No	One of (D0120, D0145) per 6 Month(s) Per patient.	

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Diagnostic						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation	3 - 20		No	One of (D0150) per 36 Month(s) Per Provider.	
D0210	intraoral-complete series (including bitewings)	2-20		No	One of (D0210, D0330) per 36 Month(s) Per patient.	
D0220	intraoral-periapical-1st film	0-20		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral-periapical-each additional film	0-20		No	Three of (D0230) per 1 Day(s) Per patient.	
D0240	intraoral - occlusal film	0-20		No	Two of (D0240) per 12 Month(s) Per patient.	
D0270	bitewing - single film	2-20		No	One of (D0270) per 6 Month(s) Per patient. One of (D0270, D0272) per 1 Day(s) Per patient.	
D0272	bitewings - two films	2-20		No	One of (D0272) per 6 Month(s) Per patient.	
D0330	panoramic film	8-20		No	One of (D0210, D0330) per 36 Month(s) Per patient. For members age 8 through 20, oral surgeons are allowed one additional usage of D0330 per beneficiary within the 36 month period.	

South Carolina Healthy Connections Under 21

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

BILLING AND REIMBURSEMENT FOR SPACE MAINTAINERS SHALL BE BASED ON CEMENTATION OR INSERTION DATE.

Child members of Healthy Connections are covered through the month of their 21st birthday.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	12-20		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1120	prophylaxis - child	0-11		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1203	topical application of fluoride (prophylaxis not included) - child	0-11		No	One of (D1203, D1204, D1206) per 6 Month(s) Per patient.	
D1204	topical application of fluoride (prophylaxis not included) - adult	12-20		No	One of (D1203, D1204, D1206) per 6 Month(s) Per patient.	
D1206	topical flouride varnish	0-20		No	One of (D1203, D1204, D1206) per 6 Month(s) Per patient.	
D1351	sealant - per tooth	6-14	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 36 Month(s) Per patient per tooth.	
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1515) per 1 Lifetime Per patient per quadrant.	
D1515	space maint-fixed-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1510, D1515) per 1 Lifetime Per patient per arch.	

South Carolina Healthy Connections Under 21

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Reimbursement includes local anesthesia.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Child members of Healthy Connections are covered through the month of their 21st birthday.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2160	Amalgam - three surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2161	Amalgam - four surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-1 surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2331	resin-2 surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2332	resin-3 surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2335	resin-4+ surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2391	resin-based composite - 1 surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2392	resin-based composite - 2 surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2393	resin-based composite - 3 surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2394	resin-based composite - 4 or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	Six of (D2930, D2932, D2934) per 1 Day(s) Per patient in office. One of (D2930, D2932, D2934) per 36 Month(s) Per patient per tooth. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated steel crown-permanent tooth	0-20	Teeth 1 - 32	No	Six of (D2931, D2932) per 1 Day(s) Per patient per tooth, per surface in office. One of (D2931) per 60 Month(s) Per patient per tooth. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	
D2932	prefabricated resin crown	0-20	Teeth 1 - 32, A - T	No	Six of (D2930, D2932, D2934) per 1 Day(s) Per patient in office. One of (D2930, D2932, D2934) per 36 Month(s) Per patient per tooth. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth C - H, M - R	No	Six of (D2930, D2932, D2934) per 1 Day(s) Per patient in office. One of (D2930, D2932, D2934) per 36 Month(s) Per patient per tooth. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2934, D2950, D2951, D2954, D3220, D3310, D3320, D3330) per 1 Day(s) Per patient per tooth. One of (D2940) per 36 Month(s) Per patient per tooth. Not allowed with D2000 or D3000 series codes on the same date of service.	
D2950	core buildup, including any pins	0-20	Teeth 1 - 32	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2951	pin retention - per tooth in addition to restoration	0-20	Teeth 1 - 32	No	One of (D2951) per 1 Lifetime Per patient per tooth.	
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	

South Carolina Healthy Connections Under 21

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Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the DentaQuest Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Child members of Healthy Connections are covered through the month of their 21st birthday.

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration)	0-20	Teeth 2 - 15, 18 - 31, A - T	No	Six of (D3220) per 1 Day(s) Per patient in office. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	
D3310	Endodontic therapy, anterior (exc final rest)	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3310, D3320, D3330) per 1 Lifetime Per patient per tooth. Pre-treatment and post-treatment radiographs must be maintained in the patient record.	narr. of med. necessity, pre-op x-ray(s)

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3320	Endodontic therapy, bicuspid (exc final restore)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3310, D3320, D3330) per 1 Lifetime Per patient per tooth. Pre-treatment and post-treatment radiographs must be maintained in the patient record.	narr. of med. necessity, pre-op x-ray(s)
D3330	Endodontic therapy, molar(excluding final restore)	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	One of (D3310, D3320, D3330) per 1 Lifetime Per patient per tooth. Pre-treatment and post-treatment radiographs must be maintained in the patient record.	narr. of med. necessity, pre-op x-ray(s)

South Carolina Healthy Connections Under 21

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Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence is submitted that indicatesthat the masticatory insufficiencies are likely to impair the general health of the member.

Authorization for partial dentures for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing. Partial dentures are not a covered benefit when 8 or more posterior teeth are in occlusion.

Dentures will not be preauthorized when:

Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining or rebasing of the patient's present dentures will make them serviceable.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

BILLING AND REIMBURSEMENT FOR REMOVABLE PROSTHETICS SHALL BE BASED ON THE INSERTION DATE.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Child members of Healthy Connections are covered through the month of their 21st birthday.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	14-20		Yes	One of (D5110) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	14-20		Yes	One of (D5120) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture-resin base	14-20		Yes	One of (D5211) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture-resin base	14-20		Yes	One of (D5212) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5510	repair broken complete denture base	14-20	Per Arch (01, 02, LA, UA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	14-20	Teeth 1 - 32	No		
D5610	repair resin denture base	14-20	Per Arch (01, 02, LA, UA)	No		
D5640	replace broken teeth-per tooth	14-20	Teeth 1 - 32	No		

South Carolina Healthy Connections Under 21

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Reimbursement includes local anesthesia and post-operative care up to 30 days from the date of service.

The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Child members of Healthy Connections are covered through the month of their 21st birthday.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	coronal remnants - erupted or exposed root	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction - erupted or exposed root	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)

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Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241) per 1 Lifetime Per Provider OR Location per tooth. Not allowed by same office or provider who performed original extraction.	pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes	Two of (D7280) per 1 Day(s) Per patient.	pre-operative x-ray(s)
D7285	biopsy of oral tissue - hard (bone, tooth)	0-20		Yes		Pathology report
D7286	biopsy of oral tissue - soft (all others)	0-20		Yes		Pathology report
D7410	radical excision - lesion diameter up to 1.25cm	0-20		Yes		Pathology report

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7411	excision of benign lesion greater than 1.25 cm	0-20		Yes		Pathology report
D7412	excision of benign lesion, complicated	0-20		Yes		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	0-20		Yes		Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	0-20		Yes		Pathology report
D7415	excision of malignant lesion, complicated	0-20		Yes		Pathology report
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	0-20		Yes		Pathology report
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7465	destruction of lesion(s) by physical or chemical method, by report	0-20		Yes		Pathology report

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		Yes		narrative of medical necessity
D7530	removal of foreign body, skin, or subcutaneous alveolar tissue	0-20		Yes	One of (D7530) per 1 Day(s) Per patient.	narrative of medical necessity
D7550	sequestrectomy for osteomyelitis	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Not to be billed for treatment of dry socket.	narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7770	alveolus-stabilization of teeth, open reduction splinting	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7771	alveolus, closed reduction stabilization of teeth	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7910	suture small wounds up to 5 cm	0-20		Yes	Excludes closure of surgical incision.	narrative of medical necessity
D7911	complicated suture-up to 5 cm	0-20		Yes	Excludes closure of surgical incision.	narrative of medical necessity
D7912	complex suture - greater than 5cm	0-20		Yes	Excludes closure of surgical incision.	narrative of medical necessity

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Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Adjunctive services are not reimburseable if unaccompanied by a covered treatment procedure (unless the reimbursement request is a resubmission of a previously denied line).

Child members of Healthy Connections are covered through the month of their 21st birthday.

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9220	general anesthesia - first 30 minutes	0-20		Yes	One of (D9220, D9230, D9241, D9248, D9920) per 1 Day(s) Per patient. Not allowed in conjunction with D9220,D9230,D9241,D9248 or D9920. Allow only one of these procedure(s) per date of service.	narrative of medical necessity
D9230	inhalation of nitrous oxide/anxiolysis, analgesia	0-20		No	One of (D9220, D9230, D9241, D9920) per 1 Day(s) Per patient.	
D9241	intravenous sedation/analgesia - first 30 minutes	0-20		Yes	One of (D9220, D9230, D9241, D9248, D9920) per 1 Day(s) Per patient. Not allowed in conjunction with D9220,D9230,D9241,D9248 or D9920. Allow only one of these procedure(s) per date of service.	narrative of medical necessity
D9248	non-intravenous conscious sedation	0-20		No	One of (D9220, D9241, D9248, D9920) per 1 Day(s) Per patient.	

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9420	hospital of ambulatory surgical center call	0-20		Yes	May be billed when rendering prior approved treatment in hospital or ASC. Code must be included on the place of service prior authorization request. SCDHHS prohibits the billing of beneficiaries to schedule appointments or to hold appointment blocks prior to treatment in a hospital or ambulatory center setting.	narr. of med. necessity, pre-op x-ray(s)
D9920	behavior management, by report	0-20		Yes	One of (D9920) per 1 Day(s) Per patient. One of (D9220, D9230, D9241, D9248, D9920) per 1 Day(s) Per patient. Documentation in the patient record must be unique to that visit and must include a description of the known condition of the patient and additional time to provide treatment.	narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	0-20		Yes		narrative of medical necessity

South Carolina Healthy Connections Under 21

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Reimbursement includes local anesthesia and post-operative care up to 30 days from the date of service.

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Child members of Healthy Connections are covered through the month of their 21st birthday.

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	0-20		No		
20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
20902	Bone graft, any donor area; major or large	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21031	Excision of Torus Mandibularis	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21032	Excision of Maxillary Torus Palatinus	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21034	Excision of Malignant Tumor of Maxilla or Zygoma	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21040	Excision Benign Cyst/Tumor Mandible by Enucleation and or curett	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21044	Excision of malignant tumor of mandible	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21045	Excision Of Malignant Tumor Of Mandible; Radical Resection	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21050	Condylectomy, Temporomandibular Joint (Separate Procedure)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21060	Meniscectomy, Partial Or Complete, Temporomandibular Joint (Separate Proced	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21070	Coronoidectomy (separate procedure)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21110	Application Of Interdental Fixation Device For Conditions Other Than Fractu	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21116	Inject Proc Tempoman Arthrotomography	0-20		Yes		narrative of medical necessity
21210	Graft, Bone; Nasal, Maxillary Or Malar Areas (Includes Obtaining Graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21242	Arthroplasty, Temporomandibular Joint, With Allograft	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21243	Arthroplasty, Temporomandibular Joint, With Prosthetic Joint Replacement	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21310	Closed TX of Nasal Bone Fracture-without manipulation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21315	Closed Treatment Of Nasal Bone Fracture; With Out Stabilization	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21320	Closed treatment of nasal bone fracture; with stabilization	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21325	Open treatment of nasal fracture; uncomplicated	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21330	Open treatment of nasal fracture; complicated with internal and/or external skeletal fixation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire, or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21344	Open treatment of complicated frontal sinus fracture, via coronal or multiple approaches	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21356	Open treatment of depressed zygomatic arch fracture	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21365	Open treatment of complicated fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21366	Open treatment of complicated fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21386	Open treatment of orbital floor blowout fracture; periorbital approach	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21387	Open treatment of orbital floor blowout fracture; combined approach	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21390	Open treatment of orbital floor blowout fracture; periorbital approach with alloplastic or other implant	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21406	Open treatment of fracture of orbit, except blowout; without implant	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21407	Open treatment of fracture of orbit, except blowout; with implant	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21408	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21423	Open treatment of palatal or maxillary fracture (LeFort I type) complicated (comminuted or involving cranial nerve foramina), multiple approaches	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21433	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21435	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21445	Open treatment of mandibular or maxillary alveolar ridge fracture	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21450	Closed treatment of mandibular fracture; without manipulation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21451	Closed treatment of mandibular fracture; with manipulation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21452	Percutaneous treatment of mandibular fracture, with external fixation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21453	Closed treatment of mandibular fracture with interdental fixation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21454	Open treatment of mandibular fracture with external fixation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21461	Open treatment of mandibular fracture; without interdental fixation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21462	Open treatment of mandibular fracture; with interdental fixation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21465	Open treatment of mandibular condylar fracture	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21485	Closed treatment of temporomandibular dislocation; complicated, initial or subsequent	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
21497	Interdental wiring, for condition other than fracture	0-20		Yes		narrative of medical necessity
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
29804	Arthroscopy, temporomandibular joint, surgical	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
31000	Lavage by cannulation; maxillary (antrotomy); intranasal	0-20		Yes		narrative of medical necessity
31020	Sinusotomy, maxillary (antrotomy); intranasal	0-20		Yes		narrative of medical necessity
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	0-20		Yes		narrative of medical necessity
31040	Pterygomaxillary fossa surgery	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
31225	Maxillectomy; without orbital exenteration	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
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31230	Maxillectomy with orbital exenteration	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
31603	Tracheostomy, emergency procedure; transtracheal	0-20		Yes		narrative of medical necessity
31605	Tracheostomy, emergency procedure; cricothyroid membrane	0-20		Yes		narrative of medical necessity
40500	Vermilionectomy (lip shave), with mucosal advancement	0-20		Yes		narrative of medical necessity
40510	Excision of lip; transverse wedge excision with primary closure	0-20		Yes		narrative of medical necessity
40520	Excision of lip; V excision with primary direct linear closure	0-20		Yes		narrative of medical necessity
40530	Resection of lip, more than one-fourth, without reconstruction	0-20		Yes		narrative of medical necessity
40650	Repair lip, full thickness; vermilion only	0-20		Yes		narrative of medical necessity
40652	Repair lip, full thickness; up to half vertical height	0-20		Yes		narrative of medical necessity
40654	Repair lip, full thickness; over one-half vertical height, or complex	0-20		Yes		narrative of medical necessity
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	0-20		Yes		narrative of medical necessity
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure	0-20		Yes		narrative of medical necessity
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages	0-20		Yes		narrative of medical necessity

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
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40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	0-20		Yes		narrative of medical necessity
40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe Estlander type), including sectioning and inserting of pedicle	0-20		Yes		narrative of medical necessity
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual	0-20		Yes		narrative of medical necessity
41008	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	0-20		Yes		narrative of medical necessity
41009	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space	0-20		Yes		narrative of medical necessity
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	0-20		Yes		narrative of medical necessity
41016	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental	0-20		Yes		narrative of medical necessity
41017	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular	0-20		Yes		narrative of medical necessity
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space	0-20		Yes		narrative of medical necessity

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
41112	Excision of lesion of tongue with closure; anterior two-thirds	0-20		Yes		narrative of medical necessity
41113	Excision of lesion of tongue with closure; posterior one-third	0-20		Yes		narrative of medical necessity
41116	Excision, lesion of floor of mouth	0-20		Yes		narrative of medical necessity
41120	Glossectomy; less than one-half tongue	0-20		Yes		narrative of medical necessity
41130	Hemiglossectomy	0-20		Yes		narrative of medical necessity
41135	Glossectomy; partial, with unilateral radical neck dissection	0-20		Yes		narrative of medical necessity
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	0-20		Yes		narrative of medical necessity
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	0-20		Yes		narrative of medical necessity
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	0-20		Yes		narrative of medical necessity
41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	0-20		Yes		narrative of medical necessity
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	0-20		Yes		narrative of medical necessity

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	0-20		Yes		narrative of medical necessity
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissue	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
41806	Removal of embedded foreign body from dentoalveolar structures; bone	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
41828	Excision of hyperplastic alveolar mucosa, each quadrant	0-20		Yes		narrative of medical necessity
41874	Alveoloplasty, each quadrant	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
42106	Excision, lesion of palate, uvula; with simple primary closure	0-20		Yes		narrative of medical necessity
42120	Resection of palate or extensive resection of lesion	0-20		Yes		narrative of medical necessity
42200	Palatoplasty for cleft palate, soft and/or hard palate only	0-20		Yes		narrative of medical necessity
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
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42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
42215	Palatoplasty for cleft palate; major revision	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
42220	Palatoplasty for cleft palate; secondary lengthening procedure	0-20		Yes		narrative of medical necessity
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	0-20		Yes		narrative of medical necessity
42235	Repair of anterior palate, including vomer flap	0-20		Yes		narrative of medical necessity
42260	Repair of nasolabial fistula	0-20		Yes		narrative of medical necessity
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	0-20		Yes		narrative of medical necessity
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	0-20		Yes		narrative of medical necessity
42408	Excision of sublingual salivary cyst (ranula)	0-20		Yes		narrative of medical necessity
42409	Marsupialization of sublingual salivary cyst (ranula)	0-20		Yes		narrative of medical necessity
42440	Excision of submandibular (submaxillary) gland	0-20		Yes		narrative of medical necessity
42450	Excision of sublingual gland	0-20		Yes		narrative of medical necessity

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
42550	Injection procedure for sialography	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
88160	Cytopathology, smears, any other source; screening and interpretation	0-20		Yes		narrative of medical necessity
88300	Level I surgical pathology-gross examination only	0-20		No		
88302	Level II surgical pathology--gross and microscopic examination	0-20		No		
88304	Level III surgical pathology--gross and microscopic examination	0-20		No		
88305	Level IV surgical pathology---gross and microscopic examination	0-20		No		
88307	Level V surgical pathology---gross and microscopic examination	0-20		No		
88309	Level VI surgical pathology---gross and microscopic examination	0-20		No		
88311	Decalcification procedure (List separately in addition to code for surgical pathology examination)	0-20		No		
88312	Special Stains	0-20		No		
99201	Office or outpatient visit for new patient requires: a problem focused history; a problem focused examination; and straightforward medical decision making	0-20		No		

South Carolina Healthy Connections Under 21

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99202	Office or outpatient visit for new patient requires: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making	0-20		No		
99203	Office or outpatient visit for new patient requires: a detailed history; a detailed examination; and medical decision making of low complexity	0-20		No		
99204	Office or outpatient visit for new patient requires: a comprehensive history; a comprehensive examination; and medical decision making of a moderate complexity	0-20		No		
99205	Office or outpatient visit for new patient requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	0-20		No		
99211	E/M office/op serv est patient level I	0-20		No		
99212	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	0-20		No		
99213	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	0-20		No		

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99214	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	0-20		No		
99215	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	0-20		No		
99217	Observation Care Discharge Day Management	0-20		No		
99218	Initial observation care per day level 1	0-20		No		
99219	Initial observation care per day level 2	0-20		No		
99220	Initial observation care per day level 3	0-20		No		
99221	Initial hospital care, per day, requires: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity:	0-20		No		
99222	Initial hospital care, per day, requires: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity:	0-20		No		

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99223	Initial hospital care, per day, requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity:	0-20		No		
99231	Subsequent hospital care, per day, requires two of the three: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity	0-20		No		
99232	Subsequent hospital care, per day, requires two of the three: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity	0-20		No		
99233	Subsequent hospital care, per day, requires two of the three: a detailed interval history; a detailed examination; and medical decision making of high complexity	0-20		No		
99234	Observation OR IP care E/M pat adm and discharge; low service	0-20		No		
99235	Observation OR IP care E/M pat adm and discharge; moderate service	0-20		No		
99236	Observation OR IP care E/M pat adm and discharge; high service	0-20		No		
99238	Hospital discharge day management; 30 min or less	0-20		No		

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99239	Hospital discharge day management; more than 30 minutes	0-20		No		
99241	E/M consult office consult level 1	0-20		No		
99242	E/M consult office consult level 2	0-20		No		
99243	E/M consult office consult level 3	0-20		No		
99244	E/M consult office consult level 4	0-20		No		
99245	E/M consult office consult level 5	0-20		No		
99251	Initial inpatient consultation for a new or established patient, requires: a problem focused history; a problem focused examination; and straightforward medical decision making	0-20		No		
99252	Initial inpatient consultation for a new or established patient, requires: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making	0-20		No		
99253	Initial inpatient consultation for a new or established patient, requires: a detailed history; an detailed examination; and medical decision making of low complexity	0-20		No		

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99254	Initial inpatient consultation for a new or established patient, requires: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity	0-20		No		
99255	Initial inpatient consultation for a new or established patient, requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	0-20		No		
99281	Emergency department visit requires: a problem focused history; a problem focused examination; and straightforward medical decision making	0-20		No		
99282	Emergency department visit requires: an expanded problem focused history; an extended problem focused examination; and medical decision making of low complexity	0-20		No		
99283	Emergency department visit requires: an expanded problem focused history; an extended problem focused examination; and medical decision making of moderate complexity	0-20		No		
99284	Emergency department visit requires: a detailed history; a detailed examination; and medical decision making of moderate complexity	0-20		No		

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99285	Emergency department visit requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	0-20		No		
99291	E/M critical care service 1st hour on given date	0-20		No		
99292	E/M critical care service each 30 minutes beyond 1 hour	0-20		No		
99304	E/M NF service comp NF assesments level 1	0-20		No		
99305	E/M NF service comp NF assesments level 2	0-20		No		
99306	E/M NF service comp NF assesments level 3	0-20		No		
99307	E/M NF service subsequent NF assesments level 1	0-20		No		
99308	E/M NF service subsequent NF assesments level 2	0-20		No		
99309	E/M NF service subsequent NF assesments level 3	0-20		No		
99310	E/M NF service subsequent NF assesments level 4	0-20		No		
99324	E/M DOM, RH or cust serv new patient level 1	0-20		No		
99325	E/M DOM, RH or cust serv new patient level 2	0-20		No		
99326	E/M DOM, RH or cust serv new patient level 3	0-20		No		

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99327	E/M DOM, RH or cust serv new patient level 4	0-20		No		
99328	E/M DOM, RH or cust serv new patient level 5	0-20		No		
99334	E/M DOM, RH or cust serv est patient level 1	0-20		No		
99335	E/M DOM, RH or cust serv est patient level 2	0-20		No		
99336	E/M DOM, RH or cust serv est patient level 3	0-20		No		
99337	E/M DOM, RH or cust serv est patient level 4	0-20		No		
99341	E/M home visit new patient, low sev, 20 min, F-F	0-20		No		
99342	E/M home visit new patient, low comp, 30 min, F-F	0-20		No		
99343	E/M home visit new patient, mod comp, 45 min, F-F	0-20		No		
99344	E/M home visit new patient, mod comp, 60 min, F-F	0-20		No		
99345	E/M home visit new patient, hi comp, 75 min, F-F	0-20		No		
99347	E/M home visit est pat, low-med se, 15M F-F	0-20		No		
99348	E/M home visit est pat, low-med se, 25M F-F	0-20		No		
99349	E/M home visit est pat, mod-hi se, 40M F-F	0-20		No		

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Exhibit A Benefits Covered for
South Carolina Healthy Connections Under 21

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99350	E/M home visit est pat, mid-hi se, 60M F-F	0-20		No		
99441	E/M case management service phone call simple	0-20		No		

South Carolina Healthy Connections Under 21

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

As of 02/01/2011, adult Beneficiaries are no longer eligible for dental treatment under Healthy Connections except as specified in Section 4.07 of the Dental ORM.

Oral surgeons may seek reimbursement for covered emergency medical (CPT) procedures rendered to adult Beneficiaries as of 01/01/2012.

Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series. When individual radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Diagnostic						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0140	limited oral evaluation-problem focused	21 and older		Yes	Two of (D0140) per 12 Month(s) Per Provider.	narrative of medical necessity
D0210	intraoral-complete series (including bitewings)	21 and older		Yes	One of (D0210, D0330) per 36 Month(s) Per patient.	narrative of medical necessity

South Carolina Healthy Connections Adult

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Diagnostic						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral-periapical-1st film	21 and older		Yes	One of (D0220) per 1 Day(s) Per patient.	narrative of medical necessity
D0230	intraoral-periapical-each additional film	21 and older		Yes	Three of (D0230) per 1 Day(s) Per patient.	narrative of medical necessity
D0240	intraoral - occlusal film	21 and older		Yes	Two of (D0240) per 12 Month(s) Per patient.	narrative of medical necessity
D0270	bitewing - single film	21 and older		Yes	One of (D0270) per 6 Month(s) Per patient. One of (D0270, D0272) per 1 Day(s) Per patient.	narrative of medical necessity
D0272	bitewings - two films	21 and older		Yes	One of (D0272) per 6 Month(s) Per patient.	narrative of medical necessity
D0330	panoramic film	21 and older		Yes	One of (D0210, D0330) per 36 Month(s) Per patient.	narrative of medical necessity

South Carolina Healthy Connections Adult

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

As of 02/01/2011, adult Beneficiaries are no longer eligible for dental treatment under Healthy Connections except as specified in Section 4.07 of the Dental ORM.

Oral surgeons may seek reimbursement for covered emergency medical (CPT) procedures rendered to adult Beneficiaries as of 01/01/2012.

Reimbursement includes local anesthesia and post-operative care.

The extraction of asymptomatic teeth including impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or traumatic injury.

The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	coronal remnants - erupted or exposed root	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7140	extraction - erupted or exposed root	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Single tooth extractions under this code do not require a narrative of medical necessity or an x-ray, only indication that the procedure was rendered as an emergency. Removal of asymptomatic teeth is not a covered benefit.	narr. of med. necessity, pre-op x-ray(s)

South Carolina Healthy Connections Adult

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Single tooth extractions under this code do not require a narrative of medical necessity or an x-ray, only indication that the procedure was rendered as an emergency. Removal of asymptomatic teeth is not a covered benefit.	narr. of med. necessity, pre-op x-ray(s)
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241) per 1 Lifetime Per Provider OR Location per tooth. Removal of Asymptomatic tooth not covered. Not allowed by same office or provider who performed original extraction.	pre-operative x-ray(s)

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7285	biopsy of oral tissue - hard (bone, tooth)	21 and older		Yes		Pathology report
D7286	biopsy of oral tissue - soft (all others)	21 and older		Yes		Pathology report
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7411	excision of benign lesion greater than 1.25 cm	21 and older		Yes		Pathology report
D7412	excision of benign lesion, complicated	21 and older		Yes		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	21 and older		Yes		Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	21 and older		Yes		Pathology report
D7415	excision of malignant lesion, complicated	21 and older		Yes		Pathology report
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	21 and older		Yes		Pathology report
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7465	destruction of lesion(s) by physical or chemical method, by report	21 and older		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		Yes		narrative of medical necessity
D7530	removal of foreign body, skin, or subcutaneous alveolar tissue	21 and older		Yes	One of (D7530) per 1 Day(s) Per patient.	narrative of medical necessity
D7550	sequestrectomy for osteomyelitis	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Not to be billed for treatment of dry socket.	narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7770	alveolus-stabilization of teeth, open reduction splinting	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7771	alveolus, closed reduction stabilization of teeth	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7910	suture small wounds up to 5 cm	21 and older		Yes	Excludes closure of surgical incision.	narrative of medical necessity
D7911	complicated suture-up to 5 cm	21 and older		Yes	Excludes closure of surgical incision.	narrative of medical necessity
D7912	complex suture - greater than 5cm	21 and older		Yes	Excludes closure of surgical incision.	narrative of medical necessity

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

As of 02/01/2011, adult Beneficiaries are no longer eligible for dental treatment under Healthy Connections except as specified in Section 4.07 of the Dental ORM.

Oral surgeons may seek reimbursement for covered emergency medical (CPT) procedures rendered to adult Beneficiaries as of 01/01/2012.

Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Adjunctive general services are not reimbursable if unaccompanied by a covered treatment procedure (unless the reimbursement request is a resubmission of a previously denied line)

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Adjunctive services are not reimburseable if unaccompanied by a covered treatment procedure (unless the reimbursement request is a resubmission of a previously denied line).

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9220	general anesthesia - first 30 minutes	21 and older		Yes	One of (D9220, D9230, D9241, D9248) per 1 Day(s) Per patient.	narrative of medical necessity
D9230	inhalation of nitrous oxide/anxiolysis, analgesia	21 and older		Yes	One of (D9220, D9230, D9241) per 1 Day(s) Per patient.	narrative of medical necessity
D9241	intravenous sedation/analgesia - first 30 minutes	21 and older		Yes	One of (D9220, D9230, D9241, D9248) per 1 Day(s) Per patient.	narrative of medical necessity
D9248	non-intravenous conscious sedation	21 and older		No	One of (D9220, D9241, D9248, D9920) per 1 Day(s) Per patient per tooth.	narrative of medical necessity

South Carolina Healthy Connections Adult

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Exhibit B Benefits Covered for South Carolina Healthy Connections Adult

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9420	hospital of ambulatory surgical center call	21 and older		Yes	May be billed when rendering prior approved treatment in hospital or ASC. Code must be included on the place of service prior authorization request. SCDHHS prohibits the billing of beneficiaries to schedule appointments or to hold appointment blocks prior to treatment in a hospital or ambulatory center setting.	narr. of med. necessity, pre-op x-ray(s)
D9999	unspecified adjunctive procedure, by report	21 and older		Yes		narrative of medical necessity

South Carolina Healthy Connections Adult

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As of 02/01/2011, adult Beneficiaries are no longer eligible for dental treatment under Healthy Connections except as specified in Section 4.07 of the Dental ORM.

Oral surgeons may seek reimbursement for covered emergency medical (CPT) procedures rendered to adult Beneficiaries as of 01/01/2012.

Reimbursement includes local anesthesia and post-operative care up to 30 days from the date of service.

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	21 and older		No		
20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
20902	Bone graft, any donor area; major or large	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

South Carolina Healthy Connections Adult

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Exhibit B Benefits Covered for
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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21034	Excision of Malignant Tumor of Maxilla or Zygoma	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21040	Excision Benign Cyst/Tumor Mandible by Enucleation and or curett	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21044	Excision of malignant tumor of mandible	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21045	Excision Of Malignant Tumor Of Mandible; Radical Resection	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21050	Condylectomy, Temporomandibular Joint (Separate Procedure)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21060	Meniscectomy, Partial Or Complete, Temporomandibular Joint (Separate Proced	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21070	Coronoidectomy (separate procedure)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21110	Application Of Interdental Fixation Device For Conditions Other Than Fractu	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21116	Inject Proc Tempoman Arthrotomography	21 and older		Yes		narrative of medical necessity
21210	Graft, Bone; Nasal, Maxillary Or Malar Areas (Includes Obtaining Graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21242	Arthroplasty, Temporomandibular Joint, With Allograft	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21243	Arthroplasty, Temporomandibular Joint, With Prosthetic Joint Replacement	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21310	Closed TX of Nasal Bone Fracture-without manipulation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21315	Closed Treatment Of Nasal Bone Fracture; With Out Stabilization	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21320	Closed treatment of nasal bone fracture; with stabilization	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21325	Open treatment of nasal fracture; uncomplicated	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21330	Open treatment of nasal fracture; complicated with internal and/or external skeletal fixation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit B Benefits Covered for South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire, or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21344	Open treatment of complicated frontal sinus fracture, via coronal or multiple approaches	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21356	Open treatment of depressed zygomatic arch fracture	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21365	Open treatment of complicated fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21366	Open treatment of complicated fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21386	Open treatment of orbital floor blowout fracture; periorbital approach	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21387	Open treatment of orbital floor blowout fracture; combined approach	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21390	Open treatment of orbital floor blowout fracture; periorbital approach with alloplastic or other implant	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21406	Open treatment of fracture of orbit, except blowout; without implant	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21407	Open treatment of fracture of orbit, except blowout; with implant	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21408	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21423	Open treatment of palatal or maxillary fracture (LeFort I type) complicated (comminuted or involving cranial nerve foramina), multiple approaches	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21433	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21435	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21445	Open treatment of mandibular or maxillary alveolar ridge fracture	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21450	Closed treatment of mandibular fracture; without manipulation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21451	Closed treatment of mandibular fracture; with manipulation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21452	Percutaneous treatment of mandibular fracture, with external fixation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21453	Closed treatment of mandibular fracture with interdental fixation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21454	Open treatment of mandibular fracture with external fixation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21461	Open treatment of mandibular fracture; without interdental fixation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21462	Open treatment of mandibular fracture; with interdental fixation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21465	Open treatment of mandibular condylar fracture	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21485	Closed treatment of temporomandibular dislocation; complicated, initial or subsequent	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
21497	Interdental wiring, for condition other than fracture	21 and older		Yes		narrative of medical necessity
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
29804	Arthroscopy, temporomandibular joint, surgical	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
31000	Lavage by cannulation; maxillary (antrotomy); intranasal	21 and older		Yes		narrative of medical necessity
31020	Sinusotomy, maxillary (antrotomy); intranasal	21 and older		Yes		narrative of medical necessity
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	21 and older		Yes		narrative of medical necessity
31040	Pterygomaxillary fossa surgery	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
31225	Maxillectomy; without orbital exenteration	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
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31230	Maxillectomy with orbital exenteration	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
31603	Tracheostomy, emergency procedure; transtracheal	21 and older		Yes		narrative of medical necessity
31605	Tracheostomy, emergency procedure; cricothyroid membrane	21 and older		Yes		narrative of medical necessity
40500	Vermilionectomy (lip shave), with mucosal advancement	21 and older		Yes		narrative of medical necessity
40510	Excision of lip; transverse wedge excision with primary closure	21 and older		Yes		narrative of medical necessity
40520	Excision of lip; V excision with primary direct linear closure	21 and older		Yes		narrative of medical necessity
40530	Resection of lip, more than one-fourth, without reconstruction	21 and older		Yes		narrative of medical necessity
40650	Repair lip, full thickness; vermilion only	21 and older		Yes		narrative of medical necessity
40652	Repair lip, full thickness; up to half vertical height	21 and older		Yes		narrative of medical necessity
40654	Repair lip, full thickness; over one-half vertical height, or complex	21 and older		Yes		narrative of medical necessity
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual	21 and older		Yes		narrative of medical necessity
41008	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	21 and older		Yes		narrative of medical necessity

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
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41009	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space	21 and older		Yes		narrative of medical necessity
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	21 and older		Yes		narrative of medical necessity
41016	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental	21 and older		Yes		narrative of medical necessity
41017	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular	21 and older		Yes		narrative of medical necessity
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space	21 and older		Yes		narrative of medical necessity
41112	Excision of lesion of tongue with closure; anterior two-thirds	21 and older		Yes		narrative of medical necessity
41113	Excision of lesion of tongue with closure; posterior one-third	21 and older		Yes		narrative of medical necessity
41116	Excision, lesion of floor of mouth	21 and older		Yes		narrative of medical necessity
41120	Glossectomy; less than one-half tongue	21 and older		Yes		narrative of medical necessity
41130	Hemiglossectomy	21 and older		Yes		narrative of medical necessity
41135	Glossectomy; partial, with unilateral radical neck dissection	21 and older		Yes		narrative of medical necessity

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	21 and older		Yes		narrative of medical necessity
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	21 and older		Yes		narrative of medical necessity
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	21 and older		Yes		narrative of medical necessity
41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	21 and older		Yes		narrative of medical necessity
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	21 and older		Yes		narrative of medical necessity
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	21 and older		Yes		narrative of medical necessity
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissue	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
41806	Removal of embedded foreign body from dentoalveolar structures; bone	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
41828	Excision of hyperplastic alveolar mucosa, each quadrant	21 and older		Yes		narrative of medical necessity
42106	Excision, lesion of palate, uvula; with simple primary closure	21 and older		Yes		narrative of medical necessity
42120	Resection of palate or extensive resection of lesion	21 and older		Yes		narrative of medical necessity
42200	Palatoplasty for cleft palate, soft and/or hard palate only	21 and older		Yes		narrative of medical necessity
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
42215	Palatoplasty for cleft palate; major revision	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
42220	Palatoplasty for cleft palate; secondary lengthening procedure	21 and older		Yes		narrative of medical necessity
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	21 and older		Yes		narrative of medical necessity
42235	Repair of anterior palate, including vomer flap	21 and older		Yes		narrative of medical necessity
42260	Repair of nasolabial fistula	21 and older		Yes		narrative of medical necessity

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	21 and older		Yes		narrative of medical necessity
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	21 and older		Yes		narrative of medical necessity
42408	Excision of sublingual salivary cyst (ranula)	21 and older		Yes		narrative of medical necessity
42409	Marsupialization of sublingual salivary cyst (ranula)	21 and older		Yes		narrative of medical necessity
42440	Excision of submandibular (submaxillary) gland	21 and older		Yes		narrative of medical necessity
42450	Excision of sublingual gland	21 and older		Yes		narrative of medical necessity
42550	Injection procedure for sialography	21 and older		No		
88160	Cytopathology, smears, any other source; screening and interpretation	21 and older		Yes		narrative of medical necessity
88300	Level I surgical pathology-gross examination only	21 and older		No		
88302	Level II surgical pathology--gross and microscopic examination	21 and older		No		
88304	Level III surgical pathology--gross and microscopic examination	21 and older		No		
88305	Level IV surgical pathology---gross and microscopic examination	21 and older		No		
88307	Level V surgical pathology---gross and microscopic examination	21 and older		No		

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Exhibit B Benefits Covered for South Carolina Healthy Connections Adult

Medical						
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88309	Level VI surgical pathology---gross and microscopic examination	21 and older		No		
88311	Decalcification procedure (List separately in addition to code for surgical pathology examination)	21 and older		No		
88312	Special Stains	21 and older		No		
99201	Office or outpatient visit for new patient requires: a problem focused history; a problem focused examination; and straightforward medical decision making	21 and older		No		
99202	Office or outpatient visit for new patient requires: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making	21 and older		No		
99203	Office or outpatient visit for new patient requires: a detailed history; a detailed examination; and medical decision making of low complexity	21 and older		No		
99204	Office or outpatient visit for new patient requires: a comprehensive history; a comprehensive examination; and medical decision making of a moderate complexity	21 and older		No		
99205	Office or outpatient visit for new patient requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	21 and older		No		
99211	E/M office/op serv est patient level I	21 and older		No		

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Exhibit B Benefits Covered for South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99212	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	21 and older		No		
99213	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	21 and older		No		
99214	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	21 and older		No		
99215	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	21 and older		No		
99217	Observation Care Discharge Day Management	21 and older		No		
99218	Initial observation care per day level 1	21 and older		No		
99219	Initial observation care per day level 2	21 and older		No		
99220	Initial observation care per day level 3	21 and older		No		

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Exhibit B Benefits Covered for South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99221	Initial hospital care, per day, requires: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity:	21 and older		No		
99222	Initial hospital care, per day, requires: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity:	21 and older		No		
99223	Initial hospital care, per day, requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity:	21 and older		No		
99231	Subsequent hospital care, per day, requires two of the three: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity	21 and older		No		
99232	Subsequent hospital care, per day, requires two of the three: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity	21 and older		No		
99233	Subsequent hospital care, per day, requires two of the three: a detailed interval history; a detailed examination; and medical decision making of high complexity	21 and older		No		

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99234	Observation OR IP care E/M pat adm and discharge; low service	21 and older		No		
99235	Observation OR IP care E/M pat adm and discharge; moderate service	21 and older		No		
99236	Observation OR IP care E/M pat adm and discharge; high service	21 and older		No		
99238	Hospital discharge day management; 30 min or less	21 and older		No		
99239	Hospital discharge day management; more than 30 minutes	21 and older		No		
99241	E/M consult office consult level 1	21 and older		No		
99242	E/M consult office consult level 2	21 and older		No		
99243	E/M consult office consult level 3	21 and older		No		
99244	E/M consult office consult level 4	21 and older		No		
99245	E/M consult office consult level 5	21 and older		No		
99251	Initial inpatient consultation for a new or established patient, requires: a problem focused history; a problem focused examination; and straightforward medical decision making	21 and older		No		

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99252	Initial inpatient consultation for a new or established patient, requires: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making	21 and older		No		
99253	Initial inpatient consultation for a new or established patient, requires: a detailed history; an detailed examination; and medical decision making of low complexity	21 and older		No		
99254	Initial inpatient consultation for a new or established patient, requires: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity	21 and older		No		
99255	Initial inpatient consultation for a new or established patient, requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	21 and older		No		
99281	Emergency department visit requires: a problem focused history; a problem focused examination; and straightforward medical decision making	21 and older		No		

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99282	Emergency department visit requires: an expanded problem focused history; an extended problem focused examination; and medical decision making of low complexity	21 and older		No		
99283	Emergency department visit requires: an expanded problem focused history; an extended problem focused examination; and medical decision making of moderate complexity	21 and older		No		
99284	Emergency department visit requires: a detailed history; a detailed examination; and medical decision making of moderate complexity	21 and older		No		
99285	Emergency department visit requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	21 and older		No		
99291	E/M critical care service 1st hour on given date	21 and older		No		
99292	E/M critical care service each 30 minutes beyond 1 hour	21 and older		No		
99304	E/M NF service comp NF assesments level 1	21 and older		No		
99305	E/M NF service comp NF assesments level 2	21 and older		No		
99306	E/M NF service comp NF assesments level 3	21 and older		No		

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Exhibit B Benefits Covered for
South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99307	E/M NF service subsequent NF assesments level 1	21 and older		No		
99308	E/M NF service subsequent NF assesments level 2	21 and older		No		
99309	E/M NF service subsequent NF assesments level 3	21 and older		No		
99310	E/M NF service subsequent NF assesments level 4	21 and older		No		
99324	E/M DOM, RH or cust serv new patient level 1	21 and older		No		
99325	E/M DOM, RH or cust serv new patient level 2	21 and older		No		
99326	E/M DOM, RH or cust serv new patient level 3	21 and older		No		
99327	E/M DOM, RH or cust serv new patient level 4	21 and older		No		
99328	E/M DOM, RH or cust serv new patient level 5	21 and older		No		
99334	E/M DOM, RH or cust serv est patient level 1	21 and older		No		
99335	E/M DOM, RH or cust serv est patient level 2	21 and older		No		
99336	E/M DOM, RH or cust serv est patient level 3	21 and older		No		
99337	E/M DOM, RH or cust serv est patient level 4	21 and older		No		
99341	E/M home visit new patient, low sev, 20 min, F-F	21 and older		No		

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Exhibit B Benefits Covered for South Carolina Healthy Connections Adult

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99342	E/M home visit new patient, low comp, 30 min, F-F	21 and older		No		
99343	E/M home visit new patient, mod comp, 45 min, F-F	21 and older		No		
99344	E/M home visit new patient, mod comp, 60 min, F-F	21 and older		No		
99345	E/M home visit new patient, hi comp, 75 min, F-F	21 and older		No		
99347	E/M home visit est pat, low-med se, 15M F-F	21 and older		No		
99348	E/M home visit est pat, low-med se, 25M F-F	21 and older		No		
99349	E/M home visit est pat, mod-hi se, 40M F-F	21 and older		No		
99350	E/M home visit est pat, mid-hi se, 60M F-F	21 and older		No		
99441	E/M case management service phone call simple	21 and older		No		

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Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series. When individual radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Diagnostic						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation	All Ages		No	One of (D0120, D0145) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	All Ages		No	Two of (D0140) per 12 Month(s) Per Provider.	
D0145	oral evaluation under 3 years of age	0-2		No	One of (D0120, D0145) per 6 Month(s) Per patient.	
D0150	comprehensive oral evaluation	3 and older		No	One of (D0150) per 36 Month(s) Per Provider.	

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Diagnostic						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0210	intraoral-complete series (including bitewings)	2 and older		No	One of (D0210, D0330) per 36 Month(s) Per patient.	
D0220	intraoral-periapical-1st film	All Ages		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral-periapical-each additional film	All Ages		No	Three of (D0230) per 1 Day(s) Per patient.	
D0240	intraoral - occlusal film	All Ages		No	Two of (D0240) per 12 Month(s) Per patient.	
D0270	bitewing - single film	2 and older		No	One of (D0270) per 6 Month(s) Per patient. One of (D0270, D0272) per 1 Day(s) Per patient.	
D0272	bitewings - two films	2 and older		No	One of (D0272) per 6 Month(s) Per patient.	
D0330	panoramic film	8 and older		No	One of (D0210, D0330) per 36 Month(s) Per patient. For members age 8 through 20, oral surgeons are allowed one additional usage of D0330 per beneficiary within the 36 month period.	

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Exhibit C Benefits Covered for
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Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

BILLING AND REIMBURSEMENT FOR SPACE MAINTAINERS SHALL BE BASED ON CEMENTATION OR INSERTION DATE.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	12 and older		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1120	prophylaxis - child	0-11		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1203	topical application of fluoride (prophylaxis not included) - child	0-11		No	One of (D1203, D1204, D1206) per 6 Month(s) Per patient.	
D1204	topical application of fluoride (prophylaxis not included) - adult	12 and older		No	One of (D1203, D1204, D1206) per 6 Month(s) Per patient.	
D1206	topical flouride varnish	All Ages		No	One of (D1203, D1204, D1206) per 6 Month(s) Per patient.	
D1351	sealant - per tooth	6-14	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 36 Month(s) Per patient per tooth.	
D1510	space maintainer-fixed-unilateral	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1515) per 1 Lifetime Per patient per quadrant.	
D1515	space maint-fixed-bilateral	All Ages	Per Arch (01, 02, LA, UA)	No	One of (D1510, D1515) per 1 Lifetime Per patient per arch.	

South Carolina Healthy Connections MR/RD Waiver Enrollees

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Reimbursement includes local anesthesia.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	All Ages	Teeth 1 - 32, A - T	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	All Ages	Teeth 1 - 32, A - T	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2160	Amalgam - three surface, primary or permanent	All Ages	Teeth 1 - 32, A - T	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2161	Amalgam - four surfaces, primary or permanent	All Ages	Teeth 1 - 32, A - T	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2330	resin-1 surface, anterior	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2331	resin-2 surfaces, anterior	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2332	resin-3 surfaces, anterior	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2335	resin-4+ surfaces or involving incisal angle (anterior)	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2391	resin-based composite - 1 surface, posterior	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2392	resin-based composite - 2 surfaces, posterior	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2393	resin-based composite - 3 surfaces, posterior	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2394	resin-based composite - 4 or more surfaces, posterior	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	
D2930	prefabricated stainless steel crown - primary tooth	All Ages	Teeth A - T	No	Six of (D2930, D2932, D2934) per 1 Day(s) Per patient per tooth in office. One of (D2930, D2932, D2934) per 36 Month(s) Per patient per tooth. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	

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Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated steel crown-permanent tooth	All Ages	Teeth 1 - 32	No	Six of (D2931, D2932) per 1 Day(s) Per patient per tooth, per surface in office. One of (D2931) per 60 Month(s) Per patient per tooth. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	
D2932	prefabricated resin crown	All Ages	Teeth 1 - 32, A - T	No	Six of (D2930, D2932, D2934) per 1 Day(s) Per patient in office. One of (D2930, D2932, D2934) per 36 Month(s) Per patient per tooth. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	All Ages	Teeth C - H, M - R	No	Six of (D2930, D2932, D2934) per 1 Day(s) Per patient per tooth in office. One of (D2930, D2932, D2934) per 36 Month(s) Per patient per tooth. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	
D2940	protective restoration	All Ages	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2934, D2950, D2951, D2954, D3220, D3310, D3320, D3330) per 1 Day(s) Per patient per tooth. One of (D2940) per 36 Month(s) Per patient per tooth. Not allowed with D2000 or D3000 series codes on the same date of service.	
D2950	core buildup, including any pins	All Ages	Teeth 1 - 32	No	One of (D2950, D2954) per 1 Lifetime Per patient per tooth.	

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South Carolina Healthy Connections MR/RD Waiver Enrollees

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2951	pin retention - per tooth in addition to restoration	All Ages	Teeth 1 - 32	No	One of (D2951) per 1 Lifetime Per patient per tooth.	
D2954	prefabricated post and core in addition to crown	All Ages	Teeth 1 - 32	No	One of (D2950, D2954) per 1 Lifetime Per patient per tooth.	

South Carolina Healthy Connections MR/RD Waiver Enrollees

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Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the DentaQuest Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered. The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration)	All Ages	Teeth 2 - 15, 18 - 31, A - T	No	Six of (D3220) per 1 Day(s) Per Provider OR Location in office. Maximum of six allowed per 1 day per patient in office. Pre-treatment radiographs must be maintained in patient record.	
D3310	Endodontic therapy, anterior (exc final rest)	All Ages	Teeth 6 - 11, 22 - 27	Yes	One of (D3310, D3320, D3330) per 1 Lifetime Per patient per tooth. Pre-treatment and post-treatment radiographs must be maintained in the patient record.	narr. of med. necessity, pre-op x-ray(s)
D3320	Endodontic therapy, bicuspid (exc final restore)	All Ages	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3310, D3320, D3330) per 1 Lifetime Per patient per tooth. Pre-treatment and post-treatment radiographs must be maintained in the patient record.	narr. of med. necessity, pre-op x-ray(s)

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Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3330	Endodontic therapy, molar(excluding final restore)	All Ages	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	One of (D3310, D3320, D3330) per 1 Lifetime Per patient per tooth. Pre-treatment and post-treatment radiographs must be maintained in the patient record.	narr. of med. necessity, pre-op x-ray(s)

South Carolina Healthy Connections MR/RD Waiver Enrollees

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Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence is submitted that indicates that the masticatory insufficiencies are likely to impair the general health of the member.

Authorization for partial dentures for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing. Partial dentures are not a covered benefit when 8 or more posterior teeth are in occlusion.

Dentures will not be preauthorized when:

Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining or rebasing of the patient's present dentures will make them serviceable.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

BILLING AND REIMBURSEMENT FOR REMOVABLE PROSTHETICS SHALL BE BASED ON THE INSERTION DATE.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	14 and older		Yes	One of (D5110) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	14 and older		Yes	One of (D5120) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture-resin base	14 and older		Yes	One of (D5211) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5212	mandibular partial denture-resin base	14 and older		Yes	One of (D5212) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)

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Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5510	repair broken complete denture base	14 and older	Per Arch (01, 02, LA, UA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	14 and older	Teeth 1 - 32	No		
D5610	repair resin denture base	14 and older	Per Arch (01, 02, LA, UA)	No		
D5640	replace broken teeth-per tooth	14 and older	Teeth 1 - 32	No		

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Reimbursement includes local anesthesia and post-operative care up to 30 days from the date of service.

The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Covered dental and medical services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	coronal remnants - erupted or exposed root	All Ages	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction - erupted or exposed root	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7220	removal of impacted tooth-soft tissue	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)

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South Carolina Healthy Connections MR/RD Waiver Enrollees

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241) per 1 Lifetime Per Provider OR Location per tooth. Removal of asymptomatic teeth is not a covered benefit. Not allowed by same office or provider who performed original extraction.	pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	All Ages	Teeth 1 - 32	Yes		narrative of medical necessity
D7280	Surgical access of an unerupted tooth	All Ages	Teeth 1 - 32	Yes	Two of (D7280) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7285	biopsy of oral tissue - hard (bone, tooth)	All Ages		Yes		Pathology report
D7286	biopsy of oral tissue - soft (all others)	All Ages		Yes		Pathology report

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Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7410	radical excision - lesion diameter up to 1.25cm	All Ages		Yes		Pathology report
D7411	excision of benign lesion greater than 1.25 cm	All Ages		Yes		Pathology report
D7412	excision of benign lesion, complicated	All Ages		Yes		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	All Ages		Yes		Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	All Ages		Yes		Pathology report
D7415	excision of malignant lesion, complicated	All Ages		Yes		Pathology report
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	All Ages		Yes		Pathology report
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	All Ages		Yes		Pathology report
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	All Ages		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	All Ages		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	All Ages		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	All Ages		Yes		Pathology report
D7465	destruction of lesion(s) by physical or chemical method, by report	All Ages		Yes		Pathology report

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7510	incision and drainage of abscess - intraoral soft tissue	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	All Ages		Yes		narrative of medical necessity
D7530	removal of foreign body, skin, or subcutaneous alveolar tissue	All Ages		Yes	One of (D7530) per 1 Day(s) Per patient.	narrative of medical necessity
D7550	sequestrectomy for osteomyelitis	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Not to be billed for treatment of dry socket.	narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
D7770	alveolus-stabilization of teeth, open reduction splinting	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
D7771	alveolus, closed reduction stabilization of teeth	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
D7910	suture small wounds up to 5 cm	All Ages		Yes	Excludes closure of surgical incision.	narrative of medical necessity
D7911	complicated suture-up to 5 cm	All Ages		Yes	Excludes closure of surgical incision.	narrative of medical necessity
D7912	complex suture - greater than 5cm	All Ages		Yes	Excludes closure of surgical incision.	narrative of medical necessity

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Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Adjunctive services are not reimburseable if unaccompanied by a covered treatment procedure (unless the reimbursement request is a resubmission of a previously denied line).

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9220	general anesthesia - first 30 minutes	All Ages		Yes	One of (D9220, D9230, D9241, D9248, D9920) per 1 Day(s) Per patient. Not allowed in conjunction with D9220,D9230,D9241,D9248 or D9920. Allow only one of these procedure(s) per date of service.	narrative of medical necessity
D9230	inhalation of nitrous oxide/anxiolysis, analgesia	All Ages		No	One of (D9220, D9230, D9241, D9920) per 1 Day(s) Per patient.	
D9241	intravenous sedation/analgesia - first 30 minutes	All Ages		Yes	One of (D9220, D9230, D9241, D9248, D9920) per 1 Day(s) Per patient. Not allowed in conjunction with D9220,D9230,D9241,D9248 or D9920. Allow only one of these procedure(s) per date of service.	narrative of medical necessity
D9248	non-intravenous conscious sedation	All Ages		No	One of (D9220, D9241, D9248, D9920) per 1 Day(s) Per patient.	

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9420	hospital of ambulatory surgical center call	All Ages		Yes	May be billed when rendering prior approved treatment in hospital or ASC. Code must be included on the place of service prior authorization request. SCDHHS prohibits the billing of beneficiaries to schedule appointments or to hold appointment blocks prior to treatment in a hospital or ambulatory center setting.	narr. of med. necessity, pre-op x-ray(s)
D9920	behavior management, by report	All Ages		Yes	One of (D9920) per 1 Day(s) Per patient. One of (D9220, D9230, D9241, D9248, D9920) per 1 Day(s) Per patient. Documentation in the patient record must be unique to that visit and must include a description of the known condition of the patient and additional time to provide treatment.	narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	All Ages		Yes		narrative of medical necessity

South Carolina Healthy Connections MR/RD Waiver Enrollees

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Reimbursement includes local anesthesia and post-operative care up to 30 days from the date of service.

Covered dental and medical services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form.

Operating Room (OR) or Ambulatory Surgical Center (ASC) usage for planned, non-emergent treatment must be prior authorized. Authorization requests must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.02 of the Dental ORM.

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	All Ages		No		
20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
20902	Bone graft, any donor area; major or large	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21031	Excision of Torus Mandibularis	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21032	Excision of Maxillary Torus Palatinus	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21034	Excision of Malignant Tumor of Maxilla or Zygoma	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21040	Excision Benign Cyst/Tumor Mandible by Enucleation and or curett	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21044	Excision of malignant tumor of mandible	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21045	Excision Of Malignant Tumor Of Mandible; Radical Resection	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21050	Condylectomy, Temporomandibular Joint (Separate Procedure)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21060	Meniscectomy, Partial Or Complete, Temporomandibular Joint (Separate Proced	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21070	Coronoidectomy (separate procedure)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21110	Application Of Interdental Fixation Device For Conditions Other Than Fractu	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21116	Inject Proc Tempoman Arthrotomography	All Ages		Yes		narrative of medical necessity
21210	Graft, Bone; Nasal, Maxillary Or Malar Areas (Includes Obtaining Graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21242	Arthroplasty, Temporomandibular Joint, With Allograft	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21243	Arthroplasty, Temporomandibular Joint, With Prosthetic Joint Replacement	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21310	Closed TX of Nasal Bone Fracture-without manipulation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21315	Closed Treatment Of Nasal Bone Fracture; With Out Stabilization	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21320	Closed treatment of nasal bone fracture; with stabilization	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21325	Open treatment of nasal fracture; uncomplicated	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21330	Open treatment of nasal fracture; complicated with internal and/or external skeletal fixation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire, or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21344	Open treatment of complicated frontal sinus fracture, via coronal or multiple approaches	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21356	Open treatment of depressed zygomatic arch fracture	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21365	Open treatment of complicated fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21366	Open treatment of complicated fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21386	Open treatment of orbital floor blowout fracture; periorbital approach	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21387	Open treatment of orbital floor blowout fracture; combined approach	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21390	Open treatment of orbital floor blowout fracture; periorbital approach with alloplastic or other implant	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21406	Open treatment of fracture of orbit, except blowout; without implant	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21407	Open treatment of fracture of orbit, except blowout; with implant	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21408	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21423	Open treatment of palatal or maxillary fracture (LeFort I type) complicated (comminuted or involving cranial nerve foramina), multiple approaches	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21433	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21435	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21445	Open treatment of mandibular or maxillary alveolar ridge fracture	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21450	Closed treatment of mandibular fracture; without manipulation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21451	Closed treatment of mandibular fracture; with manipulation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21452	Percutaneous treatment of mandibular fracture, with external fixation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21453	Closed treatment of mandibular fracture with interdental fixation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21454	Open treatment of mandibular fracture with external fixation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21461	Open treatment of mandibular fracture; without interdental fixation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21462	Open treatment of mandibular fracture; with interdental fixation	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21465	Open treatment of mandibular condylar fracture	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21485	Closed treatment of temporomandibular dislocation; complicated, initial or subsequent	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
21497	Interdental wiring, for condition other than fracture	All Ages		Yes		narrative of medical necessity
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
29804	Arthroscopy, temporomandibular joint, surgical	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
31000	Lavage by cannulation; maxillary (antrotomy); intranasal	All Ages		Yes		narrative of medical necessity
31020	Sinusotomy, maxillary (antrotomy); intranasal	All Ages		Yes		narrative of medical necessity
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	All Ages		Yes		narrative of medical necessity
31040	Pterygomaxillary fossa surgery	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
31225	Maxillectomy; without orbital exenteration	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
31230	Maxillectomy with orbital exenteration	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
31603	Tracheostomy, emergency procedure; transtracheal	All Ages		Yes		narrative of medical necessity
31605	Tracheostomy, emergency procedure; cricothyroid membrane	All Ages		Yes		narrative of medical necessity
40500	Vermilionectomy (lip shave), with mucosal advancement	All Ages		Yes		narrative of medical necessity
40510	Excision of lip; transverse wedge excision with primary closure	All Ages		Yes		narrative of medical necessity
40520	Excision of lip; V excision with primary direct linear closure	All Ages		Yes		narrative of medical necessity
40530	Resection of lip, more than one-fourth, without reconstruction	All Ages		Yes		narrative of medical necessity
40650	Repair lip, full thickness; vermilion only	All Ages		Yes		narrative of medical necessity
40652	Repair lip, full thickness; up to half vertical height	All Ages		Yes		narrative of medical necessity
40654	Repair lip, full thickness; over one-half vertical height, or complex	All Ages		Yes		narrative of medical necessity
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	All Ages		Yes		narrative of medical necessity
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure	All Ages		Yes		narrative of medical necessity
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages	All Ages		Yes		narrative of medical necessity

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	All Ages		Yes		narrative of medical necessity
40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe Estlander type), including sectioning and inserting of pedicle	All Ages		Yes		narrative of medical necessity
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual	All Ages		Yes		narrative of medical necessity
41008	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	All Ages		Yes		narrative of medical necessity
41009	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space	All Ages		Yes		narrative of medical necessity
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	All Ages		Yes		narrative of medical necessity
41016	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental	All Ages		Yes		narrative of medical necessity
41017	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular	All Ages		Yes		narrative of medical necessity
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space	All Ages		Yes		narrative of medical necessity

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
41112	Excision of lesion of tongue with closure; anterior two-thirds	All Ages		Yes		narrative of medical necessity
41113	Excision of lesion of tongue with closure; posterior one-third	All Ages		Yes		narrative of medical necessity
41116	Excision, lesion of floor of mouth	All Ages		Yes		narrative of medical necessity
41120	Glossectomy; less than one-half tongue	All Ages		Yes		narrative of medical necessity
41130	Hemiglossectomy	All Ages		Yes		narrative of medical necessity
41135	Glossectomy; partial, with unilateral radical neck dissection	All Ages		Yes		narrative of medical necessity
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection	All Ages		Yes		narrative of medical necessity
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection	All Ages		Yes		narrative of medical necessity
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	All Ages		Yes		narrative of medical necessity
41155	Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	All Ages		Yes		narrative of medical necessity
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	All Ages		Yes		narrative of medical necessity

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	All Ages		Yes		narrative of medical necessity
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissue	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
41806	Removal of embedded foreign body from dentoalveolar structures; bone	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
41828	Excision of hyperplastic alveolar mucosa, each quadrant	All Ages		Yes		narrative of medical necessity
41874	Alveoloplasty, each quadrant	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
42106	Excision, lesion of palate, uvula; with simple primary closure	All Ages		Yes		narrative of medical necessity
42120	Resection of palate or extensive resection of lesion	All Ages		Yes		narrative of medical necessity
42200	Palatoplasty for cleft palate, soft and/or hard palate only	All Ages		Yes		narrative of medical necessity
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
42215	Palatoplasty for cleft palate; major revision	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
42220	Palatoplasty for cleft palate; secondary lengthening procedure	All Ages		Yes		narrative of medical necessity
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	All Ages		Yes		narrative of medical necessity
42235	Repair of anterior palate, including vomer flap	All Ages		Yes		narrative of medical necessity
42260	Repair of nasolabial fistula	All Ages		Yes		narrative of medical necessity
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	All Ages		Yes		narrative of medical necessity
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	All Ages		Yes		narrative of medical necessity
42408	Excision of sublingual salivary cyst (ranula)	All Ages		Yes		narrative of medical necessity
42409	Marsupialization of sublingual salivary cyst (ranula)	All Ages		Yes		narrative of medical necessity
42440	Excision of submandibular (submaxillary) gland	All Ages		Yes		narrative of medical necessity
42450	Excision of sublingual gland	All Ages		Yes		narrative of medical necessity

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Medical						
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42550	Injection procedure for sialography	All Ages		Yes		narr. of med. necessity, pre-op x-ray(s)
88160	Cytopathology, smears, any other source; screening and interpretation	All Ages		Yes		narrative of medical necessity
88300	Level I surgical pathology-gross examination only	All Ages		No		
88302	Level II surgical pathology--gross and microscopic examination	All Ages		No		
88304	Level III surgical pathology--gross and microscopic examination	All Ages		No		
88305	Level IV surgical pathology---gross and microscopic examination	All Ages		No		
88307	Level V surgical pathology---gross and microscopic examination	All Ages		No		
88309	Level VI surgical pathology---gross and microscopic examination	All Ages		No		
88311	Decalcification procedure (List separately in addition to code for surgical pathology examination)	All Ages		No		
88312	Special Stains	All Ages		No		
99201	Office or outpatient visit for new patient requires: a problem focused history; a problem focused examination; and straightforward medical decision making	All Ages		No		

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Exhibit C Benefits Covered for
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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99202	Office or outpatient visit for new patient requires: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making	All Ages		No		
99203	Office or outpatient visit for new patient requires: a detailed history; a detailed examination; and medical decision making of low complexity	All Ages		No		
99204	Office or outpatient visit for new patient requires: a comprehensive history; a comprehensive examination; and medical decision making of a moderate complexity	All Ages		No		
99205	Office or outpatient visit for new patient requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	All Ages		No		
99211	E/M office/op serv est patient level I	All Ages		No		
99212	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	All Ages		No		
99213	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	All Ages		No		

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99214	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	All Ages		No		
99215	Office or outpatient visit for an established patient requires two of the three: a problem focused history; a problem focused examination; and straightforward medical decision making	All Ages		No		
99217	Observation Care Discharge Day Management	All Ages		No		
99218	Initial observation care per day level 1	All Ages		No		
99219	Initial observation care per day level 2	All Ages		No		
99220	Initial observation care per day level 3	All Ages		No		
99221	Initial hospital care, per day, requires: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity:	All Ages		No		
99222	Initial hospital care, per day, requires: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity:	All Ages		No		

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Exhibit C Benefits Covered for
South Carolina Healthy Connections MR/RD Waiver Enrollees

Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99223	Initial hospital care, per day, requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity:	All Ages		No		
99231	Subsequent hospital care, per day, requires two of the three: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity	All Ages		No		
99232	Subsequent hospital care, per day, requires two of the three: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity	All Ages		No		
99233	Subsequent hospital care, per day, requires two of the three: a detailed interval history; a detailed examination; and medical decision making of high complexity	All Ages		No		
99234	Observation OR IP care E/M pat adm and discharge; low service	All Ages		No		
99235	Observation OR IP care E/M pat adm and discharge; moderate service	All Ages		No		
99236	Observation OR IP care E/M pat adm and discharge; high service	All Ages		No		
99238	Hospital discharge day management; 30 min or less	All Ages		No		

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99239	Hospital discharge day management; more than 30 minutes	All Ages		No		
99241	E/M consult office consult level 1	All Ages		No		
99242	E/M consult office consult level 2	All Ages		No		
99243	E/M consult office consult level 3	All Ages		No		
99244	E/M consult office consult level 4	All Ages		No		
99245	E/M consult office consult level 5	All Ages		No		
99251	Initial inpatient consultation for a new or established patient, requires: a problem focused history; a problem focused examination; and straightforward medical decision making	All Ages		No		
99252	Initial inpatient consultation for a new or established patient, requires: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making	All Ages		No		
99253	Initial inpatient consultation for a new or established patient, requires: a detailed history; an detailed examination; and medical decision making of low complexity	All Ages		No		

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99254	Initial inpatient consultation for a new or established patient, requires: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity	All Ages		No		
99255	Initial inpatient consultation for a new or established patient, requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	All Ages		No		
99281	Emergency department visit requires: a problem focused history; a problem focused examination; and straightforward medical decision making	All Ages		No		
99282	Emergency department visit requires: an expanded problem focused history; an extended problem focused examination; and medical decision making of low complexity	All Ages		No		
99283	Emergency department visit requires: an expanded problem focused history; an extended problem focused examination; and medical decision making of moderate complexity	All Ages		No		
99284	Emergency department visit requires: a detailed history; a detailed examination; and medical decision making of moderate complexity	All Ages		No		

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Exhibit C Benefits Covered for
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Medical						
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99285	Emergency department visit requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	All Ages		No		
99291	E/M critical care service 1st hour on given date	All Ages		No		
99292	E/M critical care service each 30 minutes beyond 1 hour	All Ages		No		
99304	E/M NF service comp NF assesments level 1	All Ages		No		
99305	E/M NF service comp NF assesments level 2	All Ages		No		
99306	E/M NF service comp NF assesments level 3	All Ages		No		
99307	E/M NF service subsequent NF assesments level 1	All Ages		No		
99308	E/M NF service subsequent NF assesments level 2	All Ages		No		
99309	E/M NF service subsequent NF assesments level 3	All Ages		No		
99310	E/M NF service subsequent NF assesments level 4	All Ages		No		
99324	E/M DOM, RH or cust serv new patient level 1	All Ages		No		
99325	E/M DOM, RH or cust serv new patient level 2	All Ages		No		
99326	E/M DOM, RH or cust serv new patient level 3	All Ages		No		

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Medical						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99327	E/M DOM, RH or cust serv new patient level 4	All Ages		No		
99328	E/M DOM, RH or cust serv new patient level 5	All Ages		No		
99334	E/M DOM, RH or cust serv est patient level 1	All Ages		No		
99335	E/M DOM, RH or cust serv est patient level 2	All Ages		No		
99336	E/M DOM, RH or cust serv est patient level 3	All Ages		No		
99337	E/M DOM, RH or cust serv est patient level 4	All Ages		No		
99341	E/M home visit new patient, low sev, 20 min, F-F	All Ages		No		
99342	E/M home visit new patient, low comp, 30 min, F-F	All Ages		No		
99343	E/M home visit new patient, mod comp, 45 min, F-F	All Ages		No		
99344	E/M home visit new patient, mod comp, 60 min, F-F	All Ages		No		
99345	E/M home visit new patient, hi comp, 75 min, F-F	All Ages		No		
99347	E/M home visit est pat, low-med se, 15M F-F	All Ages		No		
99348	E/M home visit est pat, low-med se, 25M F-F	All Ages		No		
99349	E/M home visit est pat, mod-hi se, 40M F-F	All Ages		No		

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Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
99350	E/M home visit est pat, mid-hi se, 60M F-F	All Ages		No		
99441	E/M case management service phone call simple	All Ages		No		

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