



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections  
MEDICAID



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

**Dental Office Reference Manual  
Updated 01/01/2019**

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Eligibility or Benefit Questions:

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**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

or email:

[fraudres@scdhhs.gov](mailto:fraudres@scdhhs.gov)

Dental claims should be mailed to:

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

Electronic Claims should be sent:

Via the web - [www.dentaquest.com](http://www.dentaquest.com)

Via Clearinghouse

DentaQuest Systems Corporation  
 PO Box 2906

Milwaukee, WI 53201-2906

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

PO Box 2906

Milwaukee, WI 53201-2906

or faxed to:

262.834.3452

BENEFICIARY GRIEVANCE AND APPEALS

DentaQuest, LLC

Complaints and Appeals

PO Box 2906

Milwaukee, WI 53201-2906

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The South Carolina Department of Health and Human Services (SCDHHS) Dental Office Reference Manual is composed of SC Healthy Connections Dental Services Provider Manual and Section 1 (General Information and Administration) Provider Manual (See Appendix E).

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
01/01/19	Cover		Updated Publication Date
01/01/19		14	Corrected reference in Statement of Provider Rights and Responsibilities #8
01/01/19	1.02		Updated Provider Partner Information
01/01/19	2.04		Updated Copayment Age Exclusion
01/01/19	3.03		Removed reference of treatment plan required
01/01/19	9.00		Updated Phone information to include Option #4 added Fax number
01/01/19	A.01		Removed reference of treatment plan required (#N)
01/01/19	D-2		Corrected typo on record retention requirement from "three" years to "five" years
01/01/19	C.04		Submission requirement – replaced "treatment plan" with "supporting documentation"
01/01/19	C.09		Submission requirement – replaced "treatment plan" with "supporting documentation"
01/01/19	Exhibit A-C		Updated Narrative for Adjunctive Services to include dental sedation permit requirements.
01/01/19	Exhibit A-C		Updated CDT and CPT codes to reflect procedure code changes (ADA and CMS) effective for 01/01/2019
10/01/18	Cover		Update Publication Date
10/01/18	3.00- 3.03		Clarified Authorization of Treatment
10/01/18	3.04		Added section on Prior authorization for services requiring inpatient stay.
10/01/18	4.05		Revised language on Paper Claim submission
10/01/18	4.16		Revised Claims submission for services delivered in an outpatient setting (ASC/ OR)
10/01/18	4.17		Added section: Claims submission for dental services requiring inpatient stay
10/01/18	C.04		Revised criteria for dental services delivered in a ASC or OR
10/01/18	C.09		Revised criteria for general anesthesia/ IV sedation in the dental office
10/01/18	C.10		Revised criteria for services rendered in conjunction with Behavioral Management services and created a separate section.
10/01/18	9.03		Removed DentaQuest General Information Section
10/01/18	Exhibit A-C		Updated Narrative for approval of services delivered in an ASC/ OR
10/01/18	Exhibit A-C		Updated CPT Medical codes to remove Inpatient only procedures

08/06/18	Appendix E		Updated SCDHHS Provider Manual- General Information (Section 1)
07/01/18	Cover		Updated Publication Date
07/01/18		13	Updated Statement of Provider Rights and Responsibilities
07/01/18		14	Updated Statement of Beneficiaries Rights
07/01/18	3.02		Updated Prior Authorization for Non-State Plan Services
07/01/18	3.03		Updated Authorization for Operating Room (OR) and Ambulatory Surgical Center (ASC)
07/01/18	4.11		Updated the Charge Limits
07/01/18	4.14		Revised Appeal process with Request for Reconsideration
07/01/18	6.01-6.02		Updated Grievances, Appeals and State Fair Hearing
04/01/18	Cover		Updated Publication Date
04/01/18		2	Updated Fax Number
04/01/18		13	Updated Statement of Provider Rights and Responsibilities
04/01/18	2.01 (A-B)		Updated Medicaid Beneficiaries eligible for Dental Benefits & Medicaid Beneficiaries ineligible for Dental Benefits
04/01/18	2.04		Updated Copayment Exclusions to include "medical" emergency services
04/01/18	2.06		Updated Transportation
04/01/18	3.04		Updated Prior Authorization for Non-State Plan Covered Services Medically Necessary EPSDT Services
04/01/18	4.07		Updated language Filing Claims for the Provision of Dental Services in preparation or as the result of Exceptional Medical
04/01/18	4.08		Updated language Filing Claims for the Provision of Adult Dental Services
04/01/18	Exhibit A-C		Updated problem focus exam(D0140) narrative
04/01/18	Exhibit A- C		Updated restoration narrative
04/01/18	Exhibit B		Added primary teeth to restoration codes D2140- D2394
04/01/18	Exhibit B		Updated "Prepayment Review Required" for D7220, D7230, D7240, D7241, D7250 to Yes
02/01/18	4.11		Clarified Procedure fee inclusions
02/01/18	Exhibits A-C		Clarified Procedure fee inclusions per Service Category
01/01/18	1.02		Updated Provider Engagement Contact
01/01/18	Exhibit A and C		Added new codes D5511& D5512 (replacing D5510) and D5611 & D5612 (replacing D5610); Deleted non valid codes D5510 & D5610

01/01/18	Exhibit A-C		Added new codes D9222 & D9239; Updated benefits limitation for D9223 & D9243; Updated code edits for D9222,D9223, D9230, D9239, D9243, D9248
01/01/18	Exhibit A-C		Updated code description D3320, D3330, D7111, 99217, 99218, 99219, 99220, 99235, 20185
01/01/18	Exhibit A and C		Removed "Teeth Covered" requirements D5110 & D5120
01/01/18	Exhibit A and C		Updated codes required for monitoring in the sedation records
06/08/17	Exhibit A & C		Corrected typo on "Benefit Limitations" D0120, D0150,D1510, D1515, D2950, D2951, D2954, D9420 and "Teeth Covered" 41822,41823,41830, 41830,41874
06/08/17	Exhibits A-C		Updated "Documentation Required" for D9230, D9248
06/08/17	Exhibit B		Added CPT codes 42330,42335,42340,42408,42409,42440
05/02/17	Exhibits A-C		Corrected typo on "Benefit Limitations" for D9230, D9248. Removed D9248 from D9230 benefits limitations; removed D9230 from D9248 benefits limitations.
05/01/17	Exhibits A and C		Clarified "Benefits Limitations" for D0120, D0145, D0150
05/01/17	Exhibits A and C		Added the following CPT codes: 11900, 12011, 12013- 12015, 12020, 12051-12055, 13131, 13133, 13151-13153, 15120, 15121, 20005, 20694, 21046-21049, 21076, 21081, 21085, 21110, 21209, 21210, 21215, 21230, 21235, 21240, 21242, 21243, 21336- 21339, 21480, 21490, 21497, 30580, 30901, 30903, 30905, 30906, 31020, 31030, 31032, 31500, 40490, 40525, 40700-40702, 40720, 40800, 40801, 40808, 40810, 40812, 40814, 40816, 40818, 40819, 40830, 40831, 41005-41007, 41015-41018, 41100, 41105, 41108, 41110, 41115, 41251, 41252, 41805, 41806, 41822, 41823, 41827, 41828, 41830, 41850, 41874, 42100, 42104, 42140, 42180, 42182, 42200, 42205, 42210, 42215, 42220, 42300, 42305, 42310, 42320, 42330, 42335, 42340, 42500, 42505, 42650, 42720, 42725, 64722, 64774, 64788, 67930, 67935.
05/01/17	Exhibit B		Corrected typo on "Benefits Limitations" for D0150 and D0210 to 1 per 36 months; and "Prior Authorization required" for D9420 to Yes
05/01/17	Exhibits A and C		Corrected typo on "Benefits limitations" for D0140 to Per Provider OR Location; and "Pre Payment Review Required" for 13132 to Yes
05/01/17	Cover		Updated Publication Date and SCDHHS Logo
05/01/17	2.01		Updated Eligibility and Identification Card Samples
05/01/17	2.04		Updated Copayment Exclusions
05/01/17	3.01		Updated the year of the ADA claim form
05/01/17	3.01		Updated Treatment Prior Authorization and PrePayment Review
05/01/17	3.05		Added Provision of EPSDT for Beneficiaries under the age 21
05/01/17	4.05		Updated the year for the ADA claim form
05/01/17	4.05		Updated Place of Service Code
05/01/17	4.10		Updated Coordination of Benefits Under EPSDT
05/01/17	9.03		Updated Out of State Providers
05/01/17	Appendix A-2		Added TPL form (DHHS931) to the list of attachments

05/01/17	Appendix C- C.02		Updated Criteria for Prefabricated Crowns
05/01/17	Appendix D		Updated The Dental Treatment Record Bullet-# 11
05/01/17	Appendix E		Section 1- updated on 10/01/2016
05/01/17	Exhibit A and C		Updated "Benefit Limitations" for Codes: D2929, D2930, D2931, D2932, D2934, D3220
05/01/17	Exhibits A-C		Added Prior Authorization Column
05/01/17	Exhibits A-C		Updated the nomenclature and/ or descriptor of the 2017 CDT and 2017 CPT Medicaid State Plan covered codes
05/01/17	Exhibits A-C		Updated the Documentation Required for each procedure code
08/01/16	Cover		Updated Publication Date
08/01/16	Multiple Locations		Updated Physical Mailing Address for Appeals
08/01/16	1.02	16	Updated Contact Information for Provider Engagement Staff
08/01/16	Exhibit A and C		Updated Age Limitations for D0330 and D1351
02/01/16	Appendix E		Updated to reflect Medicaid Bulletin dated January 26, 2016 – Updates to Section 1 – All Provider Manuals
01/01/16	Cover		Updated Publication Date
	2.01	19	Update the Adult Dental Benefit Language
	Appendix E		Updated to reflect Medicaid Bulletin dated December 9, 2015 – Charge Limits.
	Exhibit A, B, and C		Replaced code D9220 with D9223. Replaced code D9241 with D9243
	Exhibit A and C		Added code D2929
	4.08	32	Updated the language –Remove the emergency adult dental filing period
05/26/15	Cover		Updated publication date
	4.04	29	Clarification of Electronic Signature
	4.05	30	Paper Claim Submission Acceptable Signature
	4.09	32	Clarified Third Party Liability policy regarding primary carrier copayments
	4.11	33	Added reference to Adult Benefit Structure Change in Fee and Charge Limits
	5.0	38	Updated Reference to CDT and CPT Terminology
	9.04	45	Updated Information on Generic Provider Information Form
	A-2	48	Added to Resources Available on Provider Web Portal

	C.01	52	Criteria: Extractions that do not meet the criteria
02/01/15	4.03	28	Corrected email address of DQ EDI Department
	C		Updated introductory language to Clinical Criteria
	D-2	61	Expanded recommendations to adequate documentation of treatment within the patient record.
	Exhibit A		Updated the limitation for the following codes: D0145
	Exhibit B		Updated the limitation for the following codes: D0140, D0150
	1.00	15	Added reference to Adult Benefit Structure Change
	1.04	16	Added reference to Adult Annual Maximum Accumulator
	2.01	17-18	Added reference to Adult Benefit Structure Change and Naming of IDRDR Waiver
	2.04	19-20	Clarified application of copayments to Adult Benefits and Naming of IDRDR Waiver
	3.04	24	Added reference to Adult Benefit Structure Change
	4.06	29	Added reference to Adult Benefit Structure Change
	4.07	29-30	Added reference to Adult Benefit Structure Change
	4.08	30	Added reference to Adult Benefit Structure Change
	4.16	33	Clarified Prior Authorization Process for Outpatient Treatment
	Appendix A		Added reference to Adult Benefit Structure Change and Naming of IDRDR Waiver
	B		Added reference to Adult Benefit Structure Change and Naming of IDRDR Waiver
	C.09		Clarified Naming of IDRDR Waiver
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
	Exhibit B		Revised Benefit Tables for Adult Benefit Structure Change
	Exhibit C		Clarified Naming of IDRDR Waiver
11/01/14	2.0	18	Added reference to "Healthy Connections Checkup"
	2.04	20	Added reference to "Healthy Connections Checkup"
	3.02	23	Clarified Prior Authorization Process for Outpatient Treatment
	4.16	33	Clarified Prior Authorization Process for Outpatient Treatment
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1



	Exhibit B		Added CPT codes to the covered code set for Adults
3/27/14	Cover		Updated publication date and SCDHHS Logo
	Table of Contents	12-14	Added Section 4.08 regarding Emergency Adult Services and Revised Numbering
	1.00	15	Added Reference to Adult Emergency Services
	2.01	17	Added Reference to Adult Emergency Services
	2.04	19-20	Added Reference to Adult Emergency Services
	2.06	20-21	Added Reference to Adult Emergency Services
	3.01	22	Added Reference to Adult Emergency Services and CMS 1500 Claim Format Requirement
	4.05	28	Added Reference to CMS 1500 Claim Format Requirement
	4.06	29	Added Reference to Adult Emergency Services
	4.08	30	Added Section Regarding Adult Emergency Services
	4.09-4.18	30-34	Revised Section Numbering
	5.00	35	Updated AMA and ADA Copyright Dates
	Appendix A	43	Added Reference to Adult Emergency Services, Revised Numbers
	A-2	45	Added Reference to CMS 1500 Claim Format Requirement
	Appendix B	46	Added Reference to Adult Emergency Services
1/17/14	Provider Rights & Responsibilities	9	Updated Provider Rights & Responsibilities to reflect SCDHHS policy on private payment by a beneficiary for noncovered services that are not medically necessary
	2.00	16	Updated Healthy Connections ID Cards and Explanations
	3.00	21	Added reference to Noncovered Service Prior Authorization Request Requirement – found in Section 3.04
	3.04	23-24	Added SCDHHS Policy Interpretation for Request of Noncovered Services under EPSDT
	4.10	30	Added reference to Fee Schedule for Frequently Submitted Noncovered Codes
	4.16	32	Corrected Phone Number for SCDHHS Provider Enrollment
	Appendix A	41	Updated EPSDT Definition
	A-2	43	Updated Additional Resources found on DentaQuest Provider Web Portal
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1

6/3/13	4.02-4.03	26	Revised instructions for electronic claim submission
	4.08	29	Modified Coordination of Benefits Section to Differentiate Claim Filing Under EPSDT
	4.09	29-30	Added Coordination of Benefits Section Specific to EPSDT
	4.09-4.17	29-32	Corrected Section Numbers
	Clinical Criteria	46	Updated Clinical Criteria for Removable Prosthodontics
4/4/13		2	Removed obsolete email address
	4.02	26	Updated list of clearinghouses for electronic claim submission
	4.03	26	Updated email address for questions on electronic claim submission
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
	Exhibits A and C		Corrected limitation on the following codes: D2950, D2954
	Exhibits A, B, and C		Added language on biopsies on biopsies of oral tissue to covered oral surgical codes
1/15/13	Contacts	2	Added SCDHHS Fraud and Abuse email address
	Provider Rights & Responsibilities	9	Updated Provider Responsibilities to include adherence to state and federal requirements for the practice of dentistry.
	4.10	30	Clarified timely filing policies
	7.05	37	Added SCDHHS Fraud and Abuse email address
	9.01	39	Updates SCDHHS Requirements for Provider Participation
	Appendix A	41	Corrected definition of clean claim
	Appendix B	44	Added reference to ADA standard for tooth numbering
	Appendix C	46	Added criteria for the use of behavior management
	Appendix D	54-59	Clarified documentation requirements for dental record
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
	Exhibits A and C		Replaced CDT Codes D1203 and D1204 with D1208
	Exhibits A, B, and C		Clarified guidance on same tooth restorations done within six month timeframe, extractions and orthodontia, and sedation/anesthesia billing and documentation.
10/2/12	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
8/2/12	9.00	39	Added link to electronic contact for Provider Enrollment

	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
5/1/12		11	Updated Table of Contents
	1.00	14	Updated language on adult coverage
	2.01	16	Updated language on adult coverage
	2.06	19	Updated language on adult coverage
	4.06 and 4.07	28-29	Updated language on adult coverage
	Appendix B	44	Updated language on adult coverage
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
4/2/12	2.01	16	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
		3	Added reference to addition of SCDHHS Provider Manual Section 1 as Appendix E
	2.01	16	Updated language on adult coverage
	2.06	19	Updated language on adult coverage
	2.07	20	Included information on broken appointment tracking
	4.03	26-27	Updated email address for dental claim submission
	4.06	28	Updated language on adult coverage
	4.07	28-29	Updated language on adult coverage
	4.12	30-31	Clarified language on timeframe for appeal requests
	4.14	31	Clarified language on dental charges associated with OR/ASC usage
	6.01	34	Clarified language on timeframe for appeal requests
	Appendix B	44	Updated language outlining available benefits
	Appendix D	54	Included information on broken appointment tracking
	Appendix E		Added Dental Services Provider Manual Section 1
8/19/11	2.06	19	Updated beneficiary transportation information
4/14/11	2.04	18	Removed reference to copayment requirements for ID/RD Waiver members

4/7/11	1.00	14	Clarified language related to adult coverage
	1.02	14	Updated Provider Relations phone number
	2.01	16	Clarified language related to adult coverage
	2.04	18	Updated copayment requirements
	2.06	19	Updated language related to adult coverage
	3.00	21	Clarified review processes for prepayment review (PPR) and prior authorization (PA); clarified language related to adult coverage
	4.06	28	Clarified language related to adult coverage
	4.07	28-29	Clarified language related to adult coverage
	4.08	29	Updated copayment requirements
	4.16	32	Updated Provider Enrollment phone number
	4.17	32	Updated terminology for web portal
	6.00	34	Clarified appeal process
	9.00	39	Updated Provider Enrollment phone number
	Appendix A	41	Added definition for "medical condition"
	Appendix B	44	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	22	Added instruction for submission of emergency authorization requests
	4.06	28	Clarified methods for indicating emergency services
	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	44	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 <i>Healthy Connections Kids</i> (HCK)
	2.05	19	Clarified federal claim filing guidelines for dually eligible Medicare and Medicaid recipients.
	3.01	21	Revised definition of prior authorization.
	Appendix C	46	Clarified criteria for dental extractions do not extend to prophylactic removal of asymptomatic teeth such as third molars.
6/10/10	1.05	15	Expanded value-added service language regarding authorization coordination.
	3.01	21	Added clarification that “authorization” can be obtained via a prior authorization or prepayment review.
	4.02	25	Updated address for claim submission.
	4.05	28	Updated paper claim completion instructions.
	6.01	34	Clarified that complaint or appeal requests must be received within 30 calendar days.
	Appendix A	44	Revised definitions for “clean claim” and “prior authorization.”
	Appendix C	46	Updated documentation and procedure criteria to reflect what’s necessary for prepayment review as opposed to prior authorization.
	Appendix D.2	55	Dental Record recommendation language changed from “must” to “should.”

## ***Healthy Connections***

### **Statement of Provider Rights and Responsibilities**

#### **Providers shall have the right to:**

1. Communicate with Beneficiaries regarding dental treatment options.
2. Recommend an appropriate, clinically sound 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. Providers may file for a reconsideration of any adverse decision made by DentaQuest to deny, reduce or delay dental services. The policies and procedures for a reconsideration process can be found in Sections 4.14 of the Office Reference Manual (ORM).
4. The Provider can request a State Fair Hearing with SCDHHS only after the reconsideration process is exhausted. (Refer to Section 6.01 of this Dental ORM).
5. Provide accurate, relevant, and factual information to any Beneficiary in connection with an appeal or complaint filed by the Beneficiary.
6. Protect the Beneficiaries' rights to privacy.
7. Comply with any applicable federal and state laws pertaining to Beneficiary rights regarding discrimination 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.
8. Notify Medicaid Provider Enrollment of any changes including, but not limited to, location, telephone number, participation limits, or a change in Provider participation within thirty (30) calendar days of the change.(Refer to section 9.00)
9. Hold the Healthy Connections Beneficiaries harmless and not liable for improper billing by the Provider.
10. Adhere to the Healthy Connections Provider Participation Agreement along with state and federal requirements regarding the practice of dentistry.

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## ***Healthy Connections***

### **Statement of Beneficiaries Rights**

#### **1. Civil Rights**

The Healthy Connections enrolled Providers cannot discriminate a Beneficiary on the basis of race, sex, age, handicap, religion, national origin, political belief or limited English proficiency. If a Beneficiary would like to report a Provider for unfair discrimination practices, they can contact Civil Rights Division by phone at 1-888-808-4238 (toll- free) or email at [civilrights@scdhhs.gov](mailto:civilrights@scdhhs.gov)

#### **2. Health Information Rights**

The ***Healthy Connections*** program provides to the Beneficiary a Notice of Privacy Practices with their Beneficiary ID Card. If the Beneficiary would like to obtain an additional copy of this notice, they can contact the SCDHHS at 1-888-549-0820 (toll-free).

#### **3. Beneficiary Complaints (Grievances) and Appeals**

Beneficiaries have the right to submit complaints to DentaQuest telephonically or in writing on any Healthy Connections dental program issue other than decisions that deny, delay, or reduce dental services. Beneficiaries have the right to appeal to DentaQuest any adverse decision made by DentaQuest to deny, reduce or delay dental services. (Refer to Section 6.02 of this Dental ORM).

#### **4. State Fair Hearing**

If the Beneficiary has exhausted the process with DentaQuest, he or she has the right to request a State Fair Hearing with SCDHHS (Refer to Section 6.02 of this Dental ORM)

#### **5. Freedom of Choice**

Except as otherwise specified, a Beneficiary has the right to choose any enrolled provider willing to accept the Beneficiary as a patient.

**Dental Office Reference Manual**  
**Table of Contents**

<b>Section</b>	<b>Page</b>
<b>1.00 What is SC <i>Healthy Connections</i>?</b> .....	<b>18</b>
<b>1.01 Dedicated Call Center for Providers</b> .....	<b>18</b>
<b>1.02 Provider Training</b> .....	<b>18</b>
<b>1.03 Provider Newsletters</b> .....	<b>18</b>
<b>1.04 DentaQuest Website</b> .....	<b>19</b>
<b>1.05 Other Value-Added Provider Benefits</b> .....	<b>19</b>
<b>2.00 Beneficiary Eligibility Criteria and Verification Processes</b> .....	<b>20</b>
<b>2.01 Eligibility and Identification Card Samples</b> .....	<b>20</b>
<b>2.02 DentaQuest Eligibility Systems</b> .....	<b>22</b>
<b>2.03 Documenting Beneficiary Eligibility</b> .....	<b>22</b>
<b>2.04 Beneficiary Co-Payments</b> .....	<b>23</b>
<b>2.05 Dual Eligibility</b> .....	<b>23</b>
<b>2.06 Beneficiary Transportation</b> .....	<b>24</b>
<b>2.07 Broken/Cancelled/Missed Appointment</b> .....	<b>24</b>
<b>3.00 Authorization for Treatment</b> .....	<b>25</b>
<b>3.01 Treatment Requiring Authorization</b> .....	<b>25</b>
<b>3.02 Prior Authorization for Non-State Plan Services</b> .....	<b>27</b>
<b>3.03 Authorization for services delivered in an outpatient setting</b> .....	<b>28</b>
<b>3.04 Authorization for services that require Inpatient stay</b> .....	<b>28</b>
<b>3.05 Electronic Attachments</b> .....	<b>28</b>
<b>4.00 Claim Submission Procedures (claim filing options)</b> .....	<b>29</b>
<b>4.01 Electronic Claim Submission Utilizing DentaQuest's Website</b> .....	<b>29</b>
<b>4.02 Electronic Claim Submission via Clearinghouse</b> .....	<b>30</b>
<b>4.03 HIPAA Compliant 837D and 837P File</b> .....	<b>30</b>
<b>4.04 NPI Requirements for Submission of Electronic Claims</b> .....	<b>30</b>
<b>4.05 Paper Claim Submission</b> .....	<b>31</b>
<b>4.06 Filing Claims for the Provision of Emergency Services</b> .....	<b>32</b>
<b>4.07 Filing Claims for the Provision of Adult Services for Exceptional Medical</b> .....	<b>32</b>
<b>4.08 Filing Claims for the Provision of Adult Services</b> .....	<b>33</b>
<b>4.09 Standard Coordination of Benefits (COB)</b> .....	<b>33</b>
<b>4.10 Coordination of Benefits Under EPSDT</b> .....	<b>34</b>
<b>4.11 Fee Schedule and Charge Limits</b> .....	<b>34</b>
<b>4.12 Filing Limits</b> .....	<b>36</b>
<b>4.13 Claims for Retro-Eligible Beneficiaries</b> .....	<b>36</b>
<b>4.14 Request for Reconsideration</b> .....	<b>37</b>
<b>4.15 Receipt and Audit of Claims</b> .....	<b>37</b>
<b>4.16 Claim Submission for services performed in an Outpatient setting (ASC/OR)</b> .....	<b>37</b>
<b>4.17 Claim for services that require Inpatient stay</b> .....	<b>37</b>



4.18	Electronic Funds Transfer .....	38
4.19	Electronic Remittance Statements .....	38
5.00	Health Insurance Portability and Accountability Act (HIPAA).....	39
6.00	Grievances, Appeals and State Fair Hearing .....	40
6.01	Provider .....	40
6.02	Beneficiary .....	40
7.00	Utilization Management Program .....	42
7.01	Introduction.....	42
7.02	Community Practice Patterns .....	42
7.03	Evaluation .....	42
7.04	Results.....	42
7.05	Fraud and Abuse .....	43
8.00	Quality Improvement Program .....	44
9.00	Provider Enrollment.....	45
9.01	Requirements for Provider Participation .....	45
9.02	Out of State Providers .....	45
	APPENDIX A- Definitions & Attachments .....	46
A.01	General Definitions .....	46
A.02	Additional Resource Forms & Attachments.....	47
	APPENDIX B- Covered Benefits.....	48
	APPENDIX C - Clinical Criteria.....	50
C.01	Criteria for Dental Extractions .....	51
C.02	Criteria for Pre-Fabricated Crown.....	51
C.03	Criteria for Endodontics .....	52
C.04	Criteria for Authorization of services in an OR or ASC.....	53
C.05	Criteria for Removable Prosthodontics (Full and Partial Dentures) .....	54
C.06	Criteria for Space Maintainers .....	55
C.07	Criteria for the Excision of Soft Tissue Lesions .....	55
C.08	Criteria for the Determination of a Non-Restorable Tooth.....	56
C.09	Criteria for General Anesthesia, Intravenous (IV) Sedation.....	56
C.10	Criteria for Behavior Management .....	57
	APPENDIX D - Recommendations/ Suggestions .....	58
D.01	Reducing Broken/Canceled/Missed Appointments.....	58
D.02	The Dental Treatment Record .....	59
D.03	Dental Recall System .....	62
	APPENDIX E - Section 1 of SCDHHS Provider Manual (General Information and Administration)	
	.....	64

## EXHIBITS

South Carolina Benefit Plan for Children.....	Exhibit A
South Carolina Benefit Plan for Adults.....	Exhibit B
South Carolina Benefit Plan for ID/RD Waiver Beneficiaries Only.....	Exhibit C

## 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 or experimental purposes. Please reference Exhibits A, B, and C of this manual for detailed coverage criteria and guidelines.

As of December 1, 2014, SCDHHS has added preventive and restorative dental service coverage for eligible adults age 21 and older. Coverage criteria for adults are detailed in Sections 4.06 through 4.08.

### 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 Partners and Outreach Coordinator for assistance. Providers may also request a personal, in-office visit, by contacting their Provider Partners, Ashley Manini and Channell Webster:

Ashley Manini  
 Phone: 803-587-9579  
 Email: [Ashley.Manini@dentaquest.com](mailto:Ashley.Manini@dentaquest.com)

Channell Webster  
 Phone: 803-240-3372  
 Email: [Channell.Webster@dentaquest.com](mailto:Channell.Webster@dentaquest.com)

## 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](http://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.

#### **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
- Annual Maximum Accumulator for Adult Beneficiaries
- 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 Representatives, and Local Dental Consultants
- Defined Prior Authorization Requirements for Place of Service

## 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. Beneficiaries may be eligible for full benefits that include dental services or limited benefits that do not include dental services. 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.

The South Carolina Department of Health and Human Services (SCDHHS) announces the release of a new Healthy Connections Medicaid card template. The new card, effective August 1, 2016, will no longer contain a magnetic data strip on the backside. The new cards will go into circulation for current members who request replacement cards and newly-eligible members. Providers shall accept all versions of the card until further notice.

#### SAMPLE ID CARDS:



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. Beneficiaries who enroll with a Medicaid Managed Care Organization (MCO) will also be issued an identification card by the MCO.

## A. Medicaid Beneficiaries eligible for Dental Benefits

Medically necessary dental services are available to beneficiaries eligible for full Medicaid benefits only, which include the following subgroups of Medicaid eligible Beneficiaries:

### 1. Dental Benefits for Children under the age of 21

Medicaid Beneficiaries from birth through the month of their 21<sup>st</sup> birthday are eligible to receive comprehensive dental services that include:

- a) State Plan covered dental services (outlined in Exhibit A)
- b) State Plan covered medical services rendered by oral surgeons (outlined in Exhibit A)
- c) Non-State Plan covered services: EPSDT services (detailed on the SCDHHS EPSDT website at: <https://msp.scdhhs.gov/epsdt/site-page/dental-services> )

\*EPSDT Services: Federal law at 42 U.S.C. § 1396d(r) [§1905(r) of the Social Security Act (SSA)] requires state Medicaid programs to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age. The scope of EPSDT benefits under the federal law covers any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the South Carolina State Plan for Medical Assistance (State Plan). EPSDT dental services include those provided at intervals that meet reasonable standards of dental practice and at intervals necessary to determine the existence of a suspected illness or condition. SCDHHS has developed a Dental Periodicity Schedule that follows the American Academy of Pediatric Dentistry recommendations on *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment for Infants, Children and Adolescents* accessible at: <https://msp.scdhhs.gov/epsdt/site-page/periodicity-schedule>

### 2. Dental Benefits for Members of the ID/RD Waiver

Medicaid Beneficiaries that are members of the ID/RD Waiver are eligible to receive dental benefits that include:

- a) State Plan covered dental services (Outlined Exhibit C)
- b) State Plan covered medical services rendered by oral surgeons (outlined in Exhibit C)

The ID/RD Waiver program is administered by the South Carolina Department of Disabilities and Special Needs (SCDDSN). Beneficiaries applying for enrollment in the ID/RD Waiver program must meet specific guidelines based on their medical condition to be enrolled in the program. The ID/RD Waiver program has limited capacity and is not inclusive of all special needs Beneficiaries.

### 3. Dental Benefits for Adults beneficiaries age 21 and older

Adult Medicaid beneficiaries are eligible to receive limited Dental benefits that include:

- a) State Plan covered adult dental services (outlined in Exhibit B)
- b) Emergency medical services (CPT procedures) rendered by oral surgeons, as detailed in Section 4.6 and outlined in Exhibit B of this document and
- c) Dental treatment resulting or in preparation for exceptional medical conditions, as outlined in Section 4.07.\*

As of December 1, 2014, eligible Medicaid Beneficiaries age 21 and over have \$750 available annually towards State Plan covered dental services. The \$750 benefit is an annual maximum that is available for a twelve month period that will match the state fiscal year (July 1 through June 30 of the following year).

\* 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.

## B. Medicaid Beneficiaries ineligible for Dental Benefits

Beneficiaries enrolled in Family Planning and Qualifying Individuals, Specified Low Income Medicare Beneficiaries (SLMB) or as Qualified Medicare Beneficiaries (QMB) are NOT eligible for dental benefits.

### 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](http://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](http://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 on the date of service and yet the claim is denied due to a possible change in eligibility 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. Providers should also verify Member's eligibility, service history and available balance (if applicable) prior to rendering services.

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. The dental copayment for affected Beneficiaries receiving non-emergency services is \$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:

- a) Children (under the age 19)
- b) Pregnant Women
- c) Individuals receiving Family Planning services
- d) Residents in a Nursing Home
- e) Individuals receiving emergency services
- f) Federally recognized Native Americans
- g) End Stage Renal Disease (ESRD) Services
- h) Individuals receiving Hospice care
- i) members of the Intellectually Disabled and Related Disabilities (ID/RD) Waiver;
- j) Institutionalized individuals

To be certain that the copayment exclusion for the provision of emergency services is applied, Providers should indicate "EMERGENCY" in the "Notes" field of the ADA Claim Form (field #35) or field #24C of the CMS 1500 Claim Form.

## 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 eligible beneficiaries 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 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**

Non-Emergency Medical Transportation (NEMT) for medically necessary dental services is available to Healthy Connections Beneficiaries. To schedule NEMT trips to a dental appointment for beneficiaries not residing in a nursing facility, contact the Transportation Broker at <https://memberinfo.logisticare.com/scmember/>. To schedule NEMT trips to a dental appointment for beneficiaries residing in a nursing facility, contact the nursing facility directly.

## **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.



### 3.00 Authorization for Treatment

#### 3.01 Treatment Requiring Authorization

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) through prior authorization or by pre-payment review.

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.

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.

**A. 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:

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

Claims with CDT procedure codes (D codes) must be submitted on an ADA approved claim form (year 2012 or newer). Claims with CPT procedure codes (medical codes) must be submitted on a CMS 1500 claim form, version (02/12).

The tables of Covered Services (Exhibits A-C) contain column marked “Pre-payment Review Required”. A “Yes” in the “Pre-payment Review” 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 describes the necessary information to be submitted with the claim for pre-payment review.

Claims processed through Prepayment review will be denied for one of the following reasons:

**1. Medical Necessity has not been demonstrated:**

Upon review of the submitted documentation by a DentaQuest Dental Director, medical necessity has not been demonstrated. Medical necessity denials occur when the supporting documentation for the service was submitted but the content of the documentation was not sufficient to support the medical necessity of the rendered service(s).

**2. Medical Necessity documentation missing or incomplete:**

Medical necessity has not been demonstrated due to a lack of or incomplete documentation.

**B. Prior Authorization-** Dental services that require an approval prior to the service being rendered must be listed on the ADA or CMS1500-form and submitted with appropriate documentation that supports the medical necessity no less than 15 days prior to the scheduled

date of treatment. The requested service(s) will be reviewed by DentaQuest for determination of medical necessity. DentaQuest will review the request and render an approval or denial. The submitting office shall receive an authorization determination letter within fifteen (15) calendar days from the date the documentation is received by means of mail or fax, and is available on the DentaQuest web portal. The approved authorization number 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.

Providers can submit Prior Authorization requests via the following routes:

- a) Electronic- via DentaQuest web portal( [www.dentaquest.com](http://www.dentaquest.com))
- b) Mail- DentaQuest- Authorizations PO. 2136 Columbia, SC 29202-2136
- c) Fax- 262.834.3589

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 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.

Services that require prior authorizations under the Health Connections benefits are:

- a) Non- State Plan covered services (EPSDT services): authorization for these services is issued by DentaQuest (refer to section 3.02 for details)
- b) Services delivered in an outpatient setting such as Operating Room (OR) and Ambulatory Surgical Center (ASC): authorization for these services is issued by DentaQuest (refer to section 3.03 for details).
- c) Services that require inpatient stay: authorization for these services is issued by KEPRO or the Managed Care Organization (MCO) (refer to section 3.04 for details).

**C. Expedited Prior Authorizations-** For services requiring prior authorization, there may be times when an Expedited Prior Authorization (EPA) is needed. The request for an Expedited Prior Authorization should indicate the urgent need and the providers must enter the full word "EXPEDITE" in the "Notes" field on the ADA Claim Form (field #35) or field #24C on the CMS 1500 Claim Form. Prior Authorization requests made in urgent situations will be reviewed and the medical necessity determination will be made within seventy-two (72) business hours of receipt. The request must include a narrative describing the urgent need for the service. Dental services requested through an Expedited Authorization must be listed on the ADA or CMS 1500 form and be submitted with appropriate documentation that supports the medical necessity. 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 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.

To ensure a timely determination of your request for an Expedited authorization (within 72 hours of receipt), we recommend the following submission methods:

**a) Email**

Scan and email your urgent request to [DQSCEmergency@DentaQuest.com](mailto: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.

**b) Fax**

Fax your expedited request to 800.521.1735

**Please DO NOT submit an Expedited PA via portal.**

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

- a) NEA – please note the NEA number on your claim form
- b) Scan the diagnostic image and email it to [DQSCEmergency@DentaQuest.com](mailto:DQSCEmergency@DentaQuest.com)

**If the provider does not have the capability to submit an NEA or image via email, the provider may still submit a prior authorization request via portal, however this request will be processed within 15 calendar days of receipt (please refer to section 3.01 B).**

**D. Prior Authorization Reasons for Denial:**

Providers filing a PA or EPA for State Plan covered services must submit detailed documentation of medical necessity (as specified in Exhibits A-C).

A PA or EPA request will be denied for one of the following reasons:

**1. Medical Necessity has not been demonstrated:**

Upon review of the submitted documentation by a DentaQuest Dental Director, medical necessity has not been demonstrated. Medical necessity denials occur when the supporting documentation for the service was submitted but the content of the documentation was not sufficient to support the medical necessity of the requested service(s).

**2. Medical Necessity documentation missing or incomplete:**

Medical necessity has not been demonstrated due to a lack of or incomplete documentation.

**3.02 Prior Authorization for Non State Plan covered services**

Providers must obtain a prior authorization (PA) for all medically necessary non-State Plan covered services (EPSDT services) for all children under the age of twenty-one (for description and details of the EPSDT services refer to section 2.01 of the manual). The authorization must have attached all documentation that supports the determination of medical necessity. Payment for approved EPSDT services must be accepted as payment in full.

Providers requesting a PA or billing for EPSDT services must select the EPSDT box in section 1 of the ADA claim form or box 24H on the CMS-1500 claim form. Providers must submit proposed treatment on the ADA or CMS-1500 form. All PA's and/or claims submitted for non- State Plan covered codes will be systemically denied if the EPSDT indicator is not selected.

DentaQuest will review all valid EPSDT PA submissions. Approved PA's must have the appropriate claim form before it will be reviewed. A denial of a PA or EPA request for EPSDT services will be for (1) of these three (3) reasons:

**1. Medical Necessity has not been determined:**

Upon review of the submitted documentation by a DentaQuest Dental Director, medical necessity has not been demonstrated. Medical necessity denials occur when the supporting documentation for the service was submitted but the content of the documentation was not sufficient to support the medical necessity of the requested service(s).

**2. Medical Necessity documentation missing or incomplete:**

Medical necessity has not been demonstrated due to a lack of or incomplete documentation.

**3. Service not filed under EPSDT:**

EPSDT review requires that "EPSDT" be indicated on the prior authorization request. There is either no indication of EPSDT on the request, or the appropriate area on the prior authorization request form is not marked.

**3.03 Authorization for services delivered in an outpatient setting**

**Outpatient setting includes Operating Room (OR) and Ambulatory Surgical Centers (ASC).**

The Participating dental provider should submit the prior authorization request to DentaQuest. The prior authorization request must include the procedure codes that the provider is planning to render as well as the procedure code that identifies the utilization of the ASC/OR facility for the services requested. Prior authorization request must include all appropriate documentation such as a detailed narrative of medical necessity, radiographs and/or other supporting documentation that will assist in the determination of medical necessity. DentaQuest will review the services for medical necessity, and render an approval or denial for each including the use of the facility. Receipt of the approved authorization from DentaQuest allows a dental provider to schedule with the facility. Participating providers do not need to seek authorization from the beneficiary's Managed Care Organization (MCO).

Please see section 4.16 for information on submitting claims for services performed in an ASC/OR facility.

**3.04 Authorization for services that require Inpatient stay**

DentaQuest will not issue and will deny any authorization that includes at least one procedure code that requires inpatient stay.

Authorization for services that require inpatient stay will be issued only by KEPRO or the beneficiary's Managed Care Organization (MCO). Dental provider must coordinate with the hospital, where these services will be rendered, to obtain the appropriate authorization.

Providers can view the Center for Medicare and Medicaid Services (CMS) rule for inpatient only services at:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3941CP.pdf>

A list of these services can be found at: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11\\_Addenda\\_Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html)

Please see section 4.17 for information on submitting claims for services that require inpatient stay.

**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](http://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](http://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.

### **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](http://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](http://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 Emdeon (1-888-255-1293), Tesia (1-800-724-7040), EDI Health Group (1-800-576-6412), Secure EDI (1-877-466-9656) and Mercury Data Exchange (1-866-633-1090) for claim submissions to DentaQuest. 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 and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest.

#### 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 directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email [EDITeam@greatdentalplans](mailto:EDITeam@greatdentalplans) to inquire about this option for electronic claim submission.

#### 4.04 NPI Requirements for Submission of Electronic Claims

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](http://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.

The following methods of authentication have been deemed **acceptable** by SCDHHS.

- Electronic signatures -- an electronic sound, symbol, or process attached to or logically associated with an electronic claim submission to signify knowledge, approval, acceptance, or obligation by the individual Provider who provided or ordered the services specified in the claim submission entry.

- Electronic signatures must be authenticated, safeguarded against misuse and modification, and should be easily identifiable as electronic, rather than typewritten, signatures.
- As the individual represented by the electronic signature bears responsibility for the authenticity of the information.

Chart 'Accepted By' with provider's name'	'Electronically signed by' with provider's name'	'Verified by' with provider's name'
'Reviewed by' with provider's name'	'Released by' with provider's name'	'Signed by' with provider's name'
'Signed before import by' with provider's name'	'Signed: John Smith, M.D.' with provider's name'	'This is an electronically verified report by John Smith, M.D.'
'Authenticated by John Smith, M.D'	'Authorized by: John Smith, M.D'	'Digital Signature: John Smith, M.D'
'Confirmed by' with provider's name'	'Closed by' with provider's name'	'Finalized by' with provider's name'
'Electronically approved by' with provider's name 'Signature Derived from Controlled Access Password'		

#### 4.05 Paper Claim Submission

Claims with CDT procedure codes (“D” codes) must be submitted on an ADA approved dental claim form (year 2012 or newer). Claims with CPT procedure codes must be submitted on the CMS 1500 medical claim form, version (02/12).

- 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.
- Acceptable Provider Signatures; Refer to Table in Section 4.04 DentaQuest requires that dental services provided will be authenticated by the provider. Acceptable method used for authentication shall be handwritten, signed initials, and/or rubber stamp signatures.
- 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 and the address location where the services were rendered.
- 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.
- Place of Service Codes (POS) approved and maintained by the Centers for Medicare & Medicaid Services (CMS), are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The SCDHHS requires POS codes for all submitted CMS 1500 and ADA claim forms. The 2012 ADA claim form (Field 38) and CMS 1500 form (Field 24 B) allow for the POS entry.

For a complete listing of Place of Service codes please visit CMS website.  
[https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html)

- 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.
- 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**

Adult Beneficiaries age 21 and older may receive emergency medical (CPT) services performed by an oral surgeon. The Emergency Medical treatment category will not consume the \$750 annual maximum under the adult preventive dental benefit as long as claims for treatment under this category is appropriately submitted. The listing of allowed 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, Oral Surgeons should indicate that the services were rendered as an emergency in field #24C on the CMS 1500 Claim Form (version 02/12). This indication can also be made by including the word "Emergency" in the "Notes" field when submitting claims through the DentaQuest Provider Web Portal.

#### **4.07 Filing Claims for the Provision of Dental Services in preparation or as the result of Exceptional Medical Conditions**

Adult Beneficiaries age 21 and older may receive medically necessary dental services as the result of or in preparation for the following exceptional medical conditions:

- 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)



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).

All claims submitted for the dental services as the result of or in preparation for the exceptional medical conditions listed above are subject to pre-payment review with submission of appropriate documentation from both dental provider and the referring medical provider. Prior authorization is optional.

These claims 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. The indication of the keywords "Medical Condition" ensures that the requested services, if allowable under medical necessity guidelines, will not be counted towards the member's \$750 annual maximum.

#### **4.08 Filing Claims for the Provision of Adult Dental Services**

##### **Adult Preventive Dental Benefit**

As of December 1, 2014, eligible Medicaid Beneficiaries age 21 and older may receive up to \$750 annually in covered dental treatment under the adult preventive dental benefit. The annual benefit begins July 1 and continues through June 30 of the following year.

The \$750 maximum benefit will be based on claim payments under the **Healthy Connections** adult dental fee schedule. Covered dental benefits are outlined in Exhibit B of this document.

Sedation is not included within the standard benefit. Only when medically necessary, Beneficiaries with special needs diagnoses or members receiving treatment by an oral surgeon may receive sedation services, which are excluded from the annual maximum benefit amount. Reimbursement for these services require review of medical necessity.

Providers are able to view an adult Beneficiary's available benefit (the unused annual maximum benefit amount) on the DentaQuest provider web portal.

#### **4.09 Standard Coordination of Benefits (COB)**

Medicaid is 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. Medicaid beneficiaries with private insurance are not to be charged the copayment amount of the primary payers.

When you accept a patient as a Medicaid patient, all Medicaid rules, including the Medicaid copayment rules, apply to that individual. These rules are federal law; they protect the Medicaid beneficiary by limiting his or her liability for payment for medical services.

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.

#### **4.10 Coordination of Benefits Under EPSDT**

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 & 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. (SCDHHS Provider Manual, pages 1-25 & 1-26 – Available as Appendix E of this document)

Providers filing claims on the ADA claim form should indicate that a claim is being filed under EPSDT by checking the EPSDT box in Field 1. Providers filing claims on the CMS 1500 form should indicate that a claim is being filed under EPSDT by checking field 24H.

All claims submitted for the Non-State Plan covered codes will be systemically denied if the EPSDT indicator is not selected.

#### **4.11 Fee Schedule and Charge Limits**

The current SCDHHS fee schedule for covered dental services can be found at: <https://www.scdhhs.gov/resource/fee-schedules>. A list of the most frequently submitted non-State Plan covered EPSDT services is in the "Related Documents" section of the Provider Web Portal at [www.dentaquest.com](http://www.dentaquest.com). Payment for approved EPSDT services must be accepted as payment in full.

The reimbursement fee for a dental procedure is inclusive of any items or related activities/services that are considered necessary to accomplish the procedure, which may include, but are not limited to: materials, supplies, trays, surgical trays, equipment, topical or local anesthesia and post-operative care. None of these items or related activities/services are separately billable to SCDHHS, the Beneficiary or to the Beneficiary's representative.

Providers may not charge SCDHHS more for services to a Beneficiary than customarily charged to the general public. Providers should bill their usual 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.

Once a provider has accepted a Beneficiary as a Medicaid patient, the Provider must accept the amount 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, Providers may not charge the patient for the primary insurance carrier's copayment.

The **Healthy Connections** 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. **Billing covered procedures prior to the date of service is prohibited.**

Providers must not bill the Beneficiary for any services the Beneficiary is eligible to receive under the Healthy Connections Medicaid program, with the exception of Co-payments when applicable. Medicaid payments may be made only to a Provider, a Provider's employer, or an authorized billing entity. **Payments will not be reimbursed to a Beneficiary.** Therefore, seeking payment from a Beneficiary is prohibited except where a copayment is applicable. For services and beneficiaries that are exempt from Co-pay refer to section 2.04 of this manual.

Providers should always check the Beneficiary's eligibility and service history for all beneficiaries. For adult beneficiaries ages 21 years and older, provider must also verify the available balance of the allowed \$750 annual limit prior to rendering services. The covered service that exhausts the maximum allowance will be paid based on the remaining dollars available. The remaining amount paid will be considered payment in full. SCDHHS will not reimburse for any service after the beneficiary's \$750 annual limit has been reached.

For details of the covered dental services please refer to section 2.01; section 4.07 and Exhibits A, B or C of this manual.

**A. For denied covered services provider can take one of the following actions:**

1. Resubmit the claim along with additional documentation or corrections as needed  
OR
2. File for a reconsideration of the DentaQuest adverse decision (for reconsideration process and protocols refer to section 4.14 of this manual), OR
3. Provider will assume the cost for the services rendered with No billing to Medicaid or Beneficiary.

**NOTE:** The billing of beneficiaries for covered services is prohibited.

**B. For services denied through Prior authorization process (including EPSDT services) provider can take one of the following actions:**

*If Medical Necessity has not been demonstrated:*

1. Resubmit the PA request along with additional documentation supporting medical necessity. OR
2. File for a reconsideration of the DentaQuest adverse decision (for reconsideration process and protocols refer to section 4.14 of this manual), OR
3. Inform the Beneficiary that the service(s) were deemed not medically necessary; no claim will be filed with Medicaid and no reimbursement is expected from Medicaid for the service(s), AND
  - Provider and beneficiary agree to forego with the service delivery, OR
  - Provider and beneficiary agree to proceed with the service delivery without Medicaid reimbursement. In this case provider may proceed as follows:
    - ✓ Provide the service to the Beneficiary free-of-charge; OR
    - ✓ Prior to the provision of the service the provider must obtain written agreement from the beneficiary indicating their willingness to assume financial responsibility for the non-medically necessary service(s). The agreement must detail the service(s) and the respective amount(s) that beneficiary is willing to assume responsibility for. If the beneficiary assumes financial responsibility for the service, the provider may deliver the service and bill the beneficiary based on the provider's usual and customary charges.

*If Medical Necessity documentation is missing or incomplete:*

1. Resubmit the PA request along with the required medical necessity documentation. OR
2. Provide the service(s) free-of-charge to the beneficiary with no billing to Medicaid

*If Service is not filed under EPSDT:*

1. Resubmit the PA request indicating “EPSDT” in the appropriate area on the form. OR
2. Provide the service free-of-charge to the Beneficiary and not bill Medicaid.

**NOTE:** Claims submitted prior to receiving an approval for services requiring a Prior Authorization, will be denied. The billing of beneficiaries is prohibited while the PA process is on-going or until a medical necessity decision has been determined. All beneficiaries have the right to appeal any decision that delays, denies or reduces a dental benefit. Providers are prohibited from billing a beneficiary during the appeals process.

**C. For services denied through prepayment review process provider can take one of the following actions:**

*If Medical Necessity has not been demonstrated:*

1. Resubmit the claim along with additional documentation supporting medical necessity. OR
2. File for a reconsideration of the DentaQuest adverse decision (for reconsideration process and protocols refer to section 4.14 of this manual), OR
3. Provider will assume the cost for the services rendered with No billing to Medicaid or Beneficiary.

*If Medical Necessity documentation is missing or incomplete:*

1. Resubmit the claim along with additional documentation supporting medical necessity. OR
2. Provider will assume the cost for the services rendered with No billing to Medicaid or Beneficiary.

**NOTE:** The billing of beneficiaries is prohibited for services denied through Prepayment Review.

#### **4.12 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 a clean 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.

It is the Provider's responsibility to follow up on claims in a timely manner to ensure that all claims are filed as a clean claim within Medicaid policy limits.

#### **4.13 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.

SCDHHS will not consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

#### **4.14 Request for Reconsideration**

A Provider may submit a request for reconsideration for any adverse decision DentaQuest has made to deny, delay or suspend covered dental services. Providers must file the request for reconsideration in writing to DentaQuest within thirty (30) calendar days of the date of receipt of the notice of adverse action or thirty (30) calendar days from receipt of the remittance advice reflecting the denial, whichever is later. DentaQuest will respond within thirty (30) calendar days from the time of request receipt with a decision to either uphold or overturn the original denial. Upon completion of the reconsideration process with DentaQuest, Providers have the right to a State Fair Hearing with the South Carolina Department of Health and Human Services (SCDHHS). The State Fair Hearing processes are outlined in Section 6.00.

#### **4.15 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 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.

#### **4.16 Claim Submission for services performed in an outpatient setting (ASC / OR)**

All services rendered in an ASC or OR facility require prior authorization. Requirements to obtain approval are outlined in Section 3.03 of this manual. All claims for approved services rendered in an ASC/ OR, regardless of the Beneficiary's managed care enrollment, should be sent directly to DentaQuest for processing. Dental provider must include the DentaQuest approved prior authorization number when filing a claim for services performed in the ASC/ OR.

#### **4.17 Claims for services that require inpatient stay**

DentaQuest will deny claims filed for services that require inpatient stay. The authorizations for these services will only be issued by KEPRO or the beneficiary's Managed Care Organization (MCO). Reimbursement for these services are included in the medical payment paid to the hospital.

#### 4.18 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 888.289.0709.
- 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.

#### 4.19 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](http://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.

## 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 (CDT2018 and CPT 2018) 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 2012 or later) and all CPT procedure codes must be submitted on the CMS 1500 claim form (version 02/12), 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](mailto:denelig.benefits@dentaquest.com).

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

## 6.00 Grievances, Appeals and State Fair Hearing

### 6.01 Provider

#### Request for Reconsideration

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

DentaQuest, LLC  
Attention: Utilization Management/Provider Appeals  
PO Box 2906  
Milwaukee, WI 53201-2906  
Requests for reconsideration can also be faxed to: 262.834.3452

DentaQuest will respond in writing to the Provider with its decision to either uphold or overturn its original decision within thirty (30) calendar days of receipt of the provider's Request for Reconsideration. If DentaQuest upholds its original decision the Provider may request a State Fair Hearing with the South Carolina Department of Health and Human Services (SCDHHS).

#### State Fair Hearing

The request for the State Fair Hearing must be in writing and sent within thirty (30) calendar days from the final date of the Reconsideration decision letter from DentaQuest. A provider can request for a State Fair Hearing with SCDHHS via one of the following routes:

- By mail send the request to the address below:

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

- by fax at (803) 255-8206;
- by email at [appeals@scdhhs.gov](mailto:appeals@scdhhs.gov)
- online at <https://msp.scdhhs.gov/appeals>

### 6.02 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. 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  
PO Box 2906  
Milwaukee, WI 53201-2906



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.

### 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 of receipt of the adverse decision notice. DentaQuest will respond in writing to Beneficiary appeals within thirty (30) days of the date of receipt, or within three (3) days if the condition needs immediate attention.

### State 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 of receipt of DentaQuest's adverse decision: Beneficiaries may request a State Fair Hearing via one of the following routes:

- By mail send to the address below:

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

- by fax at (803) 255-8206;
- by email at [appeals@scdhhs.gov](mailto:appeals@scdhhs.gov)
- online at <https://msp.scdhhs.gov/appeals>

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

## 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 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

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 contact the Program Integrity Medicaid Fraud and Abuse Hotline at 888.364.3224 or [fraudres@scdhhs.gov](mailto:fraudres@scdhhs.gov).

## 8.00 Quality Improvement Program

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](mailto:denelig.benefits@dentaquest.com)

## 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 Option 4  
Fax: 803.870.9222

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
- 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.
- 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 the United States

## 9.02 Out of State Providers

- Dental Providers located within twenty-five (25) miles of the South Carolina border, will be considered In-State dental providers. They must enroll as a participating provider with SCDHHS to be eligible for reimbursement for services provided to eligible SC Medicaid beneficiaries.  
Providers can complete the enrollment application online <https://providerservices.scdhhs.gov/ProviderEnrollmentWeb>.  
For additional information contact SCDHHS Provider Enrollment.
- Dental Providers located outside of twenty-five (25) miles of the South Carolina border will be considered Out-of-State dental providers. They must enroll as a participating provider with SCDHHS. Enrolled Out-of-State providers may be reimbursed **only** for emergency dental services provided to the eligible SC Medicaid beneficiaries.  
Providers can complete the enrollment application online <https://providerservices.scdhhs.gov/ProviderEnrollmentWeb> .  
For additional information contact SCDHHS Provider Enrollment.

## APPENDIX A Definitions & Attachments

### A.01 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.
- E. "Covered Services" means a dental or medical 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 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
- G. "Emergency" medical services" means covered services, as it relates to adult Beneficiaries, that are needed to evaluate or stabilize an emergency medical condition and are furnished by a provider that is qualified to furnish these services, in this case those qualified providers are oral surgeons.
- H. "Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention will place the health of the individual in serious jeopardy or will cause serious impairment of bodily functions, or will cause serious dysfunction of any bodily organ or part.
- I. "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 I 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.
- J. "**Healthy Connections**" is the name of the program provided to South Carolina Medicaid Beneficiaries under the direction of SCDHHS.
- K. "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**.
- L. "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.
- M. “Participating Provider” or “Provider” is a dental professional or facility that has a written participation agreement in effect with SCDHHS to provide dental services to Beneficiaries of the **Healthy Connections** programs.
- N. “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 detailed narrative of medical necessity, radiographs and/or other supporting documentation must be submitted with requests for prior authorization.
- O. “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.
- P. “Service area” means the State of South Carolina and locations within a twenty-five (25) mile radius of its border.
- Q. “SCDDSN” means the South Carolina Department of Disabilities and Special Needs, which handles enrollment for the Intellectually Disabled and Related Disabilities (ID/RD) Waiver program.
- R. “SCDHEC” means the South Carolina Department of Health and Environmental Control, which is charged with responsibility for public health programming within the state.
- S. “SCDHHS” means the South Carolina Department of Health and Human Services, the state’s Medicaid agency.

## A.02 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](http://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 (Version 02/12) and Instructions
- SCDHHS Form 205 (Provider Refund Form)
- SCDHHS Form 130 (Void/Adjustment Form)
- Reconsideration Form
- 837D and 837P Companion Guides
- **Healthy Connections** Fee Schedules
- Frequently Submitted Non-State Plan Covered Services –EPSDT Benefit
- SCDHHS Provider Bulletins
- TPL Form (DHHS 931)

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

## APPENDIX B - Covered Benefits (See Exhibits A-C)

### Covered Benefits

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

**Exhibit B** outlines the limited adult dental benefit for **Healthy Connections** Beneficiaries 21 and over. See Sections 4.06 – 4.08 of the ORM for more information on coverage categories available for treatment of adult Beneficiaries.

**Exhibit C** shows the covered benefits available to **Healthy Connections** Beneficiaries of the ID/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.

See the American Dental Association's *Current Dental Terminology* manual for additional information on proper designation of primary, permanent and supernumerary teeth.

### 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:

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.

## APPENDIX C - Clinical Criteria

### Clinical Criteria

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

Failure to submit the required documentation may result in a disallowed request and/or denied payment of a claim related to that request. Prior authorization is required for non-State Plan covered services; services delivered in an outpatient setting (ASC/ OR) or services that require inpatient stay. Some services require pre-payment review, these services are detailed in Exhibits A-C Benefits Covered in the "Pre-payment Review Required" column.

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

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

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered, however a detailed justification as why the radiographs were not obtained must be documented in the patient's records. Post-operative radiographs are required for endodontic procedures to confirm quality of care. Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the Healthy Connections Network.

The reimbursement fee for a dental procedure is inclusive of any items or related activities/services that are considered necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays, surgical trays, equipment, topical or local anesthesia and post-operative care.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

The criteria outlined in SCDHHS'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

Documentation required for submission and/or to be maintained in the patient's records must include the following:

- I. A detailed narrative demonstrating medical necessity; **AND**
- II. Appropriate pre -treatment diagnostic images such as: intraoral/ extraoral radiographs or CT that clearly show the affected tooth, its surrounding hard and soft tissues, and the adjacent teeth (Note: In rare circumstances, if diagnostic images were not possible to be obtained, but patient's physical, mental or environmental status warrants the procedure, the SCDHHS may consider a detailed narrative that documents why images were unattainable); **AND**
- III. Documentation in support of **at least one** of the following criteria
  1. tooth is determined to be non-restorable
  2. tooth is compromising the patient's dental health and /or overall health and development
  3. provider's clinical judgement determines that there is no other alternative treatment option

### C.02 Criteria for Pre-Fabricated Crown

*(Includes all pre-fabricated crowns: stainless steel/ esthetic coated stainless steel, resin and porcelain/ceramic)*

Placement of a pre-fabricated crown is allowed once per 36 months per patient per tooth without prior- authorization. No other restoration on that tooth is compensable during that period of time. Any additional placements outside of policy will require prior- authorization.

#### **Documentation and clinical criteria for placement of pre-fabricated crowns:**

Documentation in the patient's records must include the following:

- IV. A detailed narrative demonstrating medical necessity; **AND**
- V. Appropriate pre -treatment diagnostic images such as:
  - a) radiographs (bitewings, periapicals or panorex) that clearly show the affected tooth/ teeth with decay or trauma, and the adjacent and opposing teeth; **OR**
  - b) intraoral photographs, if technology is available in provider's office, may be submitted in the absence of radiographs; **OR**
  - c) a narrative documenting why neither radiographs or intraoral photographs were able to be obtained; **AND**
- VI. Documentation in support of the following clinical criteria:
  - a) **Primary teeth (anterior and posterior)**
    1. Tooth is expected to have more than 12 months of life prior to exfoliation, based on the child's eruption pattern; **AND**
    2. Tooth needs an extensive restoration when other restorative materials have a poor prognosis and the restoration is due to any of the following:
      - o substantial decay or trauma

- Cervical decalcification and/or developmental defects;
- Following pulpal therapy

**b) Permanent teeth (anterior, bicuspid, molar)**

1. Tooth needs an extensive restoration when other restorative materials have a poor prognosis and the restoration is due to any of the following:
  - substantial decay or trauma
  - Cervical decalcification and/or developmental defects;
  - Following pulpal therapy

It is the provider's responsibility to use clinical and professional judgement when planning extensive treatment and multiple crown placement, evaluating the patient's needs, risk for developing tooth decay, health history, and their physical and mental ability to support the extensive treatment.

**A Pre-fabricated crown DOES NOT meet the clinical criteria and will not be allowed for reimbursement if:**

- a) Tooth has subosseous and/or furcation caries;
- b) Tooth has advanced periodontal disease;
- c) PRIMARY tooth root is surrounded by severe pathologic destruction of bone;
- d) PERMANENT tooth apex is surrounded by untreated pathologic destruction of bone;
- e) Crown is being planned to alter vertical dimension;
- f) Crown is used as a temporizing treatment while a permanent restoration is being fabricated

**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 Services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC)**

Services delivered in an OR or ASC will be authorized when ALL of the following criteria are met:

- Authorization request must include all of the following:
  - Procedure code(s) for each treatment service that the provider plans to deliver in the ASC/OR facility, AND
  - Services requested to be delivered in an ASC/ OR must be covered services and/or approved EPSDT services, AND
  - Procedure code that identifies the utilization of the ASC/ OR facility
- Documentation required to be submitted with the authorization request includes the following:
  - Detailed narrative describing medical necessity of the services to be delivered in the ASC/OR facility AND
  - Necessary documentation as required for each procedure/ procedure category to support the medical necessity.

**Clinical Criteria required for the utilization of an ASC / OR facility includes one of the following:**

- 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 outpatient setting is not sought solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Beneficiary convenience. OR
- 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). OR

- 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. OR
- Beneficiaries requiring extensive dental procedures with a medical history or complex medical condition that renders in-office treatment not medically appropriate. OR
- Beneficiaries requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment. OR
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates outpatient setting 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 noncovered 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.

- 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.
- 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.
- 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
- Detailed narrative of medical necessity, if appropriate

#### **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, Intravenous (IV) Sedation in Dental Office**

Pre-payment review is required for General Anesthesia and IV sedation administered in the dental office. Claims filed for general anesthesia or IV sedation services must also include all the procedure codes for which the sedation services were rendered. Sedation services must be accompanied by a covered service and/or by an approved EPSDT service in order to be considered for review.

General Anesthesia/ IV sedation services administered in the dental office will be allowed when ALL of the following criteria are met:

- I. Documentation required to be submitted with the claim includes:
  - a. Detailed narrative describing medical necessity of the services delivered under general anesthesia or IV sedation AND
  - b. Necessary documentation as required for each procedure/ procedure category to support the medical necessity.



II. Clinical criteria for the use of general anesthesia or IV sedation must include one of the following:

- a. *Treatment is comprised of extensive or complex oral surgical procedure 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; **OR**
- b. Beneficiary has a medical condition(s) which requires monitoring (e.g. cardiac problems, severe hypertension), **OR**
- c. Beneficiary has an underlying hazardous medical condition or mental or physical disability which would render the Beneficiary non-compliant during treatment, **OR**
- d. Beneficiary has a documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective, **OR**
- e. Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures and the documentation justifies that in-office general/ IV sedation is appropriate and is not sought solely based on reducing, avoiding or controlling apprehension, or on Provider's or Beneficiary's convenience, **OR**
- f. Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates that in-office general anesthesia/ IV sedation is appropriate.

### C. 10 Criteria for Behavior Management

Pre-payment review is required for behavioral management services. Claims filed for Behavioral management services must also include all the procedure codes for which the behavioral management services were rendered. Behavioral management services must be accompanied by a covered service and/or by an approved EPSDT service in order to be considered for review. The Behavioral Management services are not allowed in conjunction with sedation services (Nitrous Oxide, deep sedation/ general anesthesia, IV or non-IV Moderate sedation).

Behavioral Management services will be approved when ALL of the following criteria are met:

- I. Documentation required to be submitted with the claim includes:
  - Detailed narrative describing medical necessity for rendering the treatment in conjunction with behavioral management service,
- II. Clinical Criteria for the use of behavior management must include ALL of the following:
  - a. Child Beneficiary presenting with disabilities and/or special health care needs or Beneficiary is a member of the ID/RD Waiver program and need for behavior management is documented in the patient's dental record, **AND**
  - b. Documentation supplied for adjudication of the claim and recorded in the dental record is unique to that visit and includes a description of the known condition of the patient and additional time requirement to provide treatment.

## **APPENDIX D - Recommendations/ Suggestions**

### **D.01 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.02 The Dental Treatment Record

The treatment record is a legal document, and it must contain the patient's chief complaint, diagnosis, and documentation of services performed. Documentation consists of a complete and accurate treatment record and accountability of other special services.

No other documentation (with the exception of hospital records) will be accepted in lieu of a treatment record. This includes prior authorization forms, ledger cards, claim forms, computer records, etc. ***Claims paid for Medicaid services that are not adequately documented in the treatment record are subject to repayment by the Medicaid provider.*** The dental provider's treatment record on each Beneficiary must substantiate the need for services, including all findings and information supporting medical necessity and detailing all treatment provided. As a condition of participation in the Medicaid dental program, dental providers are required to maintain and provide access to records that fully disclose the medical necessity for treatment and the extent of services provided to Medicaid patients. SCDHHS requires that documentation (including appropriate pre- and post-treatment radiographs, copies of laboratory prescription slips and laboratory tests [*i.e.*, pathology reports]) be included in the Beneficiary's treatment record.

**Medicaid providers are required to maintain *on site* all medical and fiscal records pertaining to Medicaid beneficiaries for a period of five years to facilitate audits and reviews of the patient's dental record. This requirement is in addition to all other record retention requirements included in State and Federal laws.**

The following guidelines have been established to assist Provider offices with keeping diligent and complete dental records.

1. Organization
2. 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)
3. 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
4. The design of the dental record should ensure that all permanent components are attached or secured within the record.
5. 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.

6. The organization of the dental record system should require that unique records are assigned to each patient.
7. Content-The dental record should contain the following:
8. 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
9. An adequate health history that requires documentation of these items:
  - a. Current medical treatment
  - b. Significant past illnesses
  - 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
10. 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
11. A conspicuously placed medical alert notification 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
12. 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
13. 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
14. Radiographs which are:
- a. Identified by first and last name
  - b. Dated
  - c. Designated by left and right side
  - d. Mounted (if intraoral films)
15. An indication of the Beneficiaries' clinical problems/diagnosis
16. 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)
17. 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
18. 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
19. 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
19. Adequate documentation of treatment rendered which requires entry of these items:

- a. Date of service/procedure
  - b. Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
  - 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
20. Adequate documentation of the specialty care performed by another dentist that includes:
- a. Examination
  - b. Treatment plan
  - c. Treatment status
21. Compliance
- a. The dental record has one explicitly defined format that is currently in use.
  - b. There is consistent use of each component of the dental record by all staff.
  - c. The components of the dental record that are required for complete documentation of each Beneficiary's status and care are present.
  - d. Entries in the dental records are legible.
  - e. Entries of symbols and abbreviations in the dental records are uniform, easily interpreted and are commonly understood in the practice.

### D.03 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.

#### 1. 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.

2. Non-Compliant Beneficiaries

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

3. 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

**Appendix E - Section 1 of SCDHHS Provider Manual (General Information and Administration)**



Healthy Connections

# PROVIDER MANUAL



## Dental Services

**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](http://www.dentaquest.com) for the DentaQuest ORM.

Established March 15, 2008  
Updated August 6, 2018

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections  
MEDICAID





## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-06-18	Change Control Record	2-4	Removed entries for Section 5, Appendix 1, and Managed Care Supplement after 08-02-10
08-06-18	1	25	Updated Premium Payment Project
10-01-16	1	5, 6	Deleted SC Healthy Connections Checkup Program language and moved sample Checkup card to South Carolina Healthy Connections Medicaid Card section
08-01-16	1	2, 4, 5, 24, 27	Updated to reflect Medicaid Bulletin dated July 11, 2016 – New Medicaid Cards
02-01-16	1	-	Updated to reflect Medicaid Bulletin dated January 26, 2016 – Updates to Section 1 – All Provider Manuals
01-01-16	1	19	Updated to reflect Medicaid Bulletin dated December 9, 2015 - Charge Limits
12-01-15	Cover	-	December 1, 2015 - Replaced manual cover
10-01-15	1	7 10	<ul style="list-style-type: none"> <li>• Updated to add SCDHHS alerts</li> <li>• Updated Provider Participation</li> </ul>
12-01-14	1	9, 10	Updated Provider Participation to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
10-01-14	1	33-34	Updated Medicaid Beneficiary Lock-In Program
08-01-14	1	6	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
04-01-14	1	6, 23, 25  29-31 32 33 37 39	<ul style="list-style-type: none"> <li>• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form</li> <li>• Updated the following sections: <ul style="list-style-type: none"> <li>○ Program Integrity</li> <li>○ Recovery Audit Contractor</li> <li>○ Beneficiary Oversight</li> <li>○ Fraud</li> <li>○ Referrals to the Medicaid Fraud Control Unit</li> </ul> </li> </ul>

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		41-44	<ul style="list-style-type: none"> <li>o Updated acronym for U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG)</li> </ul>
01-01-14	1	1, 2, 11 6, 23, 25  1-2 4  6  26 29-30 32 32	<p>Updated to reflect the following bulletins:</p> <ul style="list-style-type: none"> <li>• Managed Care Organizational Changes dated November 15, 2013</li> <li>• Discontinuation of Edit Correction Forms (ECFs) dated December 3, 2013</li> </ul> <p>Updated the following sections:</p> <ul style="list-style-type: none"> <li>• Eligibility Determination</li> <li>• South Carolina Health Connections Medicaid card</li> <li>• South Carolina Web-based Claims Submissions Tool</li> <li>• Retroactive Eligibility</li> <li>• Program Integrity</li> <li>• Recovery Audit Contractor</li> <li>• Beneficiary Explanation of Medical Benefits Program</li> </ul>
04-01-13	1	6	Corrected the URL for <a href="http://MedicaideLearning.com">MedicaideLearning.com</a>
02-01-13	1	18	Updated URL address for the National Correct Coding Initiative (NCCI)
12-03-12	1	6 7-8 27-32 33-41	<ul style="list-style-type: none"> <li>• Updated web addresses for provider information and provider training</li> <li>• Revised heading and language to reflect new provider enrollment requirements</li> <li>• Updated Program Integrity language (entire section)</li> <li>• Revised heading and language for Medicaid Anti-Fraud Provisions/Payment Suspension/Provider Exclusions/Terminations (entire section)</li> </ul>
10-01-12	1	4	Replaced back of Healthy Connections Medicaid card
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

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
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	<ul style="list-style-type: none"> <li>• Updated the South Carolina Medicaid Web-based Claims Submission Tool section</li> <li>• Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits</li> </ul>
12-01-10	Cover	-	Replaced “Medicaid Provider Manual” with “South Carolina Healthy Connections (Medicaid)”
10-01-10	1	1 7  10	<ul style="list-style-type: none"> <li>• Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program</li> <li>• Updated Program Description section</li> <li>• 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</li> <li>• Updated Freedom of Choice section</li> </ul>
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

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Party Liability supplement
07-01-10	5	-	Updated telephone numbers and zip codes for multiple county offices
07-01-10	Appendix 1	32 35	<ul style="list-style-type: none"> <li>• Updated edit code 714</li> <li>• Updated edit code 738</li> </ul>
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	<ul style="list-style-type: none"> <li>• Updated Managed Care Overview section</li> <li>• Updated Manage Care Organization (MCO), Core Benefits section</li> <li>• Updated the Managed Care Disenrollment Process, Overview section</li> <li>• Updated to reflect Medicaid Bulletin dated March 18, 2010 — Managed Care Organizational Change</li> </ul>
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	<ul style="list-style-type: none"> <li>• Added New Edit Codes 356,357 and 358</li> <li>• Updated Edit Code 738</li> </ul>
02-01-10	Appendix 2	All	Updated Carrier Code List
01-01-10	2	1-3     6 13	<ul style="list-style-type: none"> <li>• Updated the following sections: <ul style="list-style-type: none"> <li>◦ Dental Services for Adults Age 21 and Over (Optional Coverage Group)</li> <li>◦ Notification of Policy and Procedure Changes (Medicaid Bulletins)</li> <li>◦ Dental Hygienist Services, General Supervision</li> <li>◦ Orthodontic Services</li> <li>◦ Prior Authorization</li> </ul> </li> </ul>

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		17	<ul style="list-style-type: none"> <li>○ Beneficiary Eligibility section (unlimited number of calls for the IVRS and unlimited number transactions per call)</li> </ul>
		18	<ul style="list-style-type: none"> <li>○ Managed Care Entities</li> </ul>
		12	<ul style="list-style-type: none"> <li>● Changed Hospital Services heading to Hospital or Ambulatory Surgical Center (ASC) Facility Services and updated the policy</li> </ul>
		18	<ul style="list-style-type: none"> <li>● Deleted Preventive/Rehabilitative Services Primary Care Enhancement (P/RSPCE), Formerly Known as Family Support Services (FSS) section</li> </ul>
01-01-10	4	1, 3-5, 14, 19	<ul style="list-style-type: none"> <li>● Updated the following sections:               <ul style="list-style-type: none"> <li>○ Medical Justification and Documentation</li> <li>○ Updated the Procedure Code Table</li> <li>○ Updated the Procedure Codes Not Listed</li> <li>○ Oral and Maxillofacial Surgery</li> <li>○ Anesthesia</li> </ul> </li> </ul>
		5	<ul style="list-style-type: none"> <li>● Moved Dental Fee Schedule section</li> </ul>
		7-8,	<ul style="list-style-type: none"> <li>● Updated the MR/RD procedural key definition</li> </ul>
		10-12, 15,19, 20	<ul style="list-style-type: none"> <li>● Updated the following codes: D0330, D1206, D1351, D1510, D1515, D2391, D2950, D2954, D3220, D3310, D3330, D7280, D9220, D9920</li> </ul>
01-01-10	5	5	<ul style="list-style-type: none"> <li>● Updated Physical Address for Allendale County Office</li> </ul>
		10	<ul style="list-style-type: none"> <li>● Replaced Jasper County DSS with Jasper County DHHS</li> </ul>
		12	<ul style="list-style-type: none"> <li>● Replaced Orangeburg County DSS with Orangeburg County DHHS</li> </ul>
01-01-10	Appendix 1	49	Updated Edit Code 932
12-01-09	1	8	<ul style="list-style-type: none"> <li>● Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package</li> </ul>
		25	<ul style="list-style-type: none"> <li>● Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated November 24, 2009</li> </ul>
12-01-09	3	1-3 10-11, 13,37- 39, 42	<ul style="list-style-type: none"> <li>● Updated Claim Filing Timeliness section to reflect Medicaid Bulletin dated November 24, 2009</li> <li>● Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance</li> </ul>

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Package
12-01-09	5	8	Updated the Dorchester County office street address
12-01-09	Appendix 1	- - 18, 19 20	<ul style="list-style-type: none"> <li>• Replaced CARC 17 with CARC 16</li> <li>• Updated CARC A1</li> <li>• Updated codes 509 and 510</li> <li>• Added code 533</li> </ul>
11-01-09	Appendix 2	All	Updated carrier code list
10-01-09	1	3-4  4-6  26	<ul style="list-style-type: none"> <li>• Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs)</li> <li>• Updated SC Medicaid Healthy Connections language throughout section</li> <li>• Updated South Carolina Medicaid Bulletins and Newsletters</li> <li>• Changed heading to Medicare Cost Sharing</li> </ul>
10-01-09	5	10 11 12	<ul style="list-style-type: none"> <li>• Updated physical address for Jasper County office</li> <li>• Updated telephone number for Lexington County office</li> <li>• Updated zip codes for Orangeburg County office</li> </ul>
10-01-09	Appendix 1	3 60	<ul style="list-style-type: none"> <li>• Updated edit code 065</li> <li>• Updated edit code 852</li> </ul>
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	<ul style="list-style-type: none"> <li>• Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009</li> <li>• Updated Absolute Total Care entries as following:               <ul style="list-style-type: none"> <li>◦ Changed the company's name to Absolute Total Care</li> <li>◦ Replaced the beneficiary card samples</li> <li>◦ Corrected contact information</li> </ul> </li> </ul>
08-01-09	5	14	Updated telephone number for York County office
08-01-09	Appendix 1	3	Updated edit code 062



## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-09	Appendix 2	-	Updated carrier code list
07-01-09	5	6, 12 8 9	<ul style="list-style-type: none"> <li>• Updated address for Bamberg and Orangeburg County offices</li> <li>• Updated office zip code for Darlington County</li> <li>• Updated telephone number for Fairfield County office</li> </ul>
06-01-09	TPL Supplement	19	Updated Department of Insurance Web site address
05-01-09	1	1-6, 11 2 3 5 28-33	<ul style="list-style-type: none"> <li>• Updated to reflect managed care policies and procedures effective May 1, 2009</li> <li>• Updated the Eligibility subsection</li> <li>• Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card subsection</li> <li>• Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection</li> <li>• Updated the Medicaid Program Integrity subsection</li> </ul>
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

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
03-01-09	2	2, 4, 8, 12, 22	Updated hyperlinks
03-01-09	5	3-4 8 5, 11-13	<ul style="list-style-type: none"> <li>• Updated hyperlinks</li> <li>• Corrected Dorchester County's Orangeburg Road telephone number</li> <li>• Change DSS to DHHS in addresses for Abbeville, McCormick, Newberry, and Saluda counties</li> </ul>
03-01-09	Appendix 1	43 72	<ul style="list-style-type: none"> <li>• Added new edit codes 693 and 694</li> <li>• Changed edit code 945 Resolution to input "26" modifier in field 18</li> </ul>
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
02-01-09	Appendix 2	-	Updated list of carrier codes
01-01-09	1	8	Updated hyperlink for <a href="http://bulletin.scdhhs.gov">bulletin.scdhhs.gov</a>
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 -	<ul style="list-style-type: none"> <li>• Changed Column Four to Column Three</li> <li>• Added Dental Fee Schedule section</li> <li>• Removed Column Three – Fee</li> </ul>

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-08	3	43 44 47	<ul style="list-style-type: none"> <li>• Changed ADA 2006 field 1 to Prov/Xwalk ID</li> <li>• Changed ADA 2006 field 13 to Individual Prov/Xwalk ID</li> <li>• Changed CMS-1500 ECF field 1 to Prov/Xwalk ID</li> </ul>
10-01-08	4	-	Updated section from bulletin dated September 10, 2008
10-01-08	5	9, 13	<ul style="list-style-type: none"> <li>• Updated address for Lake City</li> <li>• Updated phone number for Sumter County office</li> </ul>
10-01-08	Forms	-	<ul style="list-style-type: none"> <li>• Revised ADA 2006 ECF example to show update for fields 1 and 13</li> <li>• Revised CMS-1500 ECF example to show update for field 1</li> </ul>
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 Supplement	27	Replaced Web site address for BlueChoice
06-12-08	Forms	-	Replaced DHEC Form 0782
06-10-08	2	1 3	<ul style="list-style-type: none"> <li>• Added restriction for full mouth extractions</li> <li>• Added additional guidelines for provider enrollment</li> </ul>

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		5 12 13	<ul style="list-style-type: none"> <li>• Updated NPI policy to reflect May 23, 2008, deadline requiring NPI only on claims</li> <li>• Updated Prior Authorization submittal requirement</li> <li>• Replaced dental program manager with dental program coordinator</li> </ul>
06-10-08	3	27, 33, 34  -  16, 17, 18, 23, 28, 30, 31, 32	<ul style="list-style-type: none"> <li>• Updated NPI policy and form instructions to reflect May 23, 2008, deadline requiring NPI only on claims for typical providers</li> <li>• Standardized field and zip code + 4 references throughout section</li> <li>• Updated all field instruction to clarify which fields do not required data entry</li> </ul>
06-10-08	5	12	Updated telephone number for Orangeburg county office
06-10-08	Forms	-	<p>Updated the following forms to reflect the May, 23, 2008, deadline requiring NPI only:</p> <ul style="list-style-type: none"> <li>• Example Dental Claim Form</li> <li>• Example Dental Claim Form Reporting Third-Party or Medicare Information</li> <li>• Example Dental Claim Form Oral and Maxillofacial Surgeons Only</li> <li>• Example Dental Claim Form Reporting Third Party and/or Medicare Payments or Denials Oral and Maxillofacial Surgeons Only</li> </ul> <p>For example dental claim forms:</p> <ul style="list-style-type: none"> <li>• Change/removed sample entries for fields 8, 15, 23, and 49</li> <li>• Added a tooth number to line 4</li> </ul>
06-01-08	Appendix 1	30, 39, 42	<ul style="list-style-type: none"> <li>• Added new edit code 529</li> <li>• Deleted NPI warning edits 578, 579, 580, 581, 582, 583, 692</li> </ul>
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

## CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
04-01-08	5	8	Updated address and phone number for Dorchester County office
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	<ul style="list-style-type: none"> <li>• Updated reference to Medicaid card name</li> <li>• Changed references to location of form from Section 5 to Forms section</li> <li>• Updated field numbers for occurrence codes on UB-04</li> <li>• Replaced sample ADA form with more attractive version</li> </ul>



# SECTION 1

## GENERAL INFORMATION AND ADMINISTRATION

### TABLE OF CONTENTS

<b>SOUTH CAROLINA MEDICAID PROGRAM</b>	<b>1</b>
PROGRAM DESCRIPTION.....	1
ELIGIBILITY DETERMINATION .....	1
ENROLLMENT COUNSELING SERVICES .....	3
MEDICARE / MEDICAID ELIGIBILITY .....	3
SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD ...	<b>ERROR! BOOKMARK NOT DEFINED.</b>
SOUTH CAROLINA MEDICAID ALERTS, BULLETINS AND NEWSLETTERS .....	7
<b>PROVIDER ENROLLMENT</b>	<b>9</b>
PROVIDER PARTICIPATION .....	9
Extent of Provider Participation.....	10
Non-Discrimination .....	11
<i>Service Delivery</i> .....	12
<i>Freedom of Choice</i> .....	12
<i>Medical Necessity</i> .....	12
<b>RECORDS/ DOCUMENTATION REQUIREMENTS</b>	<b>13</b>
GENERAL INFORMATION.....	13
Signature Policy.....	15
<i>Handwritten Signature</i> .....	15
<i>Signature Log</i> .....	15
<i>Electronic Signatures</i> .....	15
<i>Date</i> .....	16
<i>Exceptions</i> .....	16
DISCLOSURE OF INFORMATION BY PROVIDER .....	17
SAFEGUARDING BENEFICIARY INFORMATION .....	18
Confidentiality of Alcohol and Drug Abuse Case Records .....	19
SPECIAL / PRIOR AUTHORIZATION.....	19
<b>REIMBURSEMENT</b>	<b>21</b>
CHARGE LIMITS .....	21
BROKEN, MISSED, OR CANCELLED APPOINTMENTS .....	21
NATIONAL CORRECT CODING INITIATIVE (NCCI).....	21

# SECTION 1

## GENERAL INFORMATION AND ADMINISTRATION

### TABLE OF CONTENTS

MEDICAID AS PAYMENT IN FULL.....	22
PAYMENT LIMITATION .....	23
REASSIGNMENT OF CLAIMS.....	23
THIRD-PARTY LIABILITY .....	24
Health Insurance.....	24
<i>Premium Payment Project</i> .....	25
Casualty Insurance .....	25
Provider Responsibilities – TPL.....	26
TIME LIMIT FOR SUBMITTING CLAIMS .....	27
Medicare Cost Sharing Claims .....	28
Retroactive Eligibility.....	28
<i>Payment Information</i> .....	29
<b>MEDICAID PROGRAM INTEGRITY</b> .....	<b>31</b>
PROGRAM INTEGRITY .....	31
PREPAYMENT REVIEW.....	34
RECOVERY AUDIT CONTRACTOR.....	35
BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM .....	37
BENEFICIARY OVERSIGHT .....	37
MEDICAID BENEFICIARY LOCK-IN PROGRAM .....	38
DIVISION OF AUDITS .....	38
PAYMENT ERROR RATE MEASUREMENT.....	39
<b>MEDICAID ANTI- FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS</b> .....	<b>41</b>
FRAUD .....	41
PAYMENT SUSPENSION .....	41
Suspension of Provider Payments for Credible Allegation of Fraud .....	42
Notice of Suspension.....	42
<i>Referrals to the Medicaid Fraud Control Unit</i> .....	43
Good Cause not to Suspend Payments or to Suspend Only in Part.....	43



**SECTION 1**  
**GENERAL INFORMATION AND ADMINISTRATION**

**TABLE OF CONTENTS**

PROVIDER EXCLUSIONS.....	45
PROVIDER TERMINATIONS.....	46
ADMINISTRATIVE SANCTIONS .....	46
OTHER FINANCIAL PENALTIES .....	47
FAIR HEARINGS .....	47
REINSTATEMENT .....	47
<b>APPEALS</b>	<b>49</b>

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**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 a fully capitated Managed Care Program through Managed Care Organizations. A Primary Care Case Management/Medical Home Network model is only available for participants that qualify for the Medically Complex Children's Waiver. For more information regarding this care model, please see the Managed Care Supplement included with this manual.

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 and MCO Policies and Procedure guide, for certain eligibility categories. SCDHHS pays MCOs a per member per month capitated rate, primarily according to age, gender, and category of eligibility. Payments for core services provided to MCO members are the responsibility of MCOs, not the fee-for-service Medicaid program.

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 submitted online at [apply.scdhhs.gov](http://apply.scdhhs.gov). The application is also

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****SOUTH CAROLINA MEDICAID PROGRAM****ELIGIBILITY  
DETERMINATION  
(CONT'D.)**

available for download on the SCDHHS Web site at <http://www.scdhhs.gov> and can be returned by mail, fax, or in person. Individuals can continue to apply for Medicaid at outstationed locations such as county health departments, some federally qualified health centers, most hospitals, and SCDHHS county eligibility offices.

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 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.

Certain services will require prior approval and/or coordination through the managed care provider. For questions regarding the Managed Care program, please visit the SCDHHS Web site at <http://scdhhs.gov> to view the MCO Policy and Procedure Guide.

More information about managed care can also be found in the Managed Care Supplement included with 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. 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, visit <http://www.SCchoices.com> or contact South Carolina Healthy Connections Choices at (877) 552-4642.

**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.

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.**

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### SOUTH CAROLINA MEDICAID PROGRAM

#### 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.

As of August 1, 2016, SCDHHS announced the release of a new South Carolina Healthy Connections Medicaid card. The new card will no longer contain a magnetic data strip. The new cards will be issued to newly enrolled beneficiaries and current beneficiaries who request replacement cards. All active beneficiaries prior to August 1, 2016, will continue to use their current Medicaid card until further notice.

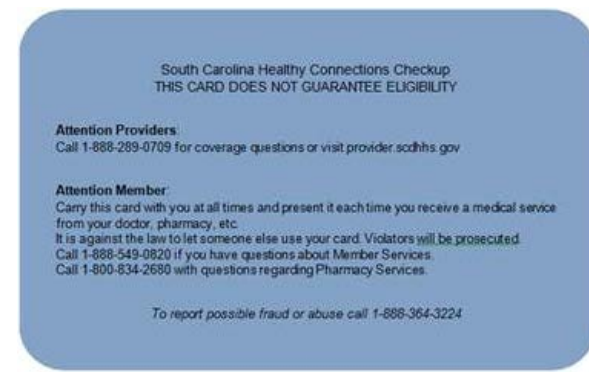
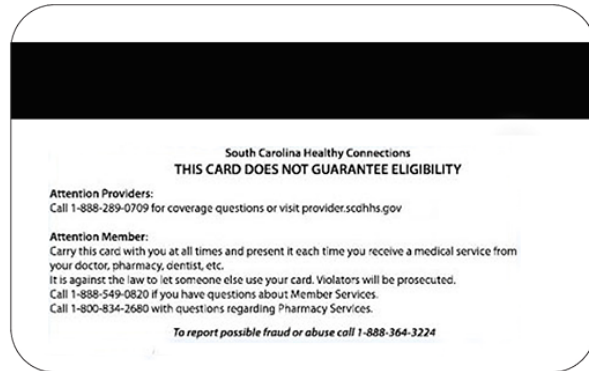
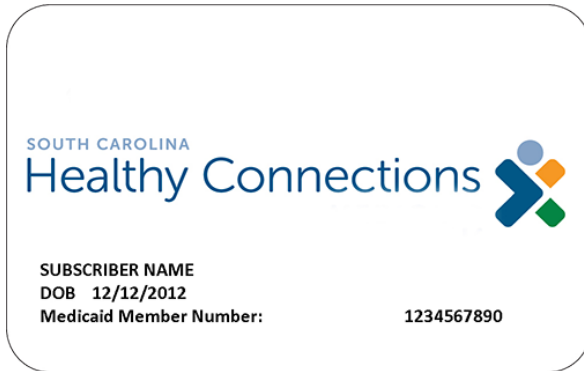
Providers shall accept all versions of the existing cards: cards with a magnetic data strip and the blue Healthy Connections Checkup card. All providers are encouraged to use the Web Tool to check eligibility. For additional information about the Web Tool, please refer to South Carolina Medicaid Web-Based Claims Submissions Tool (Web Tool) later in this section.

The following are examples of valid South Carolina Healthy Connections Medicaid cards:



**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**

**SOUTH CAROLINA MEDICAID PROGRAM**



The back of the Healthy Connections Medicaid card includes:

- A toll-free number for providers to contact the Provider Service Center for assistance
- A toll-free number for the beneficiary if he or she has questions about enrollment or Medicaid-covered services

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### SOUTH CAROLINA MEDICAID PROGRAM

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

- 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 are enrolled 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.

#### SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL (WEB TOOL)

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

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 advice, 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 Education Web site at: <http://medicaidelearning.com/> or contact the SC Medicaid EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709. A listing of training opportunities is also located on the Web site.

**Note:** Dental claims cannot be submitted on the Web Tool. Please contact the dental services vendor at 1-888-307-6553 for billing instructions.



## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### SOUTH CAROLINA MEDICAID PROGRAM

#### SOUTH CAROLINA MEDICAID ALERTS, BULLETINS AND NEWSLETTERS

SCDHHS Medicaid alerts, bulletins and newsletters are distributed electronically through e-mail and are available online at the SCDHHS Web site.

To ensure that you receive important SC Medicaid information, visit the Web site at <http://www.scdhhs.gov/> or enroll to receive alerts, bulletins and newsletters via e-mail, go to [bulletin.scdhhs.gov](http://bulletin.scdhhs.gov) to subscribe.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**  
**SOUTH CAROLINA MEDICAID PROGRAM**

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## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### PROVIDER ENROLLMENT

#### PROVIDER PARTICIPATION

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

Provider participation in the Medicaid program is voluntary. To participate in the Medicaid program, a provider must meet the following requirements:

- Complete an online provider enrollment application and agreement and submit any necessary supporting documentation. Certain provider types, depending on the type of service provided, are required to sign a contractual agreement in addition to the provider enrollment agreement.
- Accept the terms and conditions of the online application by electronic signature, indicating the provider's agreement to the contents of the participation agreement, the Electronic Funds Transfer Agreement, W-9 and Trading Partner Agreement.
- Be licensed by the appropriate licensing body, certified by the standard-setting agency, and/or other pre-contractual approval processes established by SCDHHS.
- If eligible, obtain a National Provider Identifier (NPI) and share it with SCDHHS. Refer to <https://nppes.cms.hhs.gov> for additional information about obtaining an NPI.
- Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment. This also applies to providers wanting to contract with one or all of the South Carolina Medicaid managed care organizations.
- Continuously meet South Carolina licensure and/or certification requirements of their respective professions or boards in order to maintain Medicaid enrollment.

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### PROVIDER ENROLLMENT

#### PROVIDER PARTICIPATION (CONT'D.)

- 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.
- 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 the United States.

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. Claims for Medicaid reimbursement submitted under a Medicaid ID number or NPI number other than that of the ordering, referring or rendering provider will be considered invalid and may result in a program integrity investigation and/or recoupment of the Medicaid payment. As required by 42 CFR 455.440, all claims submitted for payment for items and services that were ordered or referred must contain the NPI of the physician or other professional who ordered or referred such items or services.

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 SCDHHS Provider Service Center within 30 days of the change. Failure to report this change of information promptly could result in delay of payment and/or termination of enrollment. Provider Enrollment inquiries to South Carolina Medicaid should be directed as follows:

**Mail:** Medicaid Provider Enrollment  
PO Box 8809  
Columbia, SC 29202-8809  
**Phone:** 1-888-289-0709, Option 4  
**Fax:** 803-870-9022

#### 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

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****PROVIDER ENROLLMENT****Extent of Provider  
Participation (Cont'd.)**

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 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.

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 with the MCO.

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.

**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)

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### PROVIDER ENROLLMENT

#### Non-Discrimination (Cont'd.)

- 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 MCO, the beneficiary is required to follow that MCO'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 MCO.

#### *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

#### GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide immediate access to original and electronic medical records, including associated audit trails. Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record.

SCDHHS does not have requirements for the media formats for medical records. Providers must have and maintain a medical record system that insures that the record may be accessed and retrieved immediately. That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment to SCDHHS, the State Auditor's Office (SAO), the South Carolina Attorney General's Office (SCAG), the United States Department of Health and Human Services (HHS), Government Accountability Office (GAO), and/or their designee during normal business hours.

SCDHHS will accept electronic records and clinical notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §§ 26-6-10 et seq.) and the Health Insurance Portability and Accountability Act (HIPAA) electronic health record requirements. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

A provider is defined as an individual, firm, corporation, association or institution which is providing, or has been approved to provide, medical assistance to a beneficiary pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act of 1932, as amended.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****RECORDS / DOCUMENTATION REQUIREMENTS****GENERAL INFORMATION  
(CONT'D.)**

Records are considered to be maintained when:

- They fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries
- All required documentation is present in beneficiaries' records before the provider files claims for reimbursement, unless program policy otherwise states
- Beneficiary medical, fiscal and other required records and supporting documentation must be legible

A provider record or any part thereof will be considered illegible if at least three (3) medical or other professionals in any combination, who regularly perform post payment reviews, are unable to read the record or determine the extent of services provided. An illegible record will be subject to recoupment.

Medicaid providers must make records immediately accessible and available for review during a provider's normal business hours or as otherwise directed, with or without advance notice by authorized entities and staff as described in this section. An authorized entity may either copy, accept a copy, or may request original records. Any requested record(s) is deemed inaccessible if not immediately available when requested by an authorized entity. Unless otherwise indicated, the medical record shall be accessible at the provider's service address as documented by the SCDHHS provider enrollment record. If the requested records are not available, they must be made available within two (2) hours of the authorized entity's request, or are otherwise deemed inaccessible. It is the responsibility of the provider to transport/send records to the place of service location as documented by the SCDHHS provider enrollment record.

The following requirements apply to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. That for Medicaid purposes all fiscal and medical records shall be retained for a minimum period of five (5) years after last payment was made for services rendered, except that hospitals and nursing homes are required to retain such records for six (6) years after last payment was made for services



## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### RECORDS / DOCUMENTATION REQUIREMENTS

#### General Information (Cont'd.)

rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the appropriate retention period the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the appropriate retention period, whichever is later.

Providers may contact the Provider Service Center or submit an online inquiry at <http://scdhhs.gov/contact-us> for specific information regarding documentation requirements for services provided.

#### Signature Policy

For medical review purposes, Medicaid requires that services provided/ordered be authenticated by the author. Medical documentation must be signed by the author of the documentation except when otherwise specified within this policy. The signature may be handwritten, electronic, or digital. Stamped signatures are unacceptable.

#### *Handwritten Signature*

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, SCDHHS shall consider evidence in a signature log to determine the identity of the author of a medical record entry.
- An order must have a signature which meets the signature requirements outlined in this section. Failure to satisfy these signature requirements will result in denial of related claims.
- A stamped signature is unacceptable.

#### *Signature Log*

Providers may include a signature log in the documentation they submit. This log lists the typed or printed name of the author associated with the illegible initials or signature.

#### *Electronic Signatures*

Providers using electronic signatures need to realize that there is a potential for misuse with alternative signature methods. The system needs to have software products that are protected against modification and that apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider are responsible for the authenticity of the information for which an attestation has been provided.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****RECORDS / DOCUMENTATION REQUIREMENTS***Electronic Signatures  
(Cont'd.)*

## Acceptable Electronic Signature Examples:

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitized signature: Handwritten and scanned into the computer
- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D'
- 'Authorized by: John Smith, M.D'
- 'Digital Signature: John Smith, M.D'
- 'Confirmed by' with provider's name
- 'Closed by' with provider's name
- 'Finalized by' with provider's name
- 'Electronically approved by' with provider's name
- 'Signature Derived from Controlled Access Password'

*Date*

The signature should be dated. However, for review purposes, if there is sufficient documentation for SCDHHS to determine the date on which the service was performed/ordered then SCDHHS may accept the signature without a date.

The only time it is acceptable for an entry to not be signed at the time of the entry is in the case of medical transcription.

*Exceptions*

There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub. 100-02, chapter 15, section 80.6.1,

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****RECORDS / DOCUMENTATION REQUIREMENTS***Exceptions (Cont'd.)*

state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (*e.g.*, a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

**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.

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.

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### RECORDS / DOCUMENTATION REQUIREMENTS

#### 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
- 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

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### RECORDS / DOCUMENTATION REQUIREMENTS

#### SAFEGUARDING

#### BENEFICIARY

#### INFORMATION (CONT'D.)

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.**

#### 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

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

#### CHARGE LIMITS

Except as described below for free care, providers may not charge Medicaid 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 or the provider's billed amount. Medicaid reimbursement is available for covered services under the State Medicaid Plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large.

#### 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.

#### 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 are 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

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### REIMBURSEMENT

#### NATIONAL CORRECT CODING INITIATIVE (NCCI) (CONT'D.)

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 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 CMS web page <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html> provides overview information to providers on Medicaid's NCCI edits and links for additional information.

#### 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'



## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### REIMBURSEMENT

#### MEDICAID AS PAYMENT IN FULL (CONT'D.)

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
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:
  - 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

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****REIMBURSEMENT****REASSIGNMENT OF CLAIMS (CONT'D.)**

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.

**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.

Medicaid providers may obtain information regarding third-party resources that are known to SCDHHS by utilizing 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,

**Health Insurance (Cont'd.)**

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### REIMBURSEMENT

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 provider must submit a new claim with the correctly coded information 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 & 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.

#### *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 1-888-289-0709 option 5, then option 4.

#### *Casualty Insurance*

Casualty insurance includes policies that provide payment

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### REIMBURSEMENT

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 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.

#### Provider Responsibilities –

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 coinsurance.) The Medicaid reimbursement and third party payment cannot exceed the amount the

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****REIMBURSEMENT****TPL (Cont'd.)**

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.

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 the 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.

**TIME LIMIT FOR  
SUBMITTING CLAIMS**

SCDHHS requires that only "clean" claims received and entered into the claims processing system within one year

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### REIMBURSEMENT

from the date of service (or date of discharge for hospital claims) be considered for payment. A “clean” claim is one that is edit and 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

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 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 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.)

#### Retroactive Eligibility (Cont’d.)

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****REIMBURSEMENT**

the beneficiary's coverage.

Please refer to Section 2 of the provider manual for any additional Retroactive Eligibility criteria that may apply.

*Payment Information*

SCDHHS establishes reimbursement rates for each Medicaid-covered service. Providers should contact the PSC or submit an online inquiry for additional information.

**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 identify and 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, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies.

#### PROGRAM INTEGRITY

The Division of Program Integrity conducts post-payment reviews of all health care provider types including but not limited to hospitals (inpatient and outpatient) rural health clinics, Federally-qualified health clinics, pharmacies, ASCs, ESRD clinics, physicians, dentists, other health care professionals, speech, PT and OT therapists, 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 and the Fraud and Abuse email for complaints of provider and beneficiary fraud and abuse. The hotline number is 1-888-364-3224, and the email address is 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.

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### MEDICAID PROGRAM INTEGRITY

#### 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
- Indications of fraud or abuse in billing the Medicaid program
- 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

The Division of Program Integrity ("Program Integrity") or its authorized entities, as described under Records Documentation/Requirements, General Information of Section 1, conduct both announced and unannounced desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. Program Integrity may conduct reviews, investigations, or inspections of any current or former enrolled provider, agency-contracted provider, or agent thereof, at any time and/or for any time period. During such reviews, Program Integrity staff will request medical records and related documents ("the documentation"). Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the entity into a usable form that allows authorized entities, described under Records Documentation/Requirements, General Information of

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### MEDICAID PROGRAM INTEGRITY

#### PROGRAM INTEGRITY (CONT'D.)

Section 1, the ability to review the record. Program Integrity or its designee(s) may either copy, accept a copy or may request original records. Program Integrity may evaluate any information relevant to validating that the provider received only those funds to which it is legally entitled. This includes interviewing any person Program Integrity believes has information pertinent to its review, investigation or inspection. Interviews may consist of one or more visits.

Program Integrity staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements. The provider, therefore, must submit a copy of all requested records by the date requested by Program Integrity. Providers must not void, replace, or tamper with any claim records or documentation selected for a Program Integrity review activity, until the activity is finalized.

An overpayment arises when Program Integrity denies the appropriateness or accuracy of a claim. Reasons for which Program Integrity may deny a claim include, but are not limited to the following:

- The Program Integrity review finds excessive, improper, or unnecessary payments have been made to a provider
- The Provider fails to provide medical records as requested
- The provider refuses to allow access to records

In each scenario Medicaid must be refunded for the denied claims.

The provider is notified via certified letter of the post-payment review results, including any overpayment findings. If the Provider disagrees with the findings, the provider will have the opportunity to discuss and/or present evidence to Program Integrity to support any disallowed payment amounts. If the parties remain in disagreement

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### MEDICAID PROGRAM INTEGRITY

#### PROGRAM INTEGRITY (CONT'D.)

following these discussions, the Provider may exercise its right to appeal to the Division of Appeals and Hearings.

If the provider does not contest Program Integrity's finding, or the appeal process has concluded, the provider will be required to refund the overpayment by issuing payment to SCDHHS or by having the overpayment amount deducted from future Medicaid payments. Termination of the provider enrollment agreement or contract with SCDHHS does not absolve the provider of liability for any penalties or overpayments identified by a Program Integrity review or audit.

Sanctions including but not limited to suspension, termination, or exclusion from the Medicaid program may result upon the failure of the provider to:

- Allow immediate access to records
- Repay in full the identified overpayment
- Make arrangements for the repayment of identified overpayments
- Abide by repayment terms
- Make payments which are sufficient to remedy the established overpayment

In addition, failure to provide requested records may result in one or more of the following actions by SCDHHS:

- Immediate suspension of future payments
- Denial of future claims
- Recoupment of previously paid claims

Any provider terminated for cause, suspended, or excluded will be reported to the Centers for Medicare and Medicaid Services (CMS) and U.S. Department of Health and Human (HHS) Office of Inspector General (OIG).

#### PREPAYMENT REVIEW

In order to ensure that claims presented by a provider for payment meet the requirements of federal and state laws and regulations, a provider may be required to undergo prepayment claims review. Grounds for being placed on prepayment claims review shall include, but shall not be limited to identification of aberrant billing practices as a result of reviews, investigations, or data analysis performed by Program Integrity/SUR, or other grounds as determined by Program Integrity/SUR.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID PROGRAM INTEGRITY****PREPAYMENT REVIEW  
(CONT'D.)**

Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers are required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (*e.g.*, clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were billed appropriately, and according to South Carolina Medicaid policies and procedures. Services inconsistent with South Carolina Medicaid policies and procedures are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied.

Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by Program Integrity/SUR. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns may be performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions as defined in the rules in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1.

**RECOVERY AUDIT  
CONTRACTOR**

The South Carolina Department of Health and Human Services, Division of Program Integrity, has contracted with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71. Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a) (42) of the Social Security Act and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments. The Centers for Medicare & Medicaid Services (CMS) published the final rule implementing this provision, with an effective date of

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### MEDICAID PROGRAM INTEGRITY

#### RECOVERY AUDIT CONTRACTOR (CONT'D.)

January 1, 2012. States are required to contract with Medicaid RACs “in the same manner as the Secretary enters into contracts” with the Medicare Recovery Auditors. For example, the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor.

Under this rule, State contracts with Medicaid Recovery Audit Contractors must include the following requirements (or the State must obtain an exemption from CMS for the requirement):

- That each Medicaid RAC hires a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy licensed to practice in that State.

**Note:** SCDHHS has an approved State Plan Amendment to allow the RAC to have a part-time, in-state medical director who is also a practicing physician, in lieu of a 1.0 FTE medical director.

- That each Medicaid RAC also hires certified coders (unless the State determines that certified coders are not required for the effective review of Medicaid claims)
- An education and outreach program for providers, including notification of audit policies and protocols
- Minimum customer service measures such as a toll-free telephone number for providers and mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request
- Notifying providers of overpayment findings within 60 calendar days
- A 3 year maximum claims look-back period and
- A State-established limit on the number and frequency of medical records requested by a RAC.

**Note:** SCDHHS has an approved State Plan Amendment to allow the RAC to review claims that are older than three years. The RAC will only be allowed to review claims older than three years upon written permission of the agency.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID PROGRAM INTEGRITY****RECOVERY AUDIT  
CONTRACTOR (CONT'D.)**

HMS (Health Management Systems, Inc.) is the current Recovery Audit Contractor for the SCDHHS Division of 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 several 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 any provider when the beneficiary denies having received the services.

**BENEFICIARY OVERSIGHT**

The Division of Program Integrity performs preliminary investigations on allegations of beneficiary fraud and abuse. This includes, but is not limited to, beneficiaries who are alleged to have:

- Submitted a false application for Medicaid
- Provided false or misleading information about family group, income, assets, and/or resources and/or any other information used to determine eligibility for Medicaid benefits
- Shared or lent their Medicaid card to other individuals
- Sold or bought a Medicaid card
- Diverted for re-sale prescription drugs, medical supplies, or other benefits
- Obtained Medicaid benefits that they were not entitled to through other fraudulent means
- Other fraudulent or abusive use of Medicaid services

Program Integrity reviews the initial application and other information used to determine Medicaid eligibility, and makes a fraud referral to the State Attorney General's Office or other law enforcement agencies for investigation

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### MEDICAID PROGRAM INTEGRITY

#### BENEFICIARY OVERSIGHT (CONT'D.)

as appropriate. Beneficiary cases will also be reviewed for periods of ineligibly not due to fraud but which still may result in the unnecessary payment of benefits. In these cases the beneficiary may be required to repay the Medicaid services received during a period of ineligibility.

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](mailto:fraudres@scdhhs.gov).

#### MEDICAID BENEFICIARY LOCK-IN PROGRAM

The Division of Program Integrity manages a Beneficiary Lock-In Program that screens all Medicaid members against clinically-vetted criteria designed to identify drug-seeking behavior and inappropriate use of prescription drugs. The Beneficiary Lock-In Program addresses 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 claims data in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy. Beneficiaries who are enrolled in the Lock-In Program with an effective date of October 1, 2014 and forward will remain in the program for two years. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The program also has provisions that allow the beneficiary to obtain emergency medication and/or go to another pharmacy should the first pharmacy provider be unable to provide the needed services.

#### 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 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.



**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID PROGRAM INTEGRITY****DIVISION OF AUDITS  
(CONT'D.)**

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**

The South Carolina Medicaid program, along with the Medicaid programs in other states, is required to comply with the CMS Payment Error Rate Measurement (PERM) program, which was implemented in federal fiscal year 2007. Each state will be reviewed every three years. 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.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**

**MEDICAID PROGRAM INTEGRITY**

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**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID ANTI-  
FRAUD PROVISIONS /  
PAYMENT  
SUSPENSION /  
PROVIDER  
EXCLUSIONS /  
TERMINATIONS****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 will 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. Suspicion of fraud can arise from any means, including but not limited to fraud hotline tips, provider audits and program integrity reviews, RAC audits, data mining, and other surveillance activities. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office for investigation and possible prosecution. SCDHHS also makes referrals to the Bureau of Drug Control for suspected misuse or overprescribing of prescription drugs, especially controlled substances. If a provider suspected of fraud or abuse is also enrolled in a Medicaid Managed Care Organization (MCO), Program Integrity will coordinate the investigation with the MCO(s) involved. Suspected Medicaid fraud on the part of a beneficiary is referred to a Medicaid Recipient Fraud Unit in the State Attorney General's Office for investigation.

**PAYMENT SUSPENSION**

Medicaid payments to a provider may be withheld upon credible allegation of fraud, in accordance with the requirements in 42 CFR §455.23.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****Suspension of Provider Payments for Credible Allegation of Fraud**

SCDHHS will suspend payments in cases of a credible allegation of fraud. A “credible allegation of fraud” is an allegation that has been verified by SCDHHS and that comes from any source, including but not limited to the following:

- Fraud hotline complaints
- Claims data mining
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations

SCDHHS has flexibility in determining what constitutes a “credible allegation of fraud.” Allegations are considered to be credible when they have indications of reliability based upon SCDHHS’ review of the allegations, facts, and evidence on a case-by-case basis.

**Notice of Suspension**

SCDHHS will suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity. Payments may be suspended without first notifying the provider of the intention to suspend payments. SCDHHS will send notice of its suspension of program payments within the following timeframes:

- Within five business days of suspending the payment, unless requested in writing by a law enforcement agency to temporarily withhold such notice
- Within 30 calendar days of suspending the payment, if requested by law enforcement in writing to delay sending such notice

The Notice of Payment Suspension will include all information required to be provided in accordance with 42 CFR §455.23.

All suspension of payment actions will be temporary and will not continue after either of the following:

- SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider
- Legal proceedings related to the provider’s alleged fraud are completed

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS***Referrals to the Medicaid Fraud Control Unit*

Whenever an investigation leads to the initiation of a payment suspension in whole or part, SCDHHS will make a fraud referral to the South Carolina Medicaid Fraud Control Unit.

**Good Cause not to Suspend Payments or to Suspend Only in Part**

SCDHHS may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed on an individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds;
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed;
- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
  - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
  - The individual or entity serves a large number of beneficiary's within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Law enforcement declines to certify that a matter continues to be under investigation;
- SCDHHS determines that payment suspension is not in the best interests of the Medicaid program.

SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****Good Cause not to Suspend Payments or to Suspend Only in Part (Cont'd.)**

individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
  - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
  - The individual or entity serves beneficiaries within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
- SCDHHS determines the following:
  - The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
  - A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made by SCDHHS, it will be documented in writing.
- Law enforcement declines to certify that a matter continues to be under investigation.
- SCDHHS determines that payment suspension is not in the best interest of the Medicaid program.

Even if SCDHHS exercises the good cause exceptions set forth above, this does not relieve the agency of its obligation to refer a credible allegation of fraud to the Medicaid Fraud Control Unit.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****PROVIDER EXCLUSIONS**

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:

- 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 U.S. Department of Health and Human Services, Office of Inspector General (HHS-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 that are related to and reimbursed, directly or indirectly, by a Medicaid program.

In addition, the HHS-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.

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

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****PROVIDER EXCLUSIONS  
(CONT'D.)**

reimbursement for any items or services furnished, authorized, or prescribed by the excluded provider.

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

The HHS-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. Visit the HHS-OIG Web site at <http://www.oig.hhs.gov/fraud/exclusions.asp> to search and/or download the LEIE.

SCDHHS also maintains its own list of excluded, South Carolina-only Medicaid providers (or those with a South Carolina connection) on our Web site. Visit the Provider Information page at <http://provider.scdhhs.gov> for the most current list of individuals or entities excluded from South Carolina Medicaid.

**PROVIDER TERMINATIONS**

“Termination” means that the SCDHHS has taken an action to revoke a provider’s Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary. Under Federal regulations established by the Affordable Care Act, SCDHHS has established the reasons under which a provider can be terminated from the Medicaid program “for cause”; see SCDHHS PE Policy-03, Terminations.

**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
- Post payment review
- Prepayment review



**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****ADMINISTRATIVE****SANCTIONS (CONT'D.)**

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

**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 HHS-OIG may also impose civil money penalties and assessments under the provisions of 42 CFR Part 1003.

**FAIR HEARINGS**

Proposed South Carolina initiated exclusion 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.)

Any party who has been 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 HHS-OIG. Appeals to the HHS-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 or Medicare by the HHS-OIG.

It is the provider's responsibility to satisfy these requirements. If the individual was excluded by the HHS-OIG, then the individual must first apply to HHS-OIG for reinstatement and follow any federal requirements.

**SECTION 1 GENERAL INFORMATION AND ADMINISTRATION****MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS****REINSTATEMENT (CONT'D.)**

SCDHHS may deny reinstatement to the Medicaid program based on, but not limited to, any one or a combination of the following:

1. The likelihood that the events that led to exclusion will re-occur.
2. If, since the date of the original exclusion, the provider has been convicted of fraud related to the delivery of services in a healthcare program, or has been convicted or had his license suspended or revoked due to failure to follow standards of care and/or patient harm or abuse.
3. If new information is provided that such conduct (as described above) occurred prior to the date of the exclusion but was not known to SCDHHS at the time.
4. If the provider has been excluded or had billing privileges terminated from Medicaid and/or Medicare by any state or by the HHS-OIG.
5. Any terms or conditions associated with reinstatement by the appropriate licensing board or regulatory agency, or by the HHS-OIG.
6. Whether all fines, overpayments, or any other debts owed to the Medicaid program have been paid or arrangements have been made to fulfill these obligations.

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

Any appeal of a denial of reinstatement will be in accordance with SCDHHS appeals policies and procedures as provided by South Carolina Code of Laws R. 126-150.

A terminated provider will also be required to reapply and be reenrolled with the Medicaid program if they wish billing privileges to be reinstated.

## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### 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 to file an appeal must request a hearing in writing and submit a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Appeals may be filed:

Online: [www.scdhhs.gov/appeals](http://www.scdhhs.gov/appeals)

By Fax: (803) 255-8206

By Mail to:

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

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**

### **APPEALS**

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## 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 fee for the diagnostic dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

A medically necessary problem-focused exam (D0140) is only allowed with diagnostic services and/ or non-planned treatment services that address the reason for the exam. The placement of dental sealants is also allowable on the same date of service as the medically necessary problem-focused exam (D0140), however there must be documentation of medical necessity justifying the exam. A problem-focused exam for the sole purpose of placing dental sealants is NOT allowed.

The maximum amount paid for individual or sets of radiographs taken on the same day will be limited to the allowance for a full mouth series. When individual or sets of radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if South Carolina Department of Health and Human Services (SCDHHS) determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Radiographs that do not fit the policy description will not be reimbursed for, or if already paid for, SCDHHS will recoup the funds previously paid. SCDHHS utilizes the guidelines published by the U.S. Department of Health and Human Services (DHHS), Center for Devices and Radiological Health (CDRH). However, please consult the following benefit tables for benefit limitations.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1: "General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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. Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances. Child members of Healthy Connections are covered through the month of their 21st birthday.

Diagnostic							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	0-20		No	No	One of (D0120,D0145) Per 6 months per Patient	Proper documentation must be maintained in patient's records. Refer to Appendix D-2: "Dental Treatment Records".
D0140	limited oral evaluation-problem focused	0-20		No	No	Two of (D0140) per 12 Month(s) Per Provider OR Location.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2: "Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Diagnostic							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	No	One of (D0120, D0145) per 6 Month(s) Per Provider OR Location	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0150	comprehensive oral evaluation - new or established patient	3 - 20		No	No	One of (D0150) per 36 Month(s) Per Provider OR Location. Not allowed within 6 months of D0120 or D0145 for Same Provider OR Location	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0210	intraoral - complete series of radiographic images	2-20		No	No	One of (D0210, D0330) per 36 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0220	intraoral - periapical first radiographic image	0-20		No	No	One of (D0220) per 1 Day(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0230	intraoral - periapical each additional radiographic image	0-20		No	No	Three of (D0230) per 1 Day(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0240	intraoral - occlusal radiographic image	0-20		No	No	Two of (D0240) per 12 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0270	bitewing - single radiographic image	2-20		No	No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D0272	bitewings - two radiographic images	2-20		No	No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D0274	bitewings - four radiographic images	2-20		No	No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D0330	panoramic radiographic image	6-20		No	No	One of (D0210, D0330) per 36 Month(s) Per patient. For members age 6 through 20, oral surgeons are allowed one additional usage of D0330 per beneficiary within the 36 month period.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Reimbursement fee for the preventive dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays or equipment. Billing and reimbursement for space maintainers shall be based on cementation or insertion date. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances. Child members of Healthy Connections are covered through the month of their 21st birthday.

Preventative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	12-20		No	No	One of (D1110, D1120) per 6 Month(s) per patient	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1120	prophylaxis - child	0-11		No	No	One of (D1110, D1120) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1206	topical application of fluoride varnish	0-20		No	No	One of (D1206, D1208) per 6 Month(s) per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1208	Topical application of fluoride – excluding varnish	0-20		No	No	One of (D1206, D1208) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1351	sealant - per tooth	5-14	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One (D1351) per 36 Month(s) Per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1510	Space maintainer-fixed-unilateral (excludes a distal shoe space maintainer)	0-20	Per Quadrant 10, 20, 30, 40, LL, LR, UL, UR	No	No	One of (D1510, D1516, D1517) per lifetime per patient per quadrant.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1516	Space maintainer- fixed bilateral, maxillary	0-20		No	No	One D1516 per lifetime per patient	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1517	Space maintainer- fixed bilateral, mandibular	0-20		No	No	One D1517 per lifetime per patient	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Reimbursement fee for the restorative procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, polishing, supplies, trays, equipment, topical/local anesthesia and post-operative care up to 30 days from the date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

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. Additionally, reimbursement for a tooth restored within a 12 month timeframe after the placement of a dental sealant or a restoration by the same provider or provider location is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Child members of Healthy Connections are covered through the month of their 21st birthday. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 – 32; A - T	No	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32; A - T	No	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32; A - T	No	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32; A - T	No	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11; 22 - 27; C - H; M - R	No	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11; 22 - 27; C - H; M - R	No	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11; 22 - 27; C - H; M - R	No	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11; 22 - 27; C - H; M - R	No	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5; 12 - 21; 28 - 32; A-; B; I - L; S- T	No	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5; 12 - 21; 28 - 32; A- B; I - L; S- T	No	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5; 12 - 21; 28 - 32; A- B; I - L; S- T	No	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5; 12 - 21; 28 - 32; A- B; I - L; S- T	No	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location, per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review	Prior Authorization Required	Benefit Limitations	Documentation Required
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth C - H, M - R	No	No	One of (D2929, D2930, D2932, D2934) per 36 months per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records".
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	No	One of (D2929, D2930, D2932, D2934) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records".
D2931	prefabricated stainless steel crown-permanent	0-20	Teeth 1 - 32	No	No	One of (D2931, D2932) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records".
D2932	prefabricated resin crown	0-20	Teeth 1 - 32, A - T	No	No	One of (D2929, D2930, D2931, D2932, D2934) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth C - H, M - R	No	No	One of (D2929, D2930, D2932, D2934) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records".
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	No	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.	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records".
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	No	No	One of (D2950, D2954) per Lifetime Per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix C "Clinical Criteria" and Appendix D, Section D-2:"Dental Treatment Records".
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	No	One of (D2951) per Lifetime Per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix C "Clinical Criteria" and Appendix D, Section D-2:"Dental Treatment Records".
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	No	No	One of (D2950, D2954) per Lifetime Per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix C "Clinical Criteria" and Appendix D, Section D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Reimbursement fee for the endodontic procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: extirpation treatment, temporary fillings, filling and obturation of root canals; progress radiographs and a completed fill radiograph; supplies, materials, trays, equipment; topical/ local anesthesia and post-operative care up to 30 days from the date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

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 SCDHHS's treatment standards, SCDHHS 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 Dental Consultant.

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.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorization requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

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

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Endodontics							
Cede	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentino-cemental junction and application of medicament	0-20	Teeth 2 - 15, 18 - 31, A - T	No	No	One D3220 per lifetime per patient per tooth. Not allowed in conjunction with One of (D3310, D3320, 3330) on the same tooth, on the same day.	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.03 "Clinical Criteria" and Appendix D, Section D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Endodontics							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	Yes	No	One D3310 per lifetime per patient per tooth.  Not allowed in conjunction with D3220 on the same tooth on the same day.	Detailed narrative of medical necessity and pre-op x-ray(s) must be submitted with the claim for review. Refer to Appendix C, Section C.03 "Clinical Criteria" Policy.  Proper documentation and post-treatment radiographs must be maintained in patient's records ( Refer to Appendix D, Section D-2:"Dental Treatment Records")
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One D3310 per lifetime per patient per tooth.  Not allowed in conjunction with D3220 on the same tooth on the same day	Detailed narrative of medical necessity and pre-op x-ray(s) must be submitted with the claim for review. Refer to Appendix C, Section C.03 "Clinical Criteria" Policy.  Proper documentation and post-treatment radiographs must be maintained in patient's records ( Refer to Appendix D, Section D-2:"Dental Treatment Records")
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	No	One D3330 per lifetime per patient per tooth.  Not allowed in conjunction with D3220 on the same tooth on the same day	Detailed narrative of medical necessity and pre-op x-ray(s) must be submitted with the claim for review. Refer to Appendix C, Section C.03 "Clinical Criteria" Policy.  Proper documentation and post-treatment radiographs must be maintained in patient's records ( Refer to Appendix D, Section D-2:"Dental Treatment Records")

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

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. Partial dentures are not a covered benefit when 8 or more posterior teeth are in occlusion. Partial dentures not allowed for closing a space gap without missing teeth.

Reimbursement fee for the prosthodontic procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: impressions, try-in appointments, delivery; materials, supplies, trays, equipment, topical or local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

**SCDHHS will NOT reimburse for full or partial dentures 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.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Child members of Healthy Connections are covered through the month of their 21st birthday. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Prosthodontics, removable							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	14-20		Yes	No	One D5110 per 60 Month(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D5120	complete denture - mandibular	14-20		Yes	No	One D5120 per 60 Month(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Prosthodontics, removable							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5211	maxillary partial denture - resin base (including, retentive / clasping materials, rests and teeth)	14-20		Yes	No	One D5211 per 60 Month(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D5212	mandibular partial denture - resin base (including retentive/ clasping materials, rests and teeth)	14-20		Yes	No	One D5212 per 60 Month(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D5511	Repair broken complete denture base, mandibular	14-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5512	Repair broken complete denture base, maxillary	14-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5520	replace missing or broken teeth - complete denture (each tooth)	14-20	Teeth 1 - 32	No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5611	Repair resin partial denture base, mandibular	14-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5612	Repair resin partial denture base, maxillary	14-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5640	replace broken teeth-per tooth	14-20	Teeth 1 - 32	No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"

South Carolina Healthy Connections Under 21

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South Carolina Healthy Connections Under 21**

Reimbursement fee for the surgical procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/ local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Additionally, the **incidental** removal of a cyst or lesion attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee and should not be billed as a separate procedure. Reimbursement for a tooth extracted within a 12 month timeframe after the placement of a dental sealant or a restoration by the same provider or provider location, is subject to payment adjustment based on the initial service. SCDHHS will not reimburse for the removal of primary teeth whose exfoliation is imminent.

Biopsy of Oral Tissue (code D7285 & D7286) is not billable with another surgical procedure that is part of the same procedure.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

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

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7111	extraction, coronal remnants - primary tooth	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	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, "Clinical Criteria" and Appendix D, Section D-2 "Dental Treatment Records".
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	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	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, "Clinical Criteria" and Appendix D, Section D-2 "Dental Treatment Records".

South Carolina Healthy Connections Under 21

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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	Pre-payment Review	Prior Authorization Required	Benefit Limitations	Documentation Required
D7210	extraction, 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	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, "Clinical Criteria" and Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
D7250	removal of residual tooth roots (cutting procedure)	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	No	Not allowed by same office or provider who performed original extraction.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")

South Carolina Healthy Connections Under 21

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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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7280	exposure of an unerupted tooth	0-20	Teeth 1 - 32	Yes	No	Two D7280 per 1 Day(s) Per patient. Not allowed with extraction codes	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7286	incisional biopsy of oral tissue-soft	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7410	excision –of benign lesion up to 1.25cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7411	excision of benign lesion greater than 1.25 cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7412	excision of benign lesion, complicated	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7413	excision of malignant lesion up to 1.25 cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7414	excision of malignant lesion greater than 1.25 cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7415	excision of malignant lesion, complicated	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

South Carolina Healthy Connections Under 21

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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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7465	destruction of lesion(s) by physical or chemical method, by report	0-20		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
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	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

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South Carolina Healthy Connections Under 21**

Oral and Maxillofacial Surgery							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0-20		Yes	No	One D7530 per 1 Day(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Not to be billed for treatment of dry socket.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7670	alveolus stabilization of teeth, closed reduction splinting	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7671	alveolus - open reduction, may include stabilization of teeth	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

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Oral and Maxillofacial Surgery							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7770	Alveolus-open reduction stabilization of teeth. Incision required to reduce fracture	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7771	Alveolus-closed reduction stabilization of teeth	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7910	suture small wounds up to 5 cm	0-20		Yes	No	Excludes closure of surgical incision.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7911	complicated suture-up to 5 cm	0-20		Yes	No	Excludes closure of surgical incision.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7912	complex suture - greater than 5cm	0-20		Yes	No	Excludes closure of surgical incision.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

South Carolina Healthy Connections Under 21

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Reimbursement fee for the adjunctive procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays, equipment, topical or local anesthesia. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Reimbursement for moderate or deep sedation/ general anesthesia administered in dental offices will be limited to only those providers that have a valid dental sedation permit from the State Board of Dentistry, a copy of which is on file with DentaQuest.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Claims filed for adjunctive services must also include the procedure code(s) rendered in conjunction with the adjunctive service(s). Adjunctive services will be considered for review and reimbursement only when accompanied by a covered service or by an approved EPSDT service and when the medical necessity for the service is established through supporting documentation (Refer to documents required and clinical criteria for each specific procedure/ procedure category).

All dental sedation services administered in the office must be performed by an authorized provider to assure appropriate monitoring of the beneficiary. The administration of sedation and/or anesthesia by or under the direction of an authorized dental provider shall be performed in accordance with the state laws and regulations, applicable guidelines approved by the authorizing agency that regulates the practice of dentistry in the state, including but not limited to, current American Dental Association (ADA) "Guidelines for the Use of Sedation and General Anesthesia by Dentists" ; and the joint American Academy of Pediatric Dentistry (AAPD) and American Academy of Pediatrics (AAP) Pediatrics "Guidelines for Monitoring and management of pediatric patients before, during and after sedation for diagnostic and therapeutic procedures." The rendering dental provider is solely responsible for the administration and management of sedation and/or anesthesia in the practice of dentistry, including but not limited to ordering, supplying, and prescribing medications used in the sedation procedure, and must determine which of the guidelines, as referenced above, he or she shall operate under, and shall be responsible for complying with the same, as provided above.

Providers must comply with the South Carolina 2014 Dental Sedation Act 222 (S.C. Code of Laws 40-15-450) requirements for patient's record keeping. SCDHHS also requires that both the authorized office location and administering provider must be clearly documented in the patient's record. If there is no sedation documentation in the treatment record that meets these requirements for a billed service, then the service is subject to recoupment by SCDHHS

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

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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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D9222	deep sedation/general anesthesia – first 15 minutes	0-20		Yes	No	Allowed 1 unit of D9222 per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records"). A valid dental sedation permit must be on file with DentaQuest.
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	0-20		Yes	No	Allowed 1 unit of D9223 per 1 Day(s) Per patient. Allowed with D9222 only. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records"). A valid dental sedation permit must be on file with DentaQuest.
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	No	One D9230 per 1 Day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9239, D9243, or D9920.	Proper documentation must be maintained in patient's records. Refer to Appendix C, "Clinical Criteria" and Appendix D, Section D-2"Dental Treatment Records".
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	No	Allowed 1 unit of D9239 per 1 Day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9230, D9248 or D9920.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records"). A valid dental sedation permit must be on file with DentaQuest.
D9243	intravenous moderate (conscious) sedation/ analgesia – each subsequent 15 minute increment	0-20		Yes	No	Allowed 1 unit of D9243 per 1 Day(s) Per patient. Allowed with D9239 only. Not allowed in conjunction with D9230, D9222, D9223, D9248 or D9920.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records"). A valid dental sedation permit must be on file with DentaQuest.
D9248	non-intravenous moderate (conscious) sedation	0-20		No	No	One D9248 per 1 Day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9239, D9243, or D9920.	Proper documentation must be maintained in patient's records. Refer to Appendix C, "Clinical Criteria" and Appendix D, Section D-2"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D9420	hospital or ambulatory surgical center call	0-20		No	Yes	One D9420 per 1 Day(s) Per patient. May be billed when rendering prior approved treatment in an outpatient operating room or ASC. SCDHHS prohibits the billing of beneficiaries to schedule appointments or to hold appointment blocks prior to treatment in a hospital or ambulatory center setting.	Detailed narrative of medical necessity must be submitted for prior authorization. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs, and any documentation that would supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D9920	behavior management, by report	0-20		Yes	No	One 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. Not allowed with D9222, D9223, D9230, D9239, D9243, D9248, or D9420	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D9999	unspecified adjunctive procedure, by report	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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Reimbursement fee for the medical procedure performed by an oral surgeon includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/ local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment 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.

Planned, non-emergent dental services delivered in an Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

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Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
11900	Intralesional injection	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12011	Repair of wound (2.5 cm or less)of face, ears, eyelids, nose, lips, and/or mucous membrane;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12013	Repair of wound (2.6 to 5.0 cm) of face, ears, eyelids, nose, lips, and/or mucous membrane;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12014	Repair of wound (5.1 to 7.5 cm) of face, ears, eyelids, nose, lips, and/or mucous membrane;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
12015	Repair of wound (7.6 to 12.5 cm) of face, ears, eyelids, nose, lips, and/or mucous membrane;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12020	Treatment of superficial wound dehiscence; simple closure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12051	Repair of wound, intermediate, (2.5 cm or less) of face, ears, eyelids, nose, lips, and/or mouth	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12052	Repair of wound, intermediate, (2.6 to 5.0 cm) of face, ears, eyelids, nose, lips, and/or mouth	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12053	Repair of wound ,intermediate, (5.1 to 7.5 cm) of face, ears, eyelids, nose, lips, and/or mouth	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12054	Repair of wound, intermediate, (7.6 to 12.5 cm) of face, ears, eyelids, nose, lips, and/or mouth	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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12055	Repair of wound, intermediate, (12.6 to 20.0 cm) of face, ears, eyelids, nose, lips, and/or mouth	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13131	Repair of wound complex (1.1 to 2.5 cm) of forehead, cheeks, chin, mouth, neck, underarms, genitalia, hands, and/or feet;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13132	Repair of wound complex (2.6 to 7.5 cm) of forehead, cheeks, chin, mouth, neck, underarms, genitalia, hands and/or feet;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13133	Repair of wound complex of forehead, cheeks, chin, mouth, neck, underarms, genitalia, hands, and/or feet;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13151	Repair of wound (1.1 to 2.5 cm), of eyelids, nose, ears, and/or lips;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13152	Repair of wound (2.6 to 7.5 cm) of eyelids, nose, ears, and/or lips;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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13153	Repair of wound complex, of eyelids, nose, ears, and/or lips; each additional 5 cm or less	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
15120	Skin graft of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and /or multiple fingers or toes; first 100 sq cm or less, or 1% body area of infants and children (except 15050)	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
15121	Skin graft of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and /or multiple fingers or toes; Each additional. 100 sq cm, or each additional 1% body area of infants and children or part thereof	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20694	Removal of external fixation system	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20902	Bone graft, any donor area; major or large	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21031	Excision of Torus Mandibularis	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21032	Excision of Maxillary Torus Palatinus	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21034	Excision of Malignant Tumor of Maxilla or Zygoma	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21040	Excision Benign Cyst/Tumor Mandible by Enucleation and or curettage	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21044	Excision of malignant tumor of mandible	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21047	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21050	Condylectomy, Temporomandibular Joint (Separate Procedure)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21060	Meniscectomy, Partial or Complete, Temporomandibular Joint (Separate Procedure)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21070	Coronoidectomy (separate procedure)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21076	Impression and custom preparation; surgical obturator prosthesis	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21081	Impression and custom preparation; mandibular resection prosthesis	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21085	Impression and custom preparation of oral surgical splint	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21110	Application Of Interdental Fixation Device For Conditions Other Than Fracture	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21116	Injection Procedure temporomandibular joint arthrography	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21209	Osteoplasty, facial bones; reduction (autograft, allograft, or prosthetic implant)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21210	Graft, Bone; Nasal, Maxillary Or Malar Areas (Includes Obtaining Graft)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21230	Graft; rib cartilage, autogenous, to face, chin, nose, or ear (includes obtaining graft)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21242	Arthroplasty, Temporomandibular Joint, With Allograft	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21243	Arthroplasty, Temporomandibular Joint, With Prosthetic Joint Replacement	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21310	Closed TX of Nasal Bone Fracture-without manipulation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21315	Closed Treatment Of Nasal Bone Fracture; With Out Stabilization	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21320	Closed treatment of nasal bone fracture; with stabilization	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21325	Open treatment of nasal fracture; uncomplicated	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21330	Open treatment of nasal fracture; complicated with internal and/or external skeletal fixation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21336	Open treatment of nasal septal fracture, with or without stabilization	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21337	Closed treatment of nasal septal fracture, with or without stabilization	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21338	Open treatment of nasoethmoid fracture; without external fixation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21339	Open treatment of nasoethmoid fracture; with external fixation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21340	Treatment of broken eye socket and nasal bones, accessed through the skin	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21344	Open treatment of complicated frontal sinus fracture, via coronal or multiple approaches	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21356	Open treatment of depressed zygomatic arch fracture	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21390	Open treatment of orbital floor blowout fracture; periorbital approach with alloplastic or other implant	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21406	Open treatment of fracture of orbit, except blowout; without implant	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21407	Open treatment of fracture of orbit, except blowout; with implant	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21445	Open treatment of mandibular or maxillary alveolar ridge fracture	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21450	Closed treatment of mandibular fracture; without manipulation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21451	Closed treatment of mandibular fracture; with manipulation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21452	Treatment of broken jaw with placement of external hardware, accessed through the skin.	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21453	Closed treatment of mandibular fracture with interdental fixation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21454	Open treatment of mandibular fracture with external fixation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21461	Open treatment of mandibular fracture; without interdental fixation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21462	Open treatment of mandibular fracture; with interdental fixation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21465	Open treatment of mandibular condylar fracture	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21485	Closed treatment of temporomandibular dislocation; complicated, initial or subsequent	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21490	Open treatment of temporomandibular dislocation	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21497	Interdental wiring, for condition other than fracture	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
29804	Arthroscopy, temporomandibular joint, surgical	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30906	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31000	Lavage by cannulation; maxillary (antrotomy); intranasal	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31020	Sinusotomy, maxillary (antrotomy); intranasal	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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31032	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31040	Pterygomaxillary fossa surgery	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31500	Intubation, endotracheal, emergency procedure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31603	Tracheostomy, emergency procedure; transtracheal	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31605	Tracheostomy, emergency procedure; cricothyroid membrane	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40490	Biopsy of lip	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40500	Vermilionectomy (lip shave), with mucosal advancement	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40510	Excision of lip; transverse wedge excision with primary closure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40520	Excision of lip; V excision with primary direct linear closure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40525	Excision of lip; full thickness, reconstruction with local flap	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40530	Resection of lip, more than one-fourth, without reconstruction	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40650	Repair lip, full thickness; vermilion only	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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40652	Repair lip, full thickness; up to half vertical height	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40654	Repair lip, full thickness; over one-half vertical height, or complex	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
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	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40800	Incision of abscess, cyst or blood accumulation in mouth; drainage of mouth lesion; simple	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40801	Incision of abscess, cyst or blood accumulation in mouth; drainage of mouth lesion; complicated	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40808	Biopsy, vestibule of mouth	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40812	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40816	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40818	Excision of mucosa of vestibule of mouth as donor graft	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40819	Excision of frenum, labial or buccal (frenulectomy, frenulectomy)	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40831	Closure of laceration, vestibule of mouth; over 2.5 cm or complex	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41000	Drainage of abscess, cyst, or blood accumulation of tongue	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41005	Drainage of abscess, cyst, or blood accumulation under the tongue,	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41006	Drainage of abscess, cyst, or blood accumulation under the tongue;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41007	Drainage of abscess, cyst, or blood accumulation under the tongue or lower lip ; submental space;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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41008	Drainage of abscess, cyst, or blood accumulation under the jaw bone;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41009	Drainage of abscess, cyst, or blood accumulation under lower teeth,.	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41015	Drainage of abscess, cyst, or blood accumulation under the tongue;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41016	Drainage of abscess, cyst, or blood accumulation under the tongue or lower lip;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41017	Drainage of abscess, cyst, or blood accumulation under the tongue or jaw bone; submandibular	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41018	Drainage of abscess, cyst, or blood accumulation under the tongue or lower teeth;	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41100	Extraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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41105	Biopsy of tongue; posterior one-third	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41108	Biopsy of floor of mouth	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41110	Excision of lesion of tongue without closure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41112	Excision of lesion of tongue with closure; anterior two-thirds	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41113	Excision of lesion of tongue with closure; posterior one-third	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41115	Excision of lingual frenum (frenectomy)	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41116	Excision, lesion of floor of mouth	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41120	Glossectomy; less than one-half tongue	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41251	Repair of laceration 2.5 cm or less; posterior one-third of tongue	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41800	Drainage of abscess, cyst, or blood accumulation of dental bone	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissue	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review	Prior Authorization Required	Benefit Limitations	Documentation Required
41806	Removal of embedded foreign body from dentoalveolar structures; bone	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41822	Excision of fibrous tuberosities, dentoalveolar structures	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41823	Excision of osseous tuberosities, dentoalveolar structures	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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41827	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41828	Excision of hyperplastic alveolar mucosa, each quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41830	Alveolectomy, including curettage of osteitis or sequestrectomy	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41850	Destruction of lesion (except excision), dentoalveolar structures	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41874	Alveoplasty each quadrant (specify)	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42100	Biopsy of palate, uvula	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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42104	Excision, lesion of palate, uvula; without closure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42106	Excision, lesion of palate, uvula; with simple primary closure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42120	Resection of palate or extensive resection of lesion	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42140	Uvulectomy, excision of uvula	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42180	Repair, laceration of palate; up to 2 cm	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42182	Repair, laceration of palate; over 2 cm or complex	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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42200	Palatoplasty for cleft palate, soft and/or hard palate only	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42215	Palatoplasty for cleft palate; major revision	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42220	Palatoplasty for cleft palate; secondary lengthening procedure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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42235	Repair of anterior palate, including vomer flap	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42260	Repair of nasolabial fistula	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42300	Drainage of abscess; parotid, simple	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42305	Drainage of abscess; parotid, complicated	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42310	Drainage of abscess; submaxillary of sublingual, intraoral	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42320	Drainage of abscess; submaxillary external	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42340	Sialolithotomy; parotid, extraoral or complicated intraoral	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42408	Excision of sublingual salivary cyst (ranula)	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42409	Marsupialization of sublingual salivary cyst (ranula)	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42440	Excision of submandibular (submaxillary) gland	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
42450	Excision of sublingual gland	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42505	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42550	Injection procedure for sialography	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42650	Dilation salivary duct	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42720	Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42725	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach	0-20		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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64722	Decompression , unspecified nerve(s)	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
64774	Excision of neuroma of cutaneous nerve	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
64788	Excision of neurofibroma or neurolemmoma of cutaneous nerve	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
67930	Suture of partial thickness wound of eyelid with direct closure of lid margin	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
67935	Suture of full thickness wound of eyelid	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
88160	Cytopathology, smears, any other source; screening and interpretation	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
88300	Pathology examination of tissue using a microscope, limited examination	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88302	Level II surgical pathology--gross and microscopic examination	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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88304	Pathology examination of tissue using a microscope, moderately low complexity.	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88305	Pathology examination of tissue using a microscope, intermediate complexity.	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88307	Pathology examination of tissue using a microscope, moderately high complexity.	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88309	Pathology examination of tissue using a microscope, high complexity.	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88311	Decalcification procedure (List separately in addition to code for surgical pathology examination)	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88312	Special Stains	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99201	New patient office or other outpatient visit, typically 10 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99202	New patient office or other outpatient visit, typically 20 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99203	New patient office or other outpatient visit, typically 30 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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99204	New patient office or other outpatient visit, typically 45 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99205	New patient office or other outpatient visit, typically 60 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99211	Established patient office or other outpatient visit, typically 5 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99212	Established patient office or other outpatient visit, typically 10 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99213	Established patient office or other outpatient visit, typically 15 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99214	Established patient office or other outpatient, visit typically 25 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99215	Established patient office or other outpatient, visit typically 40 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
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99217	Hospital Observation care on day of discharge Management	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99218	Hospital observation care, typically 30 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99219	Hospital observation care, typically 50 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99220	Hospital observation care, typically 70 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99221	Initial hospital inpatient care, typically 30 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99222	Initial hospital inpatient care, typically 50 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99223	Initial hospital inpatient care, typically 70 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99231	Subsequent hospital inpatient care, typically 15 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99232	Subsequent hospital inpatient care, typically 25 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99233	Subsequent hospital inpatient care, typically 35 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99234	Hospital observation or inpatient care low severity, 40 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99235	Hospital observation or inpatient care moderate severity, 50 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99236	Hospital observation or inpatient care high severity, 55 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99238	Hospital discharge day management, 30 minutes or less	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99239	Hospital discharge day management, more than 30 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99241	Patient office consultation, typically 15 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99242	Patient office consultation, typically 30 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99243	Patient office consultation, typically 40 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99244	Patient office consultation, typically 60 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99245	Patient office consultation, typically 80 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99251	Inpatient hospital consultation, typically 20 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99252	Inpatient hospital consultation, typically 40 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99253	Inpatient hospital consultation, typically 55 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99254	Inpatient hospital consultation, typically 80 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99255	Inpatient hospital consultation, typically 110 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99281	Emergency department visit, self-limited or minor problem	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99282	Emergency department visit, low to moderately severe problem	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99283	Emergency department visit, moderately severe problem	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99284	Emergency department visit, problem of high severity	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99285	Emergency department visit, problem with significant threat to life or function	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99291	Critical care delivery critically ill or injured patient, first 30-74 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99292	E/M critical care service each 30 minutes beyond 1 hour	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99304	Initial nursing facility visit, typically 25 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99305	Initial nursing facility visit, typically 35 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99306	Initial nursing facility visit, typically 45 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99307	Subsequent nursing facility visit, typically 10 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99308	Subsequent nursing facility visit, typically 15 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99309	Subsequent nursing facility visit, typically 25 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99310	Subsequent nursing facility visit, typically 35 minutes per day	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Under 21

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**Exhibit A Benefits Covered for  
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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99324	New patient assisted living visit, typically 20 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99325	New patient assisted living visit, typically 30 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99326	New patient assisted living visit, typically 45 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99327	New patient assisted living visit, typically 60 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99328	New patient assisted living visit, typically 75 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99334	Established patient assisted living visit, typically 15 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99335	Established patient assisted living visit, typically 25 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99336	Established patient assisted living visit, typically 40 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99337	Established patient assisted living visit, typically 60 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

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**Exhibit A Benefits Covered for  
South Carolina Healthy Connections Under 21**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99341	New patient home visit, typically 20 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99342	New patient home visit, typically 30 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99343	New patient home visit, typically 45 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99344	New patient home visit, typically 60 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99345	New patient home visit, typically 75 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99347	Established patient home visit, typically 15 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99348	Established patient home visit, typically 25 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99349	Established patient home visit, typically 40 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99350	Established patient home visit, typically 60 minutes	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99441	Physician telephone patient service, 5-10 minutes of medical discussion	0-20		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

South Carolina Healthy Connections Under 21

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## Exhibit B Benefits Covered for South Carolina Healthy Connections Adults

Adult Beneficiaries have a \$750 benefit year maximum for the covered codes as listed in this Exhibit. The benefit year for all beneficiaries begins July 1 and concludes June 30 of the following year, regardless of effective date of eligibility. Providers should always check the member's eligibility, service history and available balance prior to rendering services. See Sections 4.06 through 4.08 of the ORM for explanations of adult coverage.

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 fee for the diagnostic dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

A medically necessary problem-focused exam (D0140) is only allowed with diagnostic services and/ or non-planned treatment services that address the reason for the exam.

The maximum amount paid for individual or sets of radiographs taken on the same day will be limited to the allowance for a full mouth series. When individual or sets of radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if South Carolina Department of Health and Human Services (SCDHHS) determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Radiographs that do not fit the policy description will not be reimbursed for, or if already paid for, SCDHHS will recoup the funds previously paid. SCDHHS utilizes the guidelines published by the U.S. Department of Health and Human Services (DHHS), Center for Devices and Radiological Health (CDRH). However, please consult the following benefit tables for benefit limitations.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Diagnostic							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	No	One of (D0120) per 12 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0140	limited oral evaluation- problem focused	21 and older		No	No	Two of (D0140) per 12 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adults**

Diagnostic							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	No	One of (D0150) per 36 Month(s) Per patient. Not allowed within 12 months of D0120	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0210	intraoral - complete series of radiographic images	21 and older		No	No	One of (D0210, D0330) per 36 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0220	intraoral - periapical first radiographic image	21 and older		No	No	One of (D0220) per 1 Day(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0230	intraoral - periapical each additional radiographic image	21 and older		No	No	One of (D0230) per 1 Day(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0272	bitewings - two radiographic images	21 and older		No	No	One of (D0272, D0274) per 12 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0274	bitewings - four radiographic images	21 and older		No	No	One of (D0272, D0274) per 12 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0330	panoramic radiographic image	21 and older		No	No	One of (D0210, D0330) per 36 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adults**

Adult Beneficiaries have a \$750 benefit year maximum for the covered codes as listed in this Exhibit. The benefit year for all Beneficiaries begins July 1 and concludes June 30 of the following year, regardless of effective date of eligibility. Providers should always check the member's eligibility, service history and available balance prior to rendering services. See Sections 4.06 through 4.08 of the ORM for explanations of adult coverage.

Reimbursement fee for the preventive dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Preventative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	No	One of (D1110) per 12 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adults**

Adult Beneficiaries have a \$750 benefit year maximum for the covered codes as listed in this Exhibit. The benefit year for all Beneficiaries begins July 1 and concludes June 30 of the following year, regardless of effective date of eligibility. Providers should always check the member's eligibility, service history and available balance prior to rendering services. See Sections 4.06 through 4.08 of the ORM for explanations of adult coverage.

Reimbursement fee for the restorative procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: tooth preparation, temporary restoration or sedative filling, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, polishing, supplies, trays, equipment, topical/local anesthesia and post-operative care up to 30 days from the date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Restorative treatment of retained primary teeth of the beneficiaries age 21 years and older, will be allowed through a pre-payment review process with submission of radiographs and supporting documentation justifying the need for the procedure. The restorative procedures and the respective policies allowed for the permanent teeth are applicable to the retained primary teeth.

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. Additionally, reimbursement for a tooth restored within a 12 month timeframe of the initial restoration by the same provider or provider location is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 – 32, A - T	Permanent Teeth- No Retained Primary Teeth- Yes	No	One of (D2140, D2330, D2391) per 36 Month(s) Per patient per tooth, per surface for all Permanent & Primary Teeth.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 – 32, A-T	Permanent Teeth- No Retained Primary Teeth- Yes	No	One of (D2150, D2331, D2392) per 36 Month(s) Per patient per tooth, per surface for all Permanent& Primary Teeth.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit B Benefits Covered for  
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Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 – 32, A-T	Permanent Teeth- No Retained Primary Teeth- Yes	No	One of (D2160, D2332, D2393) per 36 Month(s) Per patient per tooth, per surface for all Permanent & Primary Teeth.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 – 32, A-T	Permanent Teeth- No Retained Primary Teeth- Yes	No	One of (D2161, D2335, D2394) per 36 Month(s) Per patient per tooth, per surface for All Permanent & Primary Teeth.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22–27, C-H, M-R	Permanent Teeth-No Retained Primary Teeth- Yes	No	One of (D2140, D2330, D2391) per 36 Month(s) Per patient per tooth, per surface for Permanent & Primary Anterior.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 -27, C-H, M-R	Permanent Teeth-No Retained Primary Teeth- Yes	No	One of (D2150, D2331, D2392) per 36 Month(s) Per patient per tooth, per surface for Permanent & Primary Anterior.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
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Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22- 27, C-H, M-R	Permanent Teeth-No Retained Primary Teeth- Yes	No	One of (D2160, D2332, D2393) per 36 Month(s) Per patient per tooth, per surface for Permanent & Primary Anterior.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22-27, C-H, M-R	Permanent Teeth-No Retained Primary Teeth- Yes	No	One of (D2161, D2335, D2394) per 36 Month(s) Per patient per tooth, per surface for Permanent & Primary Anterior.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28- 32, A,B,I-L, S,T	Permanent Teeth-No Retained Primary Teeth- Yes	No	One of (D2140, D2330, D2391) per 36 Month(s) Per patient per tooth, per surface for Permanent & Primary Posterior.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A,B,I-L, S,T	Permanent Teeth-No Retained Primary Teeth- Yes	No	One of (D2150, D2331, D2392) per 36 Month(s) Per patient per tooth, per surface for Permanent & Primary Posterior.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A,B,I-L, S,T	Permanent Teeth-No Retained Primary Teeth- Yes	No	One of (D2160, D2332, D2393) per 36 Month(s) Per patient per tooth, per surface for Permanent & Primary Posterior.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A,B,I-L, S,T	Permanent Teeth-No Retained Primary Teeth- Yes	No	One of (D2161, D2335, D2394) per 36 Month(s) Per patient per tooth, per surface for Permanent & Primary Posterior.	Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adults

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**Exhibit B Benefits Covered for  
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Adult Beneficiaries have a \$750 benefit year maximum for the covered codes as listed in this Exhibit. The benefit year for all Beneficiaries begins July 1 and concludes June 30 of the following year, regardless of effective date of eligibility. Providers should always check the member's eligibility, service history and available balance prior to rendering services. See Sections 4.06 through 4.08 of the ORM for explanations of adult coverage.

Reimbursement fee for the surgical procedure includes any related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/ local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

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

Reimbursement for a tooth extracted within a 12 month timeframe of placement of a restoration by the same provider or provider location, is subject to payment adjustment based on the initial service.

Use of sedation may be allowable if authorized through prior authorization or prepayment review, ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon. If medically necessary, use of these codes will not count towards a Beneficiary's \$750 annual maximum.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	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	No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D7210	extraction, 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	No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adults**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
D7250	removal of residual tooth roots (cutting procedure)	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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")

South Carolina Healthy Connections Adult

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## **Exhibit B Benefits Covered for South Carolina Healthy Connections Adults**

Adult Beneficiaries have a \$750 benefit year maximum for the covered codes as listed in this Exhibit. The benefit year for all Beneficiaries begins July 1 and concludes June 30 of the following year, regardless of effective date of eligibility. Providers should always check the member's eligibility, service history and available balance prior to rendering services. See Sections 4.06 through 4.08 of the ORM for explanations of adult coverage.

Reimbursement fee for the adjunctive procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays, equipment, topical or local anesthesia. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative. Reimbursement for moderate or deep sedation/ general anesthesia administered in dental offices will be limited to only those providers that have a valid dental sedation permit from the State Board of Dentistry, a copy of which is on file with DentaQuest. Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Use of sedation for beneficiaries age 21 years and older may be allowable if authorized through prior authorization or prepayment review ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon. If medically necessary, use of these codes will not count towards a Beneficiary's \$750 annual maximum.

All dental sedation services administered in the office must be performed by an authorized provider to assure appropriate monitoring of the beneficiary. The administration of sedation and/or anesthesia by or under the direction of an authorized dental provider shall be performed in accordance with the state laws and regulations, applicable guidelines approved by the authorizing agency that regulates the practice of dentistry in the state, including but not limited to, current American Dental Association (ADA) "Guidelines for the Use of Sedation and General Anesthesia by Dentists" ; and the joint American Academy of Pediatric Dentistry (AAPD) and American Academy of Pediatrics (AAP) Pediatrics "Guidelines for Monitoring and management of pediatric patients before, during and after sedation for diagnostic and therapeutic procedures."

The rendering dental provider is solely responsible for the administration and management of sedation and/or anesthesia in the practice of dentistry, including but not limited to ordering, supplying, and prescribing medications used in the sedation procedure, and must determine which of the guidelines, as referenced above, he or she shall operate under, and shall be responsible for complying with the same, as provided above.

Providers must comply with the South Carolina 2014 Dental Sedation Act 222 (S.C. Code of Laws 40-15-450) requirements for patient's record keeping. SCDHHS also requires that both the authorized office location and administering provider must be clearly documented in the patient's record. If there is no sedation documentation in the treatment record that meets these requirements for a billed service, then the service is subject to recoupment by SCDHHS.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary Procedures that require Pre-Payment Review 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.

Claims filed for adjunctive services must also include the procedure code(s) rendered in conjunction with the adjunctive service(s). Adjunctive services will be considered for review and reimbursement only when accompanied by a covered service and when the medical necessity for the service is established through supporting documentation (Refer to documents required and clinical criteria for each specific procedure/ procedure category). Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adults**

Adjunctive General Services							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D9222	deep sedation/general anesthesia – first 15 minutes	21 and older		Yes	No	Allowed 1 unit of D9222 per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, or D9248.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”). A valid dental sedation permit must be on file with DentaQuest.
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	21 and older		Yes	No	Allowed 1 unit of D9223 per 1 Day(s) Per patient. Allowed with D9222 only. Not allowed in conjunction with D9230, D9239, D9243, or D9248.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”). A valid dental sedation permit must be on file with DentaQuest.
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Yes	No	One D9230 per 1 day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9239, or D9243	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”).
D9239	intravenous moderate (conscious) sedation/analgesia - first 15 minutes	21 and older		Yes	No	One of D9239 per 1 Day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9230, or D9248.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”). A valid dental sedation permit must be on file with DentaQuest.

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

**Adjunctive General Services**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	21 and older		Yes	No	Allowed 1 unit of D9243 per 1 Day(s) Per patient. Allowed only with D9239. Not allowed in conjunction with D9222, D9223, D9230, or D9248	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”). A valid dental sedation permit must be on file with DentaQuest.
D9248	non-intravenous moderate (conscious) sedation	21 and older		Yes	No	One of D9248 per 1 Day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9239 or D9243.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”).
D9420	hospital or ambulatory surgical center call	21 and older		No	Yes	One D9420 per 1 Day(s) Per patient. Only allowable when medically necessary for adults with special needs diagnoses or when medically necessary for treatment by an oral surgeon.	Detailed narrative of medical necessity must be submitted for prior authorization. Please include as necessary pre-operative diagnostic images such as radiographs, CT, and any documentation that would support the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”).

South Carolina Healthy Connections Adult

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## Exhibit B Benefits Covered for South Carolina Healthy Connections Adult

Adult Beneficiaries age 21 and older may receive emergency medical (CPT) services by a Medicaid enrolled oral surgeon (as outlined in Section 4.06). The emergency medical services will not consume the \$750 annual maximum that is available under the adult preventive dental benefit as long as claims for the emergency medical services are appropriately submitted. See Sections 4.06 for specific instruction on claim submission for the emergency medical services.

Reimbursement fee for the emergency medical procedure performed by an oral surgeon includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/ local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Emergency medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
11900	Intralesional injection	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12011	Repair of wound (2.5 centimeters or less) of the face, ears, eyelids, nose, lips, and/or mucous membranes	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12013	Repair of wound (2.6 to 5.0 centimeters) of the face, ears, eyelids, nose, lips, and/or mucous membranes	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12014	Repair of wound (5.1 to 7.5 centimeters) of the face, ears, eyelids, nose, lips, and/or mucous membranes	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
12015	Repair of wound (7.6 to 12.5 centimeters) of the face, ears, eyelids, nose, lips, and/or mucous membranes	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records
12020	Treatment of superficial wound dehiscence; simple closure	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12051	Repair of wound (2.5 centimeters or less) of face, ears, eyelids, nose, lips, and/or mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12052	Repair of wound (2.6 to 5.0 centimeters) of face, ears, eyelids, nose, lips, and/or mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12053	Repair of wound (5.1 to 7.5 centimeters) of face, ears, eyelids, nose, lips, and/or mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12054	Repair of wound (7.6 to 12.5 centimeters) of face, ears, eyelids, nose, lips, and/or mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
12055	Repair of wound (12.6 to 20.0 centimeters) of face, ears, eyelids, nose, lips, and/or mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13131	Repair of wound (1.1 to 2.5 centimeters) of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13132	Repair of wound (2.6 to 7.5 centimeters) of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13133	Repair of wound of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13151	Repair of wound (1.1 to 2.5 centimeters) of eyelids, nose, ears, and/or lips	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13152	Repair of wound (2.6 to 7.5 centimeters) of eyelids, nose, ears, and/or lips	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

South Carolina Healthy Connections Adults

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
13153	Repair of wound of eyelids, nose, ears, and/or lips	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
15120	Skin graft of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes (first 100 sq cm or less, or 1% body area of infants and children)	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
15121	Skin graft of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT and/or intraoral photographs, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adults

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20694	Removal of external fixation system	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20902	Bone graft, any donor area; major or large	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adults

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adults

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21034	Excision of Malignant Tumor of Maxilla or Zygoma	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21040	Excision Benign Cyst/Tumor Mandible by Enucleation and or curettage	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21044	Excision of malignant tumor of mandible	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adults

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21047	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21050	Condylectomy, Temporomandibular Joint (Separate Procedure)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21060	Meniscectomy, Partial Or Complete, Temporomandibular Joint (Separate Procedure)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21070	Coronoidectomy (separate procedure)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21076	Impression and custom preparation; surgical obturator prosthesis	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21081	Impression and custom preparation; mandibular resection prosthesis	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21085	Impression and custom preparation of oral surgical splint	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21110	Application Of Interdental Fixation Device For Conditions Other Than Fracture	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21116	Injection Procedure temporomandibular joint arthrography	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21209	Osteoplasty, facial bones; reduction (autograft, allograft, or prosthetic implant)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21210	Graft, Bone; Nasal, Maxillary Or Malar Areas (Includes Obtaining Graft)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21230	Graft; rib cartilage, autogenous, to face, chin, nose, or ear (includes obtaining graft)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21242	Arthroplasty, Temporomandibular Joint, With Allograft	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21243	Arthroplasty, Temporomandibular Joint, With Prosthetic Joint Replacement	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21310	Closed TX of Nasal Bone Fracture-without manipulation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review	Prior Authorization Required	Benefit Limitations	Documentation Required
21315	Closed Treatment Of Nasal Bone Fracture; With Out Stabilization	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21320	Closed treatment of nasal bone fracture; with stabilization	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21325	Open treatment of nasal fracture; uncomplicated	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21330	Open treatment of nasal fracture; complicated with internal and/or external skeletal fixation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21336	Open treatment of nasal septal fracture, with or without stabilization	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21337	Closed treatment of nasal septal fracture, with or without stabilization	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21338	Open treatment of nasoethmoid fracture; without external fixation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21339	Open treatment of nasoethmoid fracture; with external fixation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21340	Treatment of broken eye socket and nasal bones, accessed through the skin	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21344	Open treatment of complicated frontal sinus fracture, via coronal or multiple approaches	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21356	Open treatment of depressed zygomatic arch fracture	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21390	Open treatment of orbital floor blowout fracture; periorbital approach with alloplastic or other implant	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21406	Open treatment of fracture of orbit, except blowout; without implant	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21407	Open treatment of fracture of orbit, except blowout; with implant	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21445	Open treatment of mandibular or maxillary alveolar ridge fracture	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21450	Closed treatment of mandibular fracture; without manipulation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21451	Closed treatment of mandibular fracture; with manipulation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21452	Treatment of broken jaw bone with placement of external hardware, accessed through the skin	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21453	Closed treatment of mandibular fracture with interdental fixation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21454	Open treatment of mandibular fracture with external fixation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21461	Open treatment of mandibular fracture; without interdental fixation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21462	Open treatment of mandibular fracture; with interdental fixation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21465	Open treatment of mandibular condylar fracture	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21485	Closed treatment of temporomandibular dislocation; complicated, initial or subsequent	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21490	Open treatment of temporomandibular dislocation	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21497	Interdental wiring, for condition other than fracture	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
29804	Arthroscopy, temporomandibular joint, surgical	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30906	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31000	Lavage by cannulation; maxillary (antrotomy); intranasal	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31020	Sinusotomy, maxillary (antrotomy); intranasal	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
31032	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31040	Pterygomaxillary fossa surgery	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31500	Intubation, endotracheal, emergency procedure	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31603	Tracheostomy, emergency procedure; transtracheal	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31605	Tracheostomy, emergency procedure; cricothyroid membrane	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40490	Biopsy of lip	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40500	Vermilionectomy (lip shave), with mucosal advancement	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40510	Excision of lip; transverse wedge excision with primary closure	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40520	Excision of lip; V excision with primary direct linear closure	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40525	Excision of lip; full thickness, reconstruction with local flap	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40530	Resection of lip, more than one-fourth, without reconstruction	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40650	Repair lip, full thickness; vermilion only	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40652	Repair lip, full thickness; up to half vertical height	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40654	Repair lip, full thickness; over one-half vertical height, or complex	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40800	Incision of abscess, cyst, or blood accumulation in mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40801	Incision of abscess, cyst, or blood accumulation in mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40808	Biopsy, vestibule of mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40812	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40816	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40818	Excision of mucosa of vestibule of mouth as donor graft	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40831	Closure of laceration, vestibule of mouth; over 2.5 cm or complex	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41000	Drainage of abscess, cyst, or blood accumulation of tongue	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41005	Drainage of abscess, cyst, or blood accumulation under the tongue	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41006	Drainage of abscess, cyst, or blood accumulation under the tongue	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41007	Drainage of abscess, cyst, or blood accumulation under the tongue or lower lip	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41008	Drainage of abscess, cyst, or blood accumulation under the jaw bone	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41009	Drainage of abscess, cyst, or blood accumulation under lower teeth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41015	Drainage of abscess, cyst, or blood accumulation under the tongue	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41016	Drainage of abscess, cyst, or blood accumulation under the tongue or lower lip	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41017	Drainage of abscess, cyst, or blood accumulation under the tongue or jaw bone	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41018	Drainage of abscess, cyst, or blood accumulation under the tongue or lower teeth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41100	Extraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41105	Biopsy of tongue; posterior one-third	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41108	Biopsy of floor of mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41110	Excision of lesion of tongue without closure	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41112	Excision of lesion of tongue with closure; anterior two-thirds	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41113	Excision of lesion of tongue with closure; posterior one-third	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41115	Excision of lingual frenum (frenectomy)	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41116	Excision, lesion of floor of mouth	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41120	Glossectomy; less than one-half tongue	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D,
41251	Repair of laceration 2.5 cm or less; posterior one-third of tongue	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41800	Drainage of abscess, cyst, or blood accumulation of dental bone	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissue	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41806	Removal of embedded foreign body from dentoalveolar structures; bone	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41822	Excision of fibrous tuberosities, dentoalveolar structures	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41823	Excision of osseous tuberosities, dentoalveolar structures	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41827	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41828	Excision of hyperplastic alveolar mucosa, each quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41830	Alveolectomy, including curettage of osteitis or sequestrectomy	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41850	Destruction of lesion (except excision), dentoalveolar structures	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41874	Alveoplasty each quadrant (specify)	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42100	Biopsy of palate, uvula	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
42104	Excision, lesion of palate, uvula; without closure	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42106	Excision, lesion of palate, uvula; with simple primary closure	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42120	Resection of palate or extensive resection of lesion	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that would support the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42140	Uvulectomy, excision of uvula	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42180	Repair, laceration of palate; up to 2 cm	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42182	Repair, laceration of palate; over 2 cm or complex	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
42200	Palatoplasty for cleft palate, soft and/or hard palate only	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42215	Palatoplasty for cleft palate; major revision	21 and older		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42220	Palatoplasty for cleft palate; secondary lengthening procedure	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
42235	Repair of anterior palate, including vomer flap	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42260	Repair of nasolabial fistula	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42300	Drainage of abscess; parotid, simple	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42305	Drainage of abscess; parotid, complicated	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42310	Drainage of abscess; submaxillary of sublingual, intraoral	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42320	Drainage of abscess; submaxillary external	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
42340	Sialolithotomy; parotid, extraoral or complicated intraoral	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42408	Excision of sublingual salivary cyst (ranula)	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42409	Marsupialization of sublingual salivary cyst (ranula)	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42440	Excision of submandibular (submaxillary) gland	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
42450	Excision of sublingual gland	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42505	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42550	Injection procedure for sialography	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42650	Dilation salivary duct	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
64722	Decompression, unspecified nerve(s)	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
64774	Excision of neuroma of cutaneous nerve	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
64788	Excision of neurofibroma or neurolemmoma of cutaneous nerve	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
67930	Suture of partial thickness wound of eyelid with direct closure of lid margin	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
67935	Suture of full thickness wound of eyelid	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
88160	Cytopathology, smears, any other source; screening and interpretation	21 and older		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
88300	Pathology examination of tissue using a microscope, limited examination	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88302	Level II surgical pathology-- gross and microscopic examination	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
88304	Pathology examination of tissue using a microscope, moderately low complexity	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88305	Pathology examination of tissue using a microscope, intermediate complexity	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88307	Pathology examination of tissue using a microscope, moderately high complexity	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88309	Pathology examination of tissue using a microscope, high complexity	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88311	Decalcification procedure (List separately in addition to code for surgical pathology examination)	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88312	Special Stains	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99201	New patient office or other outpatient visit, typically 10 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99202	New patient office or other outpatient visit, typically 20 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99203	New patient office or other outpatient visit, typically 30 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99204	New patient office or other outpatient visit, typically 45 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99205	New patient office or other outpatient visit, typically 60 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99211	Established patient office or other outpatient visit, typically 5 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99212	Established patient office or other outpatient visit, typically 10 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99213	Established patient office or other outpatient visit, typically 15 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99214	Established patient office or other outpatient, visit typically 25 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99215	Established patient office or other outpatient, visit typically 40 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99217	Hospital observation care on day of discharge	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99218	Hospital observation care, typically 30 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99219	Hospital observation care, typically 50 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99220	Hospital observation care, typically 70 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99221	Initial hospital inpatient care, typically 30 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99222	Initial hospital inpatient care, typically 50 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99223	Initial hospital inpatient care, typically 70 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99231	Subsequent hospital inpatient care, typically 15 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99232	Subsequent hospital inpatient care, typically 25 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99233	Subsequent hospital inpatient care, typically 35 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99234	Hospital observation or inpatient care low severity, 40 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99235	Hospital observation or inpatient care moderate severity, 50 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99236	Hospital observation or inpatient care high severity, 55 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99238	Hospital discharge day management, 30 minutes or less	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99239	Hospital discharge day management, more than 30 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99241	Patient office consultation, typically 15 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99242	Patient office consultation, typically 30 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99243	Patient office consultation, typically 40 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99244	Patient office consultation, typically 60 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99245	Patient office consultation, typically 80 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99251	Inpatient hospital consultation, typically 20 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99252	Inpatient hospital consultation, typically 40 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99253	Inpatient hospital consultation, typically 55 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99254	Inpatient hospital consultation, typically 80 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99255	Inpatient hospital consultation, typically 110 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99281	Emergency department visit, self -limited or minor problem	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99282	Emergency department visit, low to moderately severe problem	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99283	Emergency department visit, moderately severe problem	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99284	Emergency department visit, problem of high severity	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99285	Emergency department visit, problem with significant threat to life or function	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99291	Critical care delivery critically ill or injured patient, first 30-74 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99292	E/M critical care service each 30 minutes beyond 1 hour	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99304	Initial nursing facility visit, typically 25 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99305	Initial nursing facility visit, typically 35 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99306	Initial nursing facility visit, typically 45 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99307	Subsequent nursing facility visit, typically 10 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99308	Subsequent nursing facility visit, typically 15 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99309	Subsequent nursing facility visit, typically 25 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99310	Subsequent nursing facility visit, typically 35 minutes per day	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99324	New patient assisted living visit, typically 20 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99325	New patient assisted living visit, typically 30 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99326	New patient assisted living visit, typically 45 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99327	New patient assisted living visit, typically 60 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99328	New patient assisted living visit, typically 75 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99334	Established patient assisted living visit, typically 15 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99335	Established patient assisted living visit, typically 25 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99336	Established patient assisted living visit, typically 40 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99337	Established patient assisted living visit, typically 60 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections Adult

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**Exhibit B Benefits Covered for  
South Carolina Healthy Connections Adult**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99341	New patient home visit, typically 20 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99342	New patient home visit, typically 30 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"
99343	New patient home visit, typically 45 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"
99344	New patient home visit, typically 60 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"
99345	New patient home visit, typically 75 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"
99347	Established patient home visit, typically 15 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"
99348	Established patient home visit, typically 25 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"
99349	Established patient home visit, typically 40 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"
99350	Established patient home visit, typically 60 minutes	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"
99441	Physician telephone patient service, 5-10 minutes of medical discussion	21 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records"

South Carolina Healthy Connections Adult

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South Carolina Healthy Connections ID RD Waiver Enrollees**

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 fee for the diagnostic dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

A medically necessary problem-focused exam (D0140) is only allowed with diagnostic services and/ or non-planned treatment services that address the reason for the exam. The placement of dental sealants is also allowable on the same date of service as the medically necessary problem-focused exam (D0140), however there must be documentation of medical necessity justifying the exam. A problem-focused exam for the sole purpose of placing dental sealants is NOT allowed.

The maximum amount paid for individual or sets of radiographs taken on the same day will be limited to the allowance for a full mouth series. When individual or sets of radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if South Carolina Department of Health and Human Services (SCDHHS) determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Radiographs that do not fit the policy description will not be reimbursed for, or if already paid for, SCDHHS will recoup the funds previously paid.

SCDHHS utilizes the guidelines published by the U.S. Department of Health and Human Services (DHHS), Center for Devices and Radiological Health (CDRH). However, please consult the following benefit tables for benefit limitations.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances

Diagnostic							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	All ages		No	No	One of (D0120, D0145) Per 6 months per Patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
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Diagnostic							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D0140	limited oral evaluation-problem focused	All ages		No	No	Two of (D0140) per 12 Month(s) Per Provider OR Location.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	No	One of (D0120, D0145) per 6 Month(s) Per Provider OR Location	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0150	comprehensive oral evaluation - new or established patient	3 and older		No	No	One of (D0150) per 36 Month(s) Per Provider OR Location. Not allowed within 6 months of D0120 or D0145 for Same Provider OR Location	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0210	intraoral - complete series of radiographic images	2 and older		No	No	One of (D0210, D0330) per 36 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0220	intraoral - periapical first radiographic image	All ages		No	No	One of (D0220) per 1 Day(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0230	intraoral - periapical each additional radiographic image	All ages		No	No	Three of (D0230) per 1 Day(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0240	intraoral - occlusal radiographic image	All ages		No	No	Two of (D0240) per 12 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
D0270	bitewing - single radiographic image	All ages		No	No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D0272	bitewings - two radiographic images	All ages		No	No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D0274	bitewings - four radiographic images	All ages		No	No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D0330	panoramic radiographic image	6 and older		No	No	One of (D0210, D0330) per 36 Month(s) Per patient. For members age 6 through 20, oral surgeons are allowed one additional usage of D0330 per beneficiary within the 36 month period.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

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Reimbursement fee for the preventive dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative. Billing and reimbursement for space maintainers shall be based on cementation or insertion date.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Preventative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	12 and older		No	No	One of (D1110, D1120) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1120	prophylaxis - child	0-11		No	No	One of (D1110, D1120) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1206	topical application of fluoride varnish	All ages		No	No	One of (D1206, D1208) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1208	Topical application of fluoride - excluding varnish	All ages		No	No	One of (D1206, D1208) per 6 Month(s) Per patient.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1351	sealant - per tooth	5-14	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One (D1351 per 36 Month(s) Per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1510	space maintainer-fixed-unilateral. (excludes a distal shoe space maintainer)	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1510, D1516, D1517) per lifetime per patient per quadrant.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1516	Space maintainer- fixed bilateral, maxillary	0-20		No	No	One D1516 per lifetime per patient	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D1517	Space maintainer- fixed bilateral, mandibular	0-20		No	No	One D1517 per lifetime per patient	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

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Reimbursement fee for the restorative procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, polishing, supplies, trays, equipment, topical/local anesthesia and post-operative care up to 30 days from the date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

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. Additionally, reimbursement for a tooth restored within a 12 month timeframe after the placement of a dental sealant or a restoration by the same provider or provider location is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	All ages	Teeth 1 – 32; A - T	No	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2150	Amalgam - two surfaces, primary or permanent	All ages	Teeth 1 - 32; A - T	No	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2160	amalgam - three surfaces, primary or permanent	All ages	Teeth 1 - 32; A - T	No	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2161	amalgam - four or more surfaces, primary or permanent	All ages	Teeth 1 - 32; A - T	No	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2330	resin-based composite - one surface, anterior	All ages	Teeth 6 - 11; 22 - 27; C - H; M - R	No	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2331	resin-based composite - two surfaces, anterior	All ages	Teeth 6 - 11; 22 - 27; C - H; M - R	No	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2332	resin-based composite - three surfaces, anterior	All ages	Teeth 6 - 11; 22 - 27; C - H; M - R	No	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	All ages	Teeth 6 - 11; 22 - 27; C - H; M - R	No	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2391	resin-based composite - one surface, posterior	All ages	Teeth 1 - 5; 12 - 21; 28 - 32; A; B; I - L; S- T	No	No	One of (D2140, D2330, D2391) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2392	resin-based composite - two surfaces, posterior	All ages	Teeth 1 - 5; 12 - 21; 28 - 32; A- B; I - L; S- T	No	No	One of (D2150, D2331, D2392) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2393	resin-based composite - three surfaces, posterior	All ages	Teeth 1 - 5; 12 - 21; 28 - 32; A- B; I - L; S- T	No	No	One of (D2160, D2332, D2393) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
D2394	resin-based composite - four or more surfaces, posterior	All ages	Teeth 1 - 5; 12 - 21; 28 - 32; A- B; I - L; S- T	No	No	One of (D2161, D2335, D2394) per 36 Month(s) Per Provider OR Location per tooth, per surface.	Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

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Restorative							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2929	prefabricated porcelain/ceramic crown – primary tooth	All ages	Teeth C - H, M - R	No	No	One of (D2929, D2930, D2932, D2934) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records".
D2930	prefabricated stainless steel crown - primary tooth	All ages	Teeth A - T	No	No	One of (D2929, D2930, D2932, D2934) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records".
D2931	prefabricated stainless steel crown-permanent tooth	All ages	Teeth 1 - 32	No	No	One of (D2931, D2932) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy AND Appendix D, Section D-2:"Dental Treatment Records".
D2932	prefabricated resin crown	All ages	Teeth 1 - 32, A - T	No	No	One of (D2929, D2930, D2931, D2932, D2934) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	All ages	Teeth C - H, M - R	No	No	One of (D2929, D2930, D2932, D2934) per 36 months per patient per tooth	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records".
D2940	protective restoration	All ages	Teeth 1 - 32, A - T	No	No	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.	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.02 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records".
D2950	core buildup, including any pins when required	All ages	Teeth 1 - 32	No	No	One of (D2950, D2954) per lifetime per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix C "Clinical Criteria" and Appendix D, Section D-2:"Dental Treatment Records".
D2951	pin retention - per tooth, in addition to restoration	All ages	Teeth 1 - 32	No	No	One (D2951) per lifetime per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix C "Clinical Criteria" and Appendix D, Section D-2:"Dental Treatment Records".
D2954	prefabricated post and core in addition to crown	All ages	Teeth 1 - 32	No	No	One of (D2950, D2954) per lifetime per patient per tooth.	Proper documentation must be maintained in patient's records. Refer to Appendix C "Clinical Criteria" and Appendix D, Section D-2:"Dental Treatment Records".

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Reimbursement fee for the endodontic procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: extirpation treatment, temporary fillings, filling and obturation of root canals; progress radiographs and a completed fill radiograph; supplies, materials, trays, equipment; topical/ local anesthesia and post-operative care up to 30 days from the date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

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 SCDHHS's treatment standards, SCDHHS 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 Dental Consultant.

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.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. . Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Endodontics							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentino-cemental junction and application of medicament	All ages	Teeth 2 - 15, 18 - 31, A - T	No	No	One D3220 per lifetime per patient per tooth. Not allowed in conjunction with One of (D3310, D3320, 3330) on the same tooth, on the same day.	Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.03 "Clinical Criteria" and Appendix D, Section D-2:"Dental Treatment Records".

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Endodontics							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	All ages	Teeth 6 - 11, 22 - 27	Yes	No	One D3310 per lifetime per patient per tooth.  Not allowed in conjunction with D3220 on the same tooth on the same day.	Detailed narrative of medical necessity and pre-op x-ray(s) must be submitted with the claim for review. Refer to Appendix C, Section C.03 "Clinical Criteria" Policy.  Proper documentation and post-treatment radiographs must be maintained in patient's records ( Refer to Appendix D, Section D-2:"Dental Treatment Records")
D3320	endodontic therapy, premolar tooth (excluding final restoration)	All ages	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One D3310 per lifetime per patient per tooth.  Not allowed in conjunction with D3220 on the same tooth on the same day	Detailed narrative of medical necessity and pre-op x-ray(s) must be submitted with the claim for review. Refer to Appendix C, Section C.03 "Clinical Criteria" Policy.  Proper documentation and post-treatment radiographs must be maintained in patient's records ( Refer to Appendix D, Section D-2:"Dental Treatment Records")
D3330	endodontic therapy, molar tooth (excluding final restoration)	All ages	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	No	One D3330 per lifetime per patient per tooth.  Not allowed in conjunction with D3220 on the same tooth on the same day	Detailed narrative of medical necessity and pre-op x-ray(s) must be submitted with the claim for review. Refer to Appendix C, Section C.03 "Clinical Criteria" Policy.  Proper documentation and post-treatment radiographs must be maintained in patient's records ( Refer to Appendix D, Section D-2:"Dental Treatment Records")

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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. Partial dentures are not a covered benefit when 8 or more posterior teeth are in occlusion. Partial dentures not allowed for closing a space gap without missing teeth.

Reimbursement fee for the prosthodontic procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: impressions, try-in appointments, delivery; materials, supplies, trays, equipment, topical or local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

**SCDHHS will NOT reimburse for full or partial dentures 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.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Prosthodontics, removable							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	14 and older		Yes	No	One D5110 per 60 Month(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

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Prosthodontics, removable							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5120	complete denture - mandibular	14 and older		Yes	No	One D5120 per 60 Month(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D5211	maxillary partial denture - resin base (including, retentive / clasping materials, rests and teeth)	14 and older		Yes	No	One D5211 per 60 Month(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D5212	mandibular partial denture - resin base (including retentive/ clasping materials, rests and teeth)	14 and older		Yes	No	One D5212 per 60 Month(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D5511	Repair broken complete denture base, mandibular	14 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5512	Repair broken complete denture base, mandibular	14 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5520	replace missing or broken teeth - complete denture (each tooth)	14 and older	Teeth 1 - 32	No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5611	Repair resin partial denture base, mandibular	14 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5612	Repair resin partial denture base, mandibular	14 and older		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"
D5640	replace broken teeth-per tooth	14 and older	Teeth 1 - 32	No	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, Section C.05 "Clinical Criteria" Policy and Appendix D, Section D-2:"Dental Treatment Records"

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Reimbursement fee for the surgical procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/ local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

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

Biopsy of Oral Tissue (code D7285 & D7286) is not billable with another surgical procedure that is part of the same procedure.

Reimbursement for a tooth extracted within a 12 month timeframe after the placement of a dental sealant or restoration by the same provider or provider location, is subject to payment adjustment based on the initial service. SCDHHS will not reimburse for the removal of primary teeth whose exfoliation is imminent

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorization requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7111	extraction, coronal remnants - primary tooth	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	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, "Clinical Criteria" and Appendix D, Section D-2 "Dental Treatment Records".
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	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	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, "Clinical Criteria" and Appendix D, Section D-2 "Dental Treatment Records".

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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7210	extraction, 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	No		Proper documentation must be maintained in patient's records. Refer to Appendix C, "Clinical Criteria" and Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
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	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")
D7250	removal of residual tooth roots (cutting procedure)	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	No	Not allowed by same office or provider who performed original extraction.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2 "Dental Treatment Records")

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**Exhibit C Benefits Covered for  
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Oral and Maxillofacial Surgery							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	All ages	Teeth 1 - 32	Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7280	exposure of an unerupted tooth	All ages	Teeth 1 - 32	Yes	No	Two D7280 per 1 Day(s) Per patient. Not allowed with extraction codes.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs or CT, must be submitted with the claim for review. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7286	incisional biopsy of oral tissue-soft	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7410	excision - lesion up to 1.25cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7411	excision of benign lesion greater than 1.25 cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7412	excision of benign lesion, complicated	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

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**Exhibit C Benefits Covered for  
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Oral and Maxillofacial Surgery							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7413	excision of malignant lesion up to 1.25 cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7414	excision of malignant lesion greater than 1.25 cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7415	excision of malignant lesion, complicated	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

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**Exhibit C Benefits Covered for  
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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7465	destruction of lesion(s) by physical or chemical method, by report	All ages		Yes	No		Detailed narrative of medical necessity and pathology report must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
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	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

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Oral and Maxillofacial Surgery							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7520	incision and drainage of abscess - extraoral soft tissue	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	All ages		Yes	No	One D7530 per 1 Day(s) Per patient.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Not to be billed for treatment of dry socket.	Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7670	alveolus stabilization of teeth, closed reduction splinting	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7671	alveolus - open reduction, may include stabilization of teeth	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

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**Exhibit C Benefits Covered for  
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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7770	Alveolus-open reduction stabilization of teeth. Incision required to reduce fracture	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7771	Alveolus-closed reduction stabilization of teeth	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7910	suture small wounds up to 5 cm	All ages		Yes	No	Excludes closure of surgical incision.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7911	complicated suture-up to 5 cm	All ages		Yes	No	Excludes closure of surgical incision.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")
D7912	complex suture - greater than 5cm	All ages		Yes	No	Excludes closure of surgical incision.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records")

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Reimbursement fee for the adjunctive procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays, equipment, topical or local anesthesia. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Reimbursement for moderate or deep sedation/ general anesthesia administered in dental offices will be limited to only those providers that have a valid dental sedation permit from the State Board of Dentistry, a copy of which is on file with DentaQuest.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Claims filed for adjunctive services must also include the procedure code(s) rendered in conjunction with the adjunctive service(s). Adjunctive services will be considered for review and reimbursement only when accompanied by a covered service or by an approved EPSDT service and when the medical necessity for the service is established through supporting documentation (Refer to documents required and clinical criteria for each specific procedure/ procedure category).

All dental sedation services administered in the office must be performed by an authorized provider to assure appropriate monitoring of the beneficiary. The administration of sedation and/or anesthesia by or under the direction of an authorized dental provider shall be performed in accordance with the state laws and regulations, applicable guidelines approved by the authorizing agency that regulates the practice of dentistry in the state, including but not limited to, current American Dental Association (ADA) "Guidelines for the Use of Sedation and General Anesthesia by Dentists" ; and the joint American Academy of Pediatric Dentistry (AAPD) and American Academy of Pediatrics (AAP) Pediatrics "Guidelines for Monitoring and management of pediatric patients before, during and after sedation for diagnostic and therapeutic procedures."

The rendering dental provider is solely responsible for the administration and management of sedation and/or anesthesia in the practice of dentistry, including but not limited to ordering, supplying, and prescribing medications used in the sedation procedure, and must determine which of the guidelines, as referenced above, he or she shall operate under, and shall be responsible for complying with the same, as provided above.

Providers must comply with the South Carolina 2014 Dental Sedation Act 222 (S.C. Code of Laws 40-15-450) requirements for patient's record keeping. SCDHHS also requires that both the authorized office location and administering provider must be clearly documented in the patient's record. If there is no sedation documentation in the treatment record that meets these requirements for a billed service, then the service is subject to recoupment by SCDHHS.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment Review 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

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**Exhibit C Benefits Covered for  
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**Adjunctive General Services**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9222	deep sedation/general anesthesia – first 15 minutes	All ages		Yes	No	Allowed 1 unit of D9222 per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”). A valid dental sedation permit must be on file with DentaQuest.
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	All ages		Yes	No	Allowed 1 unit of D9223 per 1 Day(s) Per patient. Allowed with D9222 only. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”). A valid dental sedation permit must be on file with DentaQuest.
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	All ages		No	No	One D9230 per 1 Day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9239, D9243, or D9920.	Proper documentation must be maintained in patient’s records. Refer to Appendix C, “Clinical Criteria” and Appendix D, Section D-2 “Dental Treatment Records”.
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	All ages		Yes	No	Allowed 1 unit of D9239 per 1 Day(s) Per patient. Not allowed in conjunction with D9222. D9223, D9230, D9248 or D9920.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”). A valid dental sedation permit must be on file with DentaQuest.
D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	All ages		Yes	No	Allowed 1 unit of D9243 per 1 Day(s) Per patient. Allowed with D9239 only. Not allowed in conjunction with D9222, D9223, D9230, D9248 or D9920.	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C “Clinical Criteria” Policy. Proper documentation must be maintained in patient’s records (Appendix D, Section D-2:”Dental Treatment Records”). A valid dental sedation permit must be on file with DentaQuest.
D9248	non-intravenous moderate (conscious) sedation	All ages		No	No	One D9248 per 1 Day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9239, D9243, or D9920.	Proper documentation must be maintained in patient’s records. Refer to Appendix C, “Clinical Criteria” and Appendix D, Section D-2 “Dental Treatment Records”.

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**Exhibit C Benefits Covered for  
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**Adjunctive General Services**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9420	hospital or ambulatory surgical center call	All ages		No	Yes	One D9420 per 1 Day(s) Per patient. May be billed when rendering prior approved treatment in an outpatient operating room or ASC. SCDHHS prohibits the billing of beneficiaries to schedule appointments or to hold appointment blocks prior to treatment in a hospital or ambulatory center setting.	Detailed narrative of medical necessity must be submitted for prior authorization. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that would support medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D9920	behavior management, by report	All ages		Yes	No	One 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. Not allowed in conjunction with D9222, D9223, D9230, D9239, D9243, or D9248	Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
D9999	unspecified adjunctive procedure, by report	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary documentation that supports the medical necessity. Refer to Appendix C "Clinical Criteria" Policy. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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Reimbursement fee for the medical procedure performed by an oral surgeon includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/ local anesthesia and post-operative care up to 30 days from date of service, None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Covered dental and medical services that indicate "Yes" in the "Pre-Payment Review Required" or "Prior Authorization Required" columns require documentation of medical necessity. Please refer to Appendix A-1:"General Definitions" for the definition of Medically Necessary. Procedures that require Pre-Payment 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.

Planned, non-emergent dental services delivered in an Outpatient Operating Room (OR) or Ambulatory Surgical Center (ASC) must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR / ASC. The Authorization request for the use of the ASC/ OR facility will be considered for review only when accompanied by a covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment. Refer to Section 3.03 of the Dental ORM.

Any reimbursement already made for an inadequate service may be recouped after the Dental Consultant reviews the circumstances.

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
11900	Intralesional injection	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12011	Repair of wound (2.5 centimeters or less) of the face, ears, eyelids, nose, lips, and/or mucous membranes	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12013	Repair of wound (2.6 to 5.0 centimeters) of the face, ears, eyelids, nose, lips, and/or mucous membranes	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12014	Repair of wound (5.1 to 7.5 centimeters) of the face, ears, eyelids, nose, lips, and/or mucous membranes	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
12015	Repair of wound (7.6 to 12.5 centimeters) of the face, ears, eyelids, nose, lips, and/or mucous membranes	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12020	Treatment of superficial wound dehiscence; simple closure	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12051	Repair of wound (2.5 centimeters or less) of face, ears, eyelids, nose, lips, and/or mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12052	Repair of wound (2.6 to 5.0 centimeters) of face, ears, eyelids, nose, lips, and/or mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12053	Repair of wound (5.1 to 7.5 centimeters) of face, ears, eyelids, nose, lips, and/or mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
12054	Repair of wound (7.6 to 12.5 centimeters) of face, ears, eyelids, nose, lips, and/or mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
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**Medical**

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12055	Repair of wound (12.6 to 20.0 centimeters) of face, ears, eyelids, nose, lips, and/or mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13131	Repair of wound (1.1 to 2.5 centimeters) of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13132	Repair of wound (2.6 to 7.5 centimeters) of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13133	Repair of wound of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13151	Repair of wound (1.1 to 2.5 centimeters) of eyelids, nose, ears, and/or lips	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
13152	Repair of wound (2.6 to 7.5 centimeters) of eyelids, nose, ears, and/or lips	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
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**Medical**

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13153	Repair of wound of eyelids, nose, ears, and/or lips	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
15120	Skin graft of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes (first 100 sq cm or less, or 1% body area of infants and children)	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
15121	Skin graft of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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Medical							
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20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20694	Removal of external fixation system	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
20902	Bone graft, any donor area; major or large	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT and/or intraoral photographs, must be submitted with the claim for review.  Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
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**Medical**

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21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21031	Excision of Torus Mandibularis	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT photographs, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Medical**

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21032	Excision of Maxillary Torus Palatinus	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21034	Excision of Malignant Tumor of Maxilla or Zygoma	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21040	Excision Benign Cyst/Tumor Mandible by Enucleation and or curettage	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21044	Excision of malignant tumor of mandible	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Medical**

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21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21047	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21050	Condylectomy, Temporomandibular Joint (Separate Procedure)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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Medical							
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21060	Meniscectomy, Partial Or Complete, Temporomandibular Joint (Separate Procedure)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21070	Coronoidectomy (separate procedure)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21076	Impression and custom preparation; surgical obturator prosthesis	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21081	Impression and custom preparation; mandibular resection prosthesis	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21085	Impression and custom preparation of oral surgical splint	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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Medical							
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21110	Application Of Interdental Fixation Device For Conditions Other Than Fracture	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21116	Injection Procedure temporomandibular joint arthrography	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21209	Osteoplasty, facial bones; reduction (autograft, allograft, or prosthetic implant)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21210	Graft, Bone; Nasal, Maxillary Or Malar Areas (Includes Obtaining Graft)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21230	Graft; rib cartilage, autogenous, to face, chin, nose, or ear (includes obtaining graft)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
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Medical							
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21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21242	Arthroplasty, Temporomandibular Joint, With Allograft	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21243	Arthroplasty, Temporomandibular Joint, With Prosthetic Joint Replacement	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21310	Closed TX of Nasal Bone Fracture-without manipulation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

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21315	Closed Treatment Of Nasal Bone Fracture; With Out Stabilization	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21320	Closed treatment of nasal bone fracture; with stabilization	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21325	Open treatment of nasal fracture; uncomplicated	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21330	Open treatment of nasal fracture; complicated with internal and/or external skeletal fixation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21336	Open treatment of nasal septal fracture, with or without stabilization	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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21337	Closed treatment of nasal septal fracture, with or without stabilization	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21338	Open treatment of nasoethmoid fracture; without external fixation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21339	Open treatment of nasoethmoid fracture; with external fixation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21340	Treatment of broken eye socket and nasal bones, accessed through the skin	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21344	Open treatment of complicated frontal sinus fracture, via coronal or multiple approaches	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
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21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21356	Open treatment of depressed zygomatic arch fracture	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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Medical							
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21390	Open treatment of orbital floor blowout fracture; periorbital approach with alloplastic or other implant	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21401	Closed treatment of fracture of orbit, except blowout; with manipulation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21406	Open treatment of fracture of orbit, except blowout; without implant	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21407	Open treatment of fracture of orbit, except blowout; with implant	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21445	Open treatment of mandibular or maxillary alveolar ridge fracture	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21450	Closed treatment of mandibular fracture; without manipulation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21451	Closed treatment of mandibular fracture; with manipulation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21452	Treatment of broken jaw bone with placement of external hardware, accessed through the skin	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21453	Closed treatment of mandibular fracture with interdental fixation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21454	Open treatment of mandibular fracture with external fixation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21461	Open treatment of mandibular fracture; without interdental fixation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21462	Open treatment of mandibular fracture; with interdental fixation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21465	Open treatment of mandibular condylar fracture	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21485	Closed treatment of temporomandibular dislocation; complicated, initial or subsequent	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21490	Open treatment of temporomandibular dislocation	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
21497	Interdental wiring, for condition other than fracture	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
29804	Arthroscopy, temporomandibular joint, surgical	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
30906	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31000	Lavage by cannulation; maxillary (antrotomy); intranasal	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31020	Sinusotomy, maxillary (antrotomy); intranasal	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
31032	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31040	Pterygomaxillary fossa surgery	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31500	Intubation, endotracheal, emergency procedure	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31603	Tracheostomy, emergency procedure; transtracheal	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
31605	Tracheostomy, emergency procedure; cricothyroid membrane	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40490	Biopsy of lip	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40500	Vermilionectomy (lip shave), with mucosal advancement	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40510	Excision of lip; transverse wedge excision with primary closure	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40520	Excision of lip; V excision with primary direct linear closure	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40525	Excision of lip; full thickness, reconstruction with local flap	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40530	Resection of lip, more than one-fourth, without reconstruction	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40650	Repair lip, full thickness; vermilion only	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40652	Repair lip, full thickness; up to half vertical height	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40654	Repair lip, full thickness; over one-half vertical height, or complex	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	0-20		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
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	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40800	Incision of abscess, cyst, or blood accumulation in mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40801	Incision of abscess, cyst, or blood accumulation in mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40808	Biopsy, vestibule of mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40812	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40816	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40818	Excision of mucosa of vestibule of mouth as donor graft	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40819	Excision of frenum, labial or buccal (frenulectomy, frenulectomy, frenectomy)	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
40831	Closure of laceration, vestibule of mouth; over 2.5 cm or complex	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41000	Drainage of abscess, cyst, or blood accumulation of tongue	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41005	Drainage of abscess, cyst, or blood accumulation under the tongue	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41006	Drainage of abscess, cyst, or blood accumulation under the tongue	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41007	Drainage of abscess, cyst, or blood accumulation under the tongue or lower lip	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41008	Drainage of abscess, cyst, or blood accumulation under the jaw bone	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41009	Drainage of abscess, cyst, or blood accumulation under lower teeth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41015	Drainage of abscess, cyst, or blood accumulation under the tongue	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41016	Drainage of abscess, cyst, or blood accumulation under the tongue or lower lip	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41017	Drainage of abscess, cyst, or blood accumulation under the tongue or jaw bone	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41018	Drainage of abscess, cyst, or blood accumulation under the tongue or lower teeth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41100	Extraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary pre-operative diagnostic images such as radiographs, CT, photographs and any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41105	Biopsy of tongue; posterior one-third	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41108	Biopsy of floor of mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41110	Excision of lesion of tongue without closure	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41112	Excision of lesion of tongue with closure; anterior two-thirds	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41113	Excision of lesion of tongue with closure; posterior one-third	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41115	Excision of lingual frenum (frenectomy)	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41116	Excision, lesion of floor of mouth	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

South Carolina Healthy Connections ID RD Waiver Enrollees

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SC Healthy Connections ORM January 1, 2019

Page 299 of 317

**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41120	Glossectomy; less than one-half tongue	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41251	Repair of laceration 2.5 cm or less; posterior one-third of tongue	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41800	Drainage of abscess, cyst, or blood accumulation of dental bone	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissue	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
41806	Removal of embedded foreign body from dentoalveolar structures; bone	All ages		Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT and/or intraoral photographs, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41822	Excision of fibrous tuberosities, dentoalveolar structures	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT and/or intraoral photographs, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41823	Excision of osseous tuberosities, dentoalveolar structures	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity and pre-operative diagnostic images such as radiographs, CT and/or intraoral photographs, must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

**Medical**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
41827	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41828	Excision of hyperplastic alveolar mucosa, each quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41830	Alveolectomy, including curettage of osteitis or sequestrectomy	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41850	Destruction of lesion (except excision), dentoalveolar structures	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
41874	Alveoplasty each quadrant (specify)	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42100	Biopsy of palate, uvula	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

**Medical**

<b>Code</b>	<b>Brief Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Pre-payment Review Required</b>	<b>Prior Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
42104	Excision, lesion of palate, uvula; without closure	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42106	Excision, lesion of palate, uvula; with simple primary closure	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42120	Resection of palate or extensive resection of lesion	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pathology report, pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42140	Uvulectomy, excision of uvula	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42180	Repair, laceration of palate; up to 2 cm	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42182	Repair, laceration of palate; over 2 cm or complex	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
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42200	Palatoplasty for cleft palate, soft and/or hard palate only	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42215	Palatoplasty for cleft palate; major revision	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42220	Palatoplasty for cleft palate; secondary lengthening procedure	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity such as pre-operative diagnostic images (radiographs, CT, intraoral photographs). Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
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Medical							
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42235	Repair of anterior palate, including vomer flap	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42260	Repair of nasolabial fistula	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42300	Drainage of abscess; parotid, simple	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42305	Drainage of abscess; parotid, complicated	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42310	Drainage of abscess; submaxillary of sublingual, intraoral	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42320	Drainage of abscess; submaxillary external	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
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Medical							
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42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42340	Sialolithotomy; parotid, extraoral or complicated intraoral	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42408	Excision of sublingual salivary cyst (ranula)	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42409	Marsupialization of sublingual salivary cyst (ranula)	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42440	Excision of submandibular (submaxillary) gland	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity.  Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
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Medical							
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42450	Excision of sublingual gland	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42505	Plastic repair of salivary duct, sialodochoplasty; secondary or complicated	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42550	Injection procedure for sialography	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42650	Dilation salivary duct	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42720	Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
42725	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").

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**Exhibit C Benefits Covered for  
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Medical							
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64722	Decompression , unspecified nerve(s)	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
64774	Excision of neuroma of cutaneous nerve	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
64788	Excision of neurofibroma or neurolemmoma of cutaneous nerve	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
67930	Suture of partial thickness wound of eyelid with direct closure of lid margin	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
67935	Suture of full thickness wound of eyelid	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
88160	Cytopathology, smears, any other source; screening and interpretation	All ages		Yes	No		Detailed narrative of medical necessity must be submitted with the claim for review. Please include as necessary any documentation that supports the medical necessity. Proper documentation must be maintained in patient's records (Appendix D, Section D-2:"Dental Treatment Records").
88300	Pathology examination of tissue using a microscope, limited examination	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88302	Level II surgical pathology--gross and microscopic examination	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
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88304	Pathology examination of tissue using a microscope, moderately low complexity	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88305	Pathology examination of tissue using a microscope, intermediate complexity	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88307	Pathology examination of tissue using a microscope, moderately high complexity	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88309	Pathology examination of tissue using a microscope, high complexity	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88311	Decalcification procedure (List separately in addition to code for surgical pathology examination)	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
88312	Special Stains	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99201	New patient office or other outpatient visit, typically 10 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99202	New patient office or other outpatient visit, typically 20 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99203	New patient office or other outpatient visit, typically 30 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
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99204	New patient office or other outpatient visit, typically 45 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99205	New patient office or other outpatient visit, typically 60 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99211	Established patient office or other outpatient visit, typically 5 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99212	Established patient office or other outpatient visit, typically 10 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99213	Established patient office or other outpatient visit, typically 15 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99214	Established patient office or other outpatient, visit typically 25 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99215	Established patient office or other outpatient, visit typically 40 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
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99217	Hospital observation care on day of discharge	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99218	Hospital observation care, typically 30 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99219	Hospital observation care, typically 50 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99220	Hospital observation care, typically 70 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99221	Initial hospital inpatient care, typically 30 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99222	Initial hospital inpatient care, typically 50 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99223	Initial hospital inpatient care, typically 70 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99231	Subsequent hospital inpatient care, typically 15 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99232	Subsequent hospital inpatient care, typically 25 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99233	Subsequent hospital inpatient care, typically 35 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

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**Exhibit C Benefits Covered for  
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Medical							
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99234	Hospital observation or inpatient care low severity, 40 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99235	Hospital observation or inpatient care moderate severity, 50 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99236	Hospital observation or inpatient care high severity, 55 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99238	Hospital discharge day management, 30 minutes or less	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99239	Hospital discharge day management, more than 30 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99241	Patient office consultation, typically 15 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99242	Patient office consultation, typically 30 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99243	Patient office consultation, typically 40 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99244	Patient office consultation, typically 60 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99245	Patient office consultation, typically 80 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

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South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99251	Inpatient hospital consultation, typically 20 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99252	Inpatient hospital consultation, typically 40 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99253	Inpatient hospital consultation, typically 55 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99254	Inpatient hospital consultation, typically 80 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99255	Inpatient hospital consultation, typically 110 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections ID RD Waiver Enrollees

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**Exhibit C Benefits Covered for  
South Carolina Healthy Connections ID RD Waiver Enrollees**

Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99281	Emergency department visit, self- limited or minor problem	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99282	Emergency department visit, low to moderately severe problem	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99283	Emergency department visit, moderately severe problem	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99284	Emergency department visit, problem of high severity	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99285	Emergency department visit, problem with significant threat to life or function	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99291	Critical care delivery critically ill or injured patient, first 30-74 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99292	E/M critical care service each 30 minutes beyond 1 hour	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections ID RD Waiver Enrollees

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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99304	Initial nursing facility visit, typically 25 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99305	Initial nursing facility visit, typically 35 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99306	Initial nursing facility visit, typically 45 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99307	Subsequent nursing facility visit, typically 10 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99308	Subsequent nursing facility visit, typically 15 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99309	Subsequent nursing facility visit, typically 25 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99310	Subsequent nursing facility visit, typically 35 minutes per day	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections ID RD Waiver Enrollees

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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99324	New patient assisted living visit, typically 20 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99325	New patient assisted living visit, typically 30 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99326	New patient assisted living visit, typically 45 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99327	New patient assisted living visit, typically 60 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99328	New patient assisted living visit, typically 75 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99334	Established patient assisted living visit, typically 15 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99335	Established patient assisted living visit, typically 25 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99336	Established patient assisted living visit, typically 40 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99337	Established patient assisted living visit, typically 60 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".

South Carolina Healthy Connections ID RD Waiver Enrollees

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Medical							
Code	Brief Description	Age Limitation	Teeth Covered	Pre-payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
99341	New patient home visit, typically 20 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records".
99342	New patient home visit, typically 30 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99343	New patient home visit, typically 45 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99344	New patient home visit, typically 60 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99345	New patient home visit, typically 75 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99347	Established patient home visit, typically 15 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99348	Established patient home visit, typically 25 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99349	Established patient home visit, typically 40 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99350	Established patient home visit, typically 60 minutes	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records
99441	Physician telephone patient service, 5-10 minutes of medical discussion	All ages		No	No		Proper documentation must be maintained in patient's records. Refer to Appendix D-2:"Dental Treatment Records

South Carolina Healthy Connections ID RD Waiver Enrollees

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