GOVERNMENT PROGRAMS

AND

COMMERCIAL MANAGED CARE PROGRAM

Please visit our website at www.Premierlife.com to obtain patient eligibility, patient benefit schedule, and patient evidence of coverage for any of the above listed programs. You may also submit on-line requests for additional forms, such as: Grievance, Encounter, and Specialty Referral forms.

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Revised: 040111

A Word from the President

Dear Provider:

This Provider Manual is to help you and your staff understand Access Dental Plan's dental benefit programs and the responsibilities of both Access Dental Plan and the provider as it relates to services provided to members. One of our primary goals in preparing this Provider Manual was to keep the information brief and simple.

I would like to thank you for participating in Access Dental Plan's provider network and encourage you to use this Provider Manual as part of your office operations when treating Access Dental Plan's members.

Sincerely,

Reza Abbaszadeh, DDS
President and Chief Executive Officer

ACCESS DENTAL

Provider Manual

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Introduction

Why the Provider Manual is an important tool for you and how to use it.

Use the information in this manual to ensure you are providing quality services to ***Access*** Dental Plan (***Access***) members, the services you provide are covered benefits, and you are paid promptly for your services.

This manual is for you! We have created this manual for the sole purpose of assisting *Access* Providers. If information in this manual is unclear, or you would like additional information included in the future, please let us know. When any changes in criteria and/or policies occur, revised pages will be issued for the purpose of updating the information in this handbook. Please carefully insert them in this provider manual as soon as possible, according to the instructions provided with each revision.

ICON KEYS	
✓	Key information
✆	Important phone number

Understanding Icon Keys

The "icon keys" at left are used throughout the manual to highlight areas of particular importance. If the "Key information" icon appears in the margin of the manual, the information is critical to providers for ensuring prompt and appropriate payment or approval of services. If the "Important phone number" icon appears in the margin of the manual, the *Access* Dental Plan phone number related to the particular topic is included in the discussion.

Health Insurance Portability and Availability Act

A**ccess* Dental Plan (Access***) takes pride in the fact that we administer our dental Plan in an effective and innovative manner while safeguarding our members' protected health information. We are committed to complying with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our commitment is demonstrated through our actions.

Access has appointed a Privacy Officer to develop, implement, maintain and provide oversight of our HIPAA compliance program as well as assist with the education and training of our employees on the requirements and implications of HIPAA.

Access has created and implemented internal corporate wide policies and procedures to comply with the provisions of HIPAA. ***Access*** has and will continue to conduct employee training and education in relation to HIPAA requirements.

Access has disseminated its Notice of Privacy Practices. Existing members were mailed a copy of the notice and all new enrollees are provided with a copy with their member materials.

Should you have any questions regarding ***Access*** Dental Plan's HIPAA compliance efforts please contact the Privacy Officer via via email at PrivacyOfficer@premierlife.com or via telephone at (916) 920-2500

Abbreviations Used in This Manual

Abbreviations used in this manual are shown below with their full text.

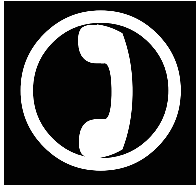
ADA....................American Dental Association
CADP.............. California Association of Dental Plans
CCS................. California Children Services
CHDP................Child Health and Disability Prevention Program
DHMO............. Dental Health Maintenance Organization
DMHC................Department of Managed Health Care
EPA................. Environmental Protection Agency
FRADS............ Federally Required Adult Dental Services
GMC................ Geographic Managed Care
HEDIS................Health Employers Data Information Set
HFP.................. Healthy Families Program
HIPAA............. Health Insurance Portability and Accountability Act
LAP....................Language Assistance Program
LAPHP............ Los Angeles Prepaid Health Plan
LEP.................. Limited English Proficient
NPDB.............. National Practitioner Data Bank
OSHA................Occupational Safety and Health Administration
PCD....................Primary Care Dentist
Plan....................Access Dental Plan
QM.......................Quality Management
QMC...................Quality Management Committee
QMP...................Quality Management Program

Program Forms Used by Providers

The following forms used by providers are discussed in detail in this manual in the chapters indicated.

FORM	CHAPTER
Encounter Form	Encounter Reporting Requirements
Grievance Form	Appeal and Grievances
Orthodontic Pre-Screening Form	California Children's Services
Specialist Referral Form	Referrals
Transfer Request Form	Member Assignment to PCD

Important Phone Numbers



Important phone numbers for quick reference when contacting ***Access*** **Dental Plan** for services:

Access Dental Plan

Administrative line-general information
916-922-5000
800-270-6743

Dental Consultant

916- 563-6011
800-270-6743, ext. 6011
DentalConsultant@premierlife.com

Emergency Referral Fax

916-648-7741
877-648-7741
AccessReferral@premierlife.com

Grievances

916-563-6013
800-270-6743, ext. 6013
Grievancedept@premierlife.com

Ordering Forms

916-563-6025
800-640-4466
Info@premierlife.com

Plan's 24 Hour Emergency Number

800-870-4290

Provider Relations / Provider Dispute

916-563-6025
800-640-4466
ProviderRelations@premierlife.com

Specialty Referrals/Claims

916-563-6012
800-270-6743, ext 6012
AccessReferral@premierlife.com

Member Services

Government Programs:

GMC (Geographic Managed Care) Medi-Cal Program.......................... 916-646-2130
HFP (Healthy Families Program).. 888-849-8440
LAPHP (Los Angeles Prepaid Health Plan) Medi-Cal Program........... 888-414-4110

Commercial Managed Care Program:

Dental Maintenance Organization... 866-650-3660

Our customer service representatives are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m.
MemberServices@ premierlife.com

Benefit Plans

A description of the Medi-Cal Managed Care Programs, the Healthy Families Program, and Commercial Managed Care Program.

ACCESS DENTAL PLAN provides prepaid dental coverage for those enrolled under Medi-Cal Managed Care Dental Programs, the Healthy Families Program, and Commercial Managed Care Program. Our dental benefits are divided between our government programs and our commercial programs as shown below:

GOVERNMENT PROGRAMS

- ♦ Medi-Cal Managed Care Dental Programs
- ♦ Healthy Families Program

COMMERCIAL PROGRAM

- ♦ Group dental benefits for employers

Above programs are administered by ***Access*** Dental Plan. Each member is assigned to a Primary Care Dentist (PCD) for receiving general dental services. These services include all dental treatment that can be rendered by a general dentist. The PCD shall request a specialty referral from ***Access*** for necessary procedures covered under the program and defined as specialty services.

Government Programs:

Our dental benefits under government programs are divided between our Medi-Cal Managed Care Dental programs and our Healthy Families program as shown below:

- ♦ Medi-Cal Managed Care Dental Programs
  - Geographic Managed Care (GMC)
  - Los Angeles Prepaid Health Plan (LAPHP)
- ♦ Healthy Families Program

◆ Medi-Cal Managed Care Dental Programs

Access Dental Plan has broad experience in providing dental coverage under California's Medi-Cal Dental Program. We are one of the participating plans in the Geographic Managed Care Program (GMC) in Sacramento. We also participate in the Los Angeles Prepaid Health Plan in Los Angeles County (LAPHP).

- Effective July 1, 2009, all optional adult dental services (age 21 and over) were eliminated. Optional services are services that are not mandated by the federal government to be provided.

  Optional services that were eliminated include:

  - Comprehensive oral evaluations for new or established patients
  - Prophylaxis and fluoride treatments
  - Amalgam and resin based composite restorations
  - Prefabricated and laboratory processed crowns
  - Endodontic treatment
  - Periodontal procedures including scaling and root planing
  - Removable prosthodontic treatment including complete and partial dentures, relines and tissue conditioning and adjustment and repairs
  - Fixed prosthodontic procedures
  - Implant procedures

  You may visit the Denti-Cal and Medi-Cal websites for updated information at www.denti-cal.ca.gov and www.medi-cal.ca.gov.

The benefit schedule available to Medi-Cal members under the managed care dental program is the same that is available to Denti-Cal (fee-for-service) members. The primary difference between the two programs is that members are assigned to a primary care dentist (PCD). Also, in most instances, the PCD is compensated through a capitation schedule and, therefore, requires no authorization for providing many of the services that fall under the primary care dentist's responsibility. In the fee-for-service program, for many of the procedures, the dentist is required to obtain prior authorization.

Under Medi-Cal Managed Care Dental Programs, the members have access to a complete array of specialists, such as orthodontists, periodontists, etc. ***Access*** Dental Plan contracts with specialists in each community to be able to service the needs of its members. Specialty services are available to members only after receipt of authorization from ***Access***, unless there is an emergency. Emergency referrals can be obtained by telephone or fax.

- **Healthy Families Program**

Access Dental Plan participates in California's Healthy Families Program. The Healthy Families Program provides health, dental and vision coverage for children one through eighteen years of age who are uninsured and have family income below the income thresholds of the program.

Unlike the Medi-Cal program, **Healthy Families Program members have some minimal copayments to meet for certain services. The PCD must collect these copayments when delivering services.**

Reimbursement for Copayments

American Indians and Alaskan Native children are exempt from all Healthy Families Program copayments.

In order to receive reimbursement for copayments amounts for services to American Indians and Alaskan Native children, providers are encouraged to use ADA claim forms or ***Access*** Dental encounter forms to report these services and request payment for these copayment amounts.

Commercial Managed Care Program

Products are administered by ***Access*** Dental Plan for the purpose of providing dental coverage to groups of employees, and union groups. All commercial group coverage includes member copayments for many services. These copayments may be significant for certain programs. When receiving services, members must pay the copayments at the time of services. Providers are responsible for collecting copayments.

Accessibility Standards

Access complies with standards of accessibility of dental services for members, as established by California State Law and Regulations. Adherence to these standards is reviewed through:

- Member/provider complaints/grievances
- Member satisfaction survey
- Facility self assessment tool
- On-site audit
- Provider survey
- PCD transfer requests

Appointment Scheduling

Appointments for an initial assessment, non-emergency routine services, and/or preventive care must be made available to members within three weeks of the date a member requests an appointment.

Appointments for acute/urgent care from a PCD shall not exceed one day from the date of the request for an appointment.

When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice.

Waiting Time for Scheduled Appointments

Member waiting time for scheduled appointments with their PCD or a specialty provider must not exceed thirty (30) minutes. Provider offices must maintain records indicating when a member arrives for an appointment and when the provider sees the member.

Plans shall ensure that during normal business hours, the waiting time for an enrollee to speak with a plan customer service representative shall not exceed ten minutes.

Access sends an Accessibility Survey to every PCD office in the network on a regular basis to obtain information on appointment availability, waiting time, acceptance of new members and staffing changes. The survey must be completed and submitted to ***Access*** in a timely manner.

After Hours and Emergency Services Availability

The provider's after-hours response system must enable members to reach an on-call dentist 24 hours a day, seven days a week.

The provider shall employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

Members may first attempt to contact their Primary Care Dentist (PCD) during regular office hours. Urgent appointments should be scheduled within 24 hours and patient should be informed that only the emergency would be treated at that time. After-hours calls should be forwarded to an answering service or directly to the PCD. If the PCD is not on duty, an on-call provider should be available to act on his behalf.

Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one hour of the time the member contacts the provider's after hours telephone service.

If the PCD or on-call dentist does not respond, the member may contact ***Access'*** 24 hour answering service at 800-870-4290.

If the member requires emergency care when outside the service area (greater than 50 miles from the PCD), the member may seek treatment from the nearest available dentist or emergency room as circumstances dictate.

Cultural and Linguistic Services

Access understands that many of the applicants and subscribers who seek dental services may be limited English proficient (LEP) and/or may be members of cultural or ethnic groups who have minimal exposure to routine dental care.

To support the Cultural and Linguistic (C& L) needs of our members, ***Access*** has translated Member vital documents into the Plan's threshold languages. ***Access*** has availability of free language assistance services for all your enrollees with interpreting services 24 hours a day, 7 days a week. A member can access the interpreting services by calling the Plan's Member Service Representatives at 1-800-70-SMILE.

Under no circumstances do we require friends or family members to serve as interpreters on dental matters, instead, we encourage members to use the qualified interpreters we provide. The Provider will document the language needs of subscribers in their medical record, and shall ensure that the request or refusal of the services is documented in the dental record.

ACCESS DENTAL

1

Medi-Cal Managed Care Dental Programs

A description of the plan benefits and coverage.

THE PLAN PROVIDES COVERAGE TO MEMBERS for all dental health care services available under the dental provisions of the California Medi-Cal program. This chapter contains a current list of procedure codes and descriptions for the **Geographic Managed Care Program** and the **Los Angeles Prepaid Health Plan**. It also contains information on prior authorization, payment policies, benefits, and exclusions.

Medi-Cal members receive their covered dental services from their PCD without payment of any copayments. **Collection of any amount from Medi-Cal members towards a dental service that is a covered benefit is strictly prohibited under the provisions of your provider agreement.**

Maximum calendar year benefit not applicable for beneficiaries on this program.

The following section contains a complete listing of all services available to Medi-Cal members under the age of 21.

Most dental services for adults, age 21 and older, are no longer covered under Medi-Cal, as of July 1, 2009 and will not be covered by the Plan. There are some exceptions, which are listed in detail in the following section. You may visit the Denti-Cal and Medi-Cal websites for updated information at www.denti-cal.ca.gov and www.medi-cal.ca.gov.

- In the following circumstances, Medi-Cal Dental providers may continue to provide services after July 1, 2009 and be reimbursed by Medi-Cal for those services:

  - Medical and surgical services provided by a doctor or dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state.
    - Federal law requires the provision of these services. The services that are allowable as Federally Required Adult Dental Services (FRADS) under this definition are listed in Table 1.
  - Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy.
    - This includes 60 days of postpartum care. Services for pregnant beneficiaries who are 21 years of age or older are payable if the procedure is listed under Table 1 (Federally Required Adult Dental Services) or Table 2 (Allowable Procedure Codes for Pregnant Women).
  - Adult beneficiaries (age 21 and older) whose course of treatment began prior to July 1, 2009 and is scheduled to continue on or after July 1, 2009.
    - In these cases, the beneficiary must have been seen by the provider and the necessary course of treatment was evident prior to July 1, 2009. Note, this relates to a specified course of treatment with a completion date (e.g., to prepare a patient for dentures, and fabricate and deliver the dentures). Treatment must be completed within 180 days of the date the treatment was determined necessary. **This provision only applies to the completion of treatment that was determined to be necessary before the benefits were eliminated.** This provision is not to be construed to continue "routine care" (i.e., exams, cleanings, fillings, etc.) beyond July 1, 2009.
  - Beneficiaries who are under 21 years of age and whose course of treatment is scheduled to continue after he/she turns 21 years of age (continuing services for EPSDT recipients) [Note: With the exception of orthodontic services which must be completed by the beneficiary's 21st birthday.]
    - In these cases, the beneficiary must have been seen by the provider and the necessary treatment was evident prior to his/her 21st birthday. Note, this relates to a specified course of treatment (e.g., to perform a root canal or complete a crown). Treatment must be completed within 180 days of the date the treatment was determined necessary. **This provision only applies to completion of treatment that was determined to be necessary before the person became ineligible for that service due to reaching age 21.**

This provision is not to be construed to continue "routine care" (i.e., exams, cleanings, fillings, etc.) after the person turns 21.

- Beneficiaries receiving long-term care in a Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF), as defined in the *Health and Safety Code* (H&S Code), Section 1250, subdivisions (c) and (d), and licensed pursuant to H&S Code Section 1250, subdivision (k) are exempt from the change in adult dental services on July 1, 2009.

Beneficiaries residing in ICF-Developmentally Disabled (DD), ICF-Developmentally Disable Habilitative (DDH) or ICF-Developmentally Disable Nursing (DDN) are also exempt from the change in adult dental services on July 1, 2009.

- The facility definitions are available on the California Department of Public Health Website at http://hfcis.cdph.ca.gov/servicesAndFacilities.aspx. Providers may confirm the licensing of a facility from this Web page.
- Dental Services do not have to be provided in the facility to be payable. Providers are reminded to follow the existing prior authorization and documentation requirements.
- If a provider receives a denial on a claim for a beneficiary who resides in a licensed SNF or ICF, the provider can submit a Claim Inquiry Form (CIF) including the facility name and address and have the claim reprocessed. If the services were denied on a prior authorization request, the provider can submit the prior authorization notice and request re-evaluation.

- Dental Service Precedent to a Covered Medical Service.
  - Beneficiaries may receive dental services that are necessary (precedent) in order to undergo a covered medical service. The majority of these dental services are covered under FRADS listed in Table 1 of the Federally Required Adult Dental Services at the end of this chapter. A precedent dental service that is not on the list of FRADS will be evaluated and adjudicated on a case by case basis.

An adult dental service may be reimbursable if any one of the above exceptions is met.

Procedures / Benefits Under Medi-Cal Dental Program For Members under age 21

Refer to your Medi-Cal Dental Program Provider Handbook for specific procedure instructions and program limitations.

Benefit: Dental or medical health care services covered by the Medi-Cal program.
Not a Benefit: Dental or medical health care services not covered by the Medi-Cal program.
Global: Treatment performed in conjunction with another procedure which is not payable separately.

CDT-4 Codes	Procedure Code Description	
Diagnostic		
D0120	Periodic oral evaluation	Benefit
D0140	Limited oral evaluation - problem focused	Benefit
D0150	Comprehensive oral evaluation - new or established patient	Benefit
D0160	Detailed and extensive oral evaluation - problem focused, by report	Benefit
D0170	Re-evaluation - limited, problem focused (established patient; not postoperative visit)	Benefit
D0180	Comprehensive periodontal evaluation - new or established patient	Global
D0210	Intraoral - complete series (including bitewings)	Benefit
D0220	Intraoral - periapical first film	Benefit
D0230	Intraoral - periapical each additional film	Benefit
D0240	Intraoral - occlusal film	Benefit
D0250	Extraoral - first film	Benefit
D0260	Extraoral - each additional film	Benefit
D0270	Bitewing - single film	Benefit
D0272	Bitewings - two films	Benefit
D0274	Bitewings - four films	Benefit
D0277	Vertical bitewings - 7 to 8 films	Global
D0290	Posterior - anterior or lateral skull and facial bone survey film	Benefit
D0310	Sialography	Benefit
D0320	Temporomandibular joint arthrogram, including injection	Benefit
D0321	Other temporomandibular joint arthrogram, including injection	Not A Benefit
D0322	Tomographic survey	Benefit
D0330	Panoramic film	Benefit
D0340	Cephalometric film	Benefit
D0350	Oral/Facial images (including intra and extraoral images)	Benefit
D0415	Bacteriologic studies for determination of pathologic agents	Not A Benefit
D0425	Caries susceptibility tests	Not A Benefit
D0460	Pulp vitality tests	Global
D0470	Diagnostic casts	Benefit
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not A Benefit
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not A Benefit
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not A Benefit

Codes	Procedure Code Description	
D0480	Processing and interpretation of cytologic smears, including the preparation and transmission of written report**CDT-4**	Not A Benefit
D0502	Other oral pathology procedures, by report	By Report
D0999	Unspecified diagnostic procedure, by report	Benefit
Preventive		
D1110	Prophylaxis - adult	Benefit
D1120	Prophylaxis - child	Benefit
D1201	Topical application of fluoride (including prophylaxis) - child	Benefit
D1203	Topical application of fluoride (prophylaxis not included) - child	Benefit
D1204	Topical application of fluoride (prophylaxis not included) - adult	Benefit
D1205	Topical application of fluoride (including prophylaxis) - adult	Benefit
D1310	Nutritional counseling for control of dental disease	Global
D1320	Tobacco counseling for the control and prevention of oral disease	Global
D1330	Oral hygiene instructions	Global
D1351	Sealant - per tooth	Benefit
D1510	Space maintainer-fixed - unilateral	Benefit
D1515	Space maintainer-fixed - bilateral	Benefit
D1520	Space maintainer-removable - unilateral	Benefit
D1525	Space maintainer-removable - bilateral	Benefit
D1550	Re-cementation of space maintainer	Benefit
Restorative		
D2140	Amalgam - one surface, primary or permanent	Benefit
D2150	Amalgam - two surfaces, primary or permanent	Benefit
D2160	Amalgam - three surfaces, primary or permanent	Benefit
D2161	Amalgam - four or more surfaces, primary or permanent	Benefit
D2330	Resin-based composite - one surface, anterior	Benefit
D2331	Resin-based composite - two surfaces, anterior	Benefit
D2332	Resin-based composite - three surfaces, anterior	Benefit
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	Benefit
D2390	Resin-based composite crown, anterior	Benefit
D2391	Resin-based composite - one surface, posterior	Benefit
D2392	Resin-based composite - two surfaces, posterior	Benefit
D2393	Resin-based composite - three surfaces, posterior	Benefit
D2394	Resin-based composite - four or more surfaces, posterior	Benefit
D2410	Gold foil - one surface	Not A Benefit
D2420	Gold foil - two surfaces	Not A Benefit
D2430	Gold foil - three surfaces	Not A Benefit
D2510	Inlay - metallic - one surface	Not A Benefit
D2520	Inlay - metallic - two surfaces	Not A Benefit
D2530	Inlay - metallic - three surfaces	Not A Benefit
D2542	Onlay - metallic - two surfaces	Not A Benefit
D2543	Onlay - metallic - three surfaces	Not A Benefit
D2544	Onlay - metallic - four or more surfaces	Not A Benefit
D2610	Inlay - porcelain/ceramic - one surface	Not A Benefit
D2620	Inlay - porcelain/ceramic - two surfaces	Not A Benefit
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not A Benefit
D2642	Onlay - porcelain/ceramic - two surfaces	Not A Benefit
D2643	Onlay - porcelain/ceramic - three surfaces	Not A Benefit
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not A Benefit

CDT-4 Codes	Procedure Code Description	
D2650	Inlay - resin-based composite - one surface	Not A Benefit
D2651	Inlay - resin-based composite - two surfaces	Not A Benefit
D2652	Inlay - resin-based composite - three or more surfaces	Not A Benefit
D2662	Onlay - resin-based composite - two surfaces	Not A Benefit
D2663	Onlay - resin-based composite - three surfaces	Not A Benefit
D2664	Onlay - resin-based composite - four or more surfaces	Not A Benefit
D2710	Crown - resin (indirect)	Benefit
D2720	Crown - resin with high noble metal	Not A Benefit
D2721	Crown - resin with predominantly base metal	Benefit
D2722	Crown - resin with noble metal	Not A Benefit
D2740	Crown - porcelain/ceramic substrate	Benefit
D2750	Crown - porcelain fused to high noble metal	Not A Benefit
D2751	Crown - porcelain fused to predominantly base metal	Benefit
D2752	Crown - porcelain fused to noble metal	Not A Benefit
D2780	Crown - 3/4 cast high noble metal	Not A Benefit
D2781	Crown - 3/4 cast predominantly base metal	Benefit
D2782	Crown - 3/4 cast noble metal	Not A Benefit
D2783	Crown - 3/4 porcelain/ceramic	Benefit
D2790	Crown - full cast high noble metal	Not A Benefit
D2791	Crown - full cast predominantly base metal	Benefit
D2792	Crown - full cast noble metal	Not A Benefit
D2799	Provisional crown	Not A Benefit
D2910	Recement inlay	Benefit
D2920	Recement crown	Benefit
D2930	Prefabricated stainless steel crown - primary tooth	Benefit
D2931	Prefabricated stainless steel crown - permanent tooth	Benefit
D2932	Prefabricated resin crown $	Benefit
D2933	Prefabricated stainless steel crown with resin window	Benefit
D2940	Sedative filling	Benefit
D2950	Core buildup, including any pins	Global
D2951	Pin retention - per tooth, in addition to restoration	Benefit
D2952	Cast post and core in addition to crown	Benefit
D2953	Each additional cast post - same tooth	Global
D2954	Prefabricated post and core in addition to crown	Benefit
D2955	Post removal (not in conjunction with endodontic therapy)	Global
D2957	Each additional prefabricated post -same tooth	Global
D2960	Labial veneer (resin laminate) - chairside	Not A Benefit
D2961	Labial veneer (resin laminate) - laboratory	Not A Benefit
D2962	Labial veneer (porcelain laminate) - laboratory	Not A Benefit
D2970	Temporary crown (fractured tooth)	Benefit
D2980	Crown repair, by report	Benefit
D2999	Unspecified restorative procedure, by report	Benefit
Endodontics		
D2940	Sedative filling	Benefit
D3110	Pulp cap - direct (excluding final restoration)	Global
D3120	Pulp cap - indirect (excluding final restoration)	Global
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction application of medicament	Benefit

CDT-4 Codes	Procedure Code Description	
D3221	Pulpal debridement, primary and permanent teeth	Benefit
D3230	Pulpal therapy (resorpable filling) - anterior, primary tooth (excluding final restoration)	Benefit
D3240	Pulpal therapy (resorpable filling) - posterior, primary tooth (excluding final restoration)	Benefit
D3310	Anterior (excluding final restoration)	Benefit
D3320	Bicuspid (excluding final restoration)	Benefit
D3330	Molar (excluding final restoration)	Benefit
D3331	Treatment of root canal obstruction; non-surgical access	Global
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	Not A Benefit
D3333	Internal root repair of perforation defects	Global
D3346	Retreatment of previous root canal therapy - anterior	Benefit
D3347	Retreatment of previous root canal therapy - bicuspid	Benefit
D3348	Retreatment of previous root canal therapy - molar	Benefit
D3351	Apexification/Recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Benefit
D3352	Apexification/Recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	Benefit
D3353	Apexification/Recalcification - final visit (apical closure/calcific repair of perforations, root resorption, etc.)	Not A Benefit
D3410	Apicoectomy/Periradicular surgery - anterior	Benefit
D3421	Apicoectomy/Periradicular surgery - bicuspid (first root)	Benefit
D3425	Apicoectomy/Periradicular surgery - molar (first root)	Benefit
D3426	Apicoectomy/Periradicular surgery - (each additional root)	Benefit
D3430	Retrograde filling - per root	Global
D3450	Root amputation - per root	Not A Benefit
D3460	Endodontic endosseous implant	Not A Benefit
D3470	Intentional reimplantation (including necessary splinting)	Not A Benefit
D3910	Surgical procedure for isolation of tooth with rubber dam	Global
D3920	Hemisection (including any root removal), not including root canal therapy	Not A Benefit
D3950	Canal preparation and fitting of preformed dowel or post	Not A Benefit
D3999	Unspecified endodontic procedure, by report	Benefit
Peridontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	Benefit
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	Benefit
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	Not A Benefit
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	Not A Benefit
D4245	Apically positioned flap	Not A Benefit
D4249	Clinical crown lengthening - hard tissue	Not A Benefit
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	Benefit
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	Benefit
D4263	Bone replacement graft - first site in quadrant	Not A Benefit
D4264	Bone replacement graft - each additional site in quadrant	Not A Benefit
D4265	Biologic materials to aid in soft and osseous tissue regeneration	Global
D4266	Guided tissue regeneration - resorpable barrier, per site	Not A Benefit
D4267	Guided tissue regeneration - nonresorpable barrier, per site (includes membrane removal)	Not A Benefit
D4268	Surgical revision procedure, per tooth	Not A Benefit
D4270	Pedicle soft tissue graft procedure	Not A Benefit

CDT-4 Codes	Procedure Code Description	
D4271	Free soft tissue graft procedure (including donor site surgery)	Not A Benefit
D4273	Subepithelial connective tissue graft procedures	Not A Benefit
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Not A Benefit
D4275	Soft tissue allograft	Not A Benefit
D4276	Combined connective tissue and double pedicle graft	Not A Benefit
D4320	Provisional splinting - intracoronal	Not A Benefit
D4321	Provisional splinting - extracoronal	Not A Benefit
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	Benefit
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	Benefit
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Global
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	Gobal
D4910	Periodontal maintenance	Not A Benefit
D4920	Unscheduled dressing change (by someone other than treating dentist)	Benefit
D4999	Unspecified periodontal procedure, by report	By Report
Prosthodontics (Removable)		
D5110	Complete denture - maxillary	Benefit
D5120	Complete denture - mandibular	Benefit
D5130	Immediate denture - maxillary	Benefit
D5140	Immediate denture - mandibular	Benefit
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	Benefit
D5212	Mandibular partial denture - resin base (including any conventional clasps, rest and teeth)	Benefit
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	Benefit
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	Benefit
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	Not A Benefit
D5410	Adjust complete denture - maxillary	Benefit
D5411	Adjust complete denture - mandibular	Benefit
D5421	Adjust partial denture - maxillary	Benefit
D5422	Adjust partial denture - mandibular	Benefit
D5510	Repair broken complete denture base	Benefit
D5520	Replace missing or broken teeth - complete denture (each tooth)	Benefit
D5610	Repair resin denture base	Benefit
D5620	Repair cast framework	Benefit
D5630	Repair or replace broken clasp	Benefit
D5640	Replace broken teeth - per tooth	Benefit
D5650	Add tooth to existing partial denture	Benefit
D5660	Add clasp to existing partial denture	Benefit
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not A Benefit
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not A Benefit
D5710	Rebase complete maxillary denture	Not A Benefit
D5711	Rebase complete mandibular denture	Not A Benefit
D5720	Rebase maxillary partial denture	Not A Benefit
D5721	Rebase mandibular partial denture	Not A Benefit
D5730	Reline complete maxillary denture (chairside)	Benefit
D5731	Reline complete mandibular denture (chairside)	Benefit

CDT-4 Codes	Procedure Code Description	
D5740	Reline maxillary partial denture (chairside)	Benefit
D5741	Reline mandibular partial denture (chairside)	Benefit
D5750	Reline complete maxillary denture (laboratory)	Benefit
D5751	Reline complete mandibular denture (laboratory)	Benefit
D5760	Reline maxillary partial denture (laboratory)	Benefit
D5761	Reline mandibular partial denture (laboratory)	Benefit
D5810	Interim complete denture (maxillary)	Not A Benefit
D5811	Interim complete denture (mandibular)	Not A Benefit
D5820	Interim partial denture (maxillary)	Not A Benefit
D5821	Interim partial denture (mandibular)	Not A Benefit
D5850	Tissue conditioning, maxillary	Benefit
D5851	Tissue conditioning, mandibular	Benefit
D5860	Overdenture - complete, by report	Benefit
D5861	Overdenture - partial, by report	Not A Benefit
D5862	Precision attachment, by report	Global
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	Not A Benefit
D5875	Modification of removable prosthesis following implant surgery	Not A Benefit
D5899	Unspecified removable prosthodontic procedure, by report	By Report
Maxillofacial Prosthetics		
D5911	Facial moulage (sectional)	Benefit
D5912	Facial moulage (complete)	Benefit
D5913	Nasal prosthesis	Benefit
D5914	Auricular prosthesis	Benefit
D5915	Orbital prosthesis	Benefit
D5916	Ocular prosthesis	Benefit
D5919	Facial prosthesis	Benefit
D5922	Nasal septal prosthesis	Benefit
D5923	Ocular prosthesis, interim	Benefit
D5924	Cranial prosthesis	Benefit
D5925	Facial augmentation implant prosthesis	Benefit
D5926	Nasal prosthesis, replacement	Benefit
D5927	Auricular prosthesis, replacement	Benefit
D5928	Orbital prosthesis, replacement	Benefit
D5929	Facial prosthesis, replacement	Benefit
D5931	Obturator prosthesis, surgical	Benefit
D5932	Obturator prosthesis, definitive	Benefit
D5933	Obturator prosthesis, modification	Benefit
D5934	Mandibular resection prosthesis with guide flange	Benefit
D5935	Mandibular resection prosthesis without guide flange	Benefit
D5936	Obturator prosthesis, interim	Benefit
D5937	Trismus appliance (not for TMD treatment)	Benefit
D5951	Feeding aid	Benefit
D5952	Speech aid prosthesis, pediatric	Benefit
D5953	Speech aid prosthesis, adult	Benefit
D5954	Palatal augmentation prosthesis	Benefit
D5955	Palatal lift prosthesis, definitive	Benefit
D5958	Palatal lift prosthesis, interim	Benefit

CDT-4 Codes	Procedure Code Description	
D5959	Palatal lift prosthesis, modification	Benefit
D5960	Speech aid prosthesis, modification	Benefit
D5982	Surgical stent	Benefit
D5983	Radiation carrier	Benefit
D5984	Radiation shield	Benefit
D5985	Radiation cone locator	Benefit
D5986	Fluoride gel carrier	Benefit
D5987	Commissure splint	Benefit
D5988	Surgical splint	Benefit
D5999	Unspecified maxillofacial prosthesis, by report	By Report
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	By Report
D6020	Surgical placement: eposteal implant	By Report
D6050	Surgical placement: transosteal implant	By Report
D6053	Implant/Abutment supported removable denture for completely edentulous arch	By Report
D6054	Implant/Abutment supported removable denture for partially edentulous arch	By Report
D6055	Dental implant supported connecting bar	By Report
D6056	Prefabricated abutment	By Report
D6057	Custom abutment	By Report
D6058	Abutment supported porcelain/ceramic crown	By Report
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	By Report
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	By Report
D6061	Abutment supported porcelain fused to metal crown (noble metal)	By Report
D6062	Abutment supported cast metal crown (high noble metal)	By Report
D6063	Abutment supported cast metal crown (predominantly base metal)	By Report
D6064	Abutment supported cast metal crown (noble metal)	By Report
D6065	Implant supported porcelain/ceramic crown	By Report
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	By Report
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	By Report
D6068	Abutment supported retainer for porcelain/ceramic FPD	By Report
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	By Report
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	By Report
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	By Report
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	By Report
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	By Report
D6074	Abutment supported retainer for cast metal FPD (noble metal)	By Report
D6075	Implant supported retainer for ceramic FPD	By Report
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	By Report
D6077l	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	By Report
D6078	Implant/Abutment supported fixed denture for completely edentulous arch	By Report
D6079	Implant/Abutment supported fixed denture for partially edentulous arch	By Report
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	By Report
D6090	Repair implant supported prosthesis, by report	By Report
D6095	Repair implant abutment, by report	By Report
D6100	Implant removal, by report	Benefit
D6199	Unspecified implant procedure, by report	By Report

CDT-4 Codes	Procedure Code Description	
Fixed Prosthodontics		
D6210	Pontic - cast high noble metal	Not A Benefit
D6211	Pontic - cast predominantly base metal	Benefit
D6212	Pontic - cast noble metal	Not A Benefit
D6240	Pontic - porcelain fused to high noble metal	Not A Benefit
D6241	Pontic - porcelain fused to predominantly base metal	Benefit
D6242	Pontic - porcelain fused to noble metal	Not A Benefit
D6245	Pontic - porcelain/ceramic	Benefit
D6250	Pontic - resin with high noble metal	Not A Benefit
D6251	Pontic - resin with predominantly base metal	Benefit
D6252	Pontic - resin with noble metal	Not A Benefit
D6253	Provisional pontic	Not A Benefit
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Not A Benefit
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not A Benefit
D6600	Inlay - porcelain/ceramic, two surfaces	Not A Benefit
D6601	Inlay - porcelain/ceramic, three or more surfaces	Not A Benefit
D6602	Inlay - cast high noble metal, two surfaces	Not A Benefit
D6603	Inlay - cast high noble metal, three or more surfaces	Not A Benefit
D6604	Inlay - cast predominantly base metal, two surfaces	Not A Benefit
D6605	Inlay - cast predominantly base metal, three or more surfaces	Not A Benefit
D6606	Inlay - cast noble metal, two surfaces	Not A Benefit
D6607	Inlay - cast noble metal, three or more surfaces	Not A Benefit
D6608	Onlay - porcelain/ceramic, two surfaces	Not A Benefit
D6609	Onlay - porcelain/ceramic, three or more surfaces	Not A Benefit
D6610	Onlay - cast high noble metal, two surfaces	Not A Benefit
D6611	Onlay - cast high noble metal, three or more surfaces	Not A Benefit
D6612	Onlay - cast predominantly base metal, two surfaces	Not A Benefit
D6613	Onlay - cast predominantly base metal, three or more surfaces	Not A Benefit
D6614	Onlay - cast noble metal, two surfaces	Not A Benefit
D6615	Onlay - cast noble metal, three or more surfaces	Not A Benefit
D6720	Crown - resin with high noble metal	Not A Benefit
D6721	Crown - resin with predominantly base metal	Benefit
D6722	Crown - resin with noble metal	Not A Benefit
D6740	Crown - porcelain/ceramic	Benefit
D6750	Crown - porcelain fused to high noble metal	Not A Benefit
D6751	Crown - porcelain fused to predominantly base metal	Benefit
D6752	Crown - porcelain fused to noble metal	Not A Benefit
D6780	Crown - 3/4 cast high noble metal	Not A Benefit
D6781	Crown - 3/4 cast predominantly base metal	Benefit
D6782	Crown - 3/4 cast noble metal	Not A Benefit
D6783	Crown - 3/4 porcelain/ceramic	Benefit
D6790	Crown - full cast high noble metal	Not A Benefit
D6791	Crown - full cast predominantly base metal	Benefit
D6792	Crown - full cast noble metal	Not A Benefit
D6793	Provisional retainer crown	Not A Benefit
D6920	Connector bar	Not A Benefit
D6930	Recement fixed partial denture	Benefit
D6940	Stress breaker	Not A Benefit

CDT-4 Codes	Procedure Code Description	
D6950	Precision attachment	Not A Benefit
D6970	Cast post and core in addition to fixed partial denture retainer	Benefit
D6971	Cast post as part of fixed partial denture retainer	Benefit
D6972	Prefabricated post and core in addition to fixed partial denture retainer	Benefit
D6973	Core build up for retainer, including any pins	Global
D6975	Coping - metal	Not A Benefit
D6976	Each additional cast post - same tooth	Global
D6977	Each additional prefabricated pos - same tooth	Global
D6980	Fixed partial denture repair, by report	Benefit
D6985	Pediatric partial denture, fixed	Not A Benefit
D6999	Unspecified fixed prosthodontic procedure, by report	By Report
Oral and Maxillofacial Surgery		
D7111	Coronal remnants - deciduous tooth	Benefit
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Benefit
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Benefit
D7220	Removal of impacted tooth - soft tissue	Benefit
D7230	Removal of impacted tooth - partially bony	Benefit
D7240	Removal of impacted tooth - completely bony	Benefit
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Benefit
D7250	Surgical removal of residual tooth roots (cutting procedure)	Benefit
D7260	Oroantral fistula closure	Benefit
D7261	Primary closure of a sinus perforation	Benefit
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Benefit
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	Not A Benefit
D7280	Surgical access of an unerupted tooth	Benefit
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	Benefit
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not A Benefit
D7285	Biopsy of oral tissue - hard (bone, tooth)	Benefit
D7286	Biopsy of oral tissue - soft (all others)	Benefit
D7287	Cytology sample collection	Not A Benefit
D7290	Surgical repositioning of teeth	Benefit
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	Benefit
D7310	Alveoloplasty in conjunction with extractions - per quadrant	Benefit
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	Benefit
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	Benefit
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Benefit
D7410	Excision of benign lesion up to 1.25 cm	Benefit
D7411	Excision of benign lesion greater than 1.25 cm	Benefit
D7412	Excision of benign lesion, complicated	Benefit
D7413	Excision of malignant lesion up to 1.25 cm	Benefit
D7414	Excision of malignant lesion greater than 1.25 cm	Benefit
D7415	Excision of malignant lesion, complicated	Benefit
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	Benefit
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	Benefit
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Benefit
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greaterthan 1.25 cm	Benefit

CDT-4 Codes	Procedure Code Description	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	Benefit
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Benefit
D7465	D7465 Destruction of lesion(s) by physical or chemical method, by report	Benefit
D7471	D7471 Removal of lateral exostosis (maxilla or mandible)	Benefit
D7472	D7472 Removal of torus palatinus	Benefit
D7473	Removal of torus mandibularis	Benefit
D7485	Surgical reduction of osseous tuberosity	Benefit
D7490	Radical resection of mandible with bone graft	Benefit
D7510	Incision and drainage of abscess - intraoral soft tissue	Benefit
D7520	Incision and drainage of abscess - extraoral soft tissue	Benefit
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Benefit
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	Benefit
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	Benefit
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Benefit
D7610	Maxilla - open reduction (teeth immobilized, if present)	Benefit
D7620	Maxilla - closed reduction (teeth immobilized, if present)	Benefit
D7630	Mandible - open reduction (teeth immobilized, if present)	Benefit
D7640	Mandible - closed reduction (teeth immobilized, if present)	Benefit
D7650	Malar and/or zygomatic arch - open reduction	Benefit
D7660	Malar and/or zygomatic arch - closed reduction	Benefit
D7670	Alveolus - closed reduction, may include stabilization of teeth	Benefit
D7671	Alveolus - open reduction, may include stabilization of teeth	Benefit
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	By Report
D7710	Maxilla - open reduction	Benefit
D7720	Maxilla - closed reduction	Benefit
D7730	Mandible - open reduction	Benefit
D7740	Mandible - closed reduction	Benefit
D7750	Malar and/or zygomatic arch - open reduction	Benefit
D7760	Malar and/or zygomatic arch - closed reduction	Benefit
D7770	Alveolus - open reduction stabilization of teeth	Benefit
D7771	Alveolus, closed reduction stabilization of teeth	Benefit
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	By Report
D7810	Open reduction of dislocation	Benefit
D7820	Closed reduction of dislocation	Benefit
D7830	Manipulation under anesthesia	Benefit
D7840	Condylectomy	Benefit
D7850	Surgical discectomy, with/without implant	Benefit
D7852	Disc repair	Benefit
D7854	Synovectomy	Benefit
D7856	Myotomy	Benefit
D7858	Joint reconstruction	Benefit
D7860	Arthrostomy	Benefit
D7865	Arthroplasty	Benefit
D7870	Arthrocentesis	Benefit
D7871	Non-arthroscopic lysis and lavage	Global
D7872	Arthroscopy - diagnosis, with or without biopsy	Benefit
D7873	Arthroscopy - surgical: lavage and lysis of adhesions	Benefit
D7874	Arthroscopy - surgical: disc repositioning and stabilization	Benefit

CDT-4 Codes	Procedure Code Description	
D7875	Arthroscopy - surgical: synovectomy	Benefit
D7876	Arthroscopy - surgical: discectomy	Benefit
D7877	Arthroscopy - surgical: debridement	Benefit
D7880	Occlusal orthotic device, by report	Benefit
D7899	Unspecified TMD therapy, by report	By Report
D7910	Suture of recent small wounds up to 5 cm	Benefit
D7911	Complicated suture - up to 5 cm	Benefit
D7912	Complicated suture - greater than 5 cm	Benefit
D7920	Skin graft (identify defect covered, location and type of graft)	Benefit
D7940	Osteoplasty - for orthognathic deformities	Benefit
D7941	Osteotomy - mandibular rami	Benefit
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	Benefit
D7944	Osteotomy - segmented or subapical - per sextant or quadrant	Benefit
D7945	Osteotomy - body of mandible	Benefit
D7946	LeFort I (maxilla - total)	Benefit
D7947	LeFort I (maxilla - segmented)	Benefit
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) without bone graft	Benefit
D7949	LeFort II or LeFort III - with bone graft	Benefit
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report	Benefit
D7955	Repair of maxillofacial soft and hard tissue defect	By Report
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	Benefit
D7970	Excision of hyperplastic tissue - per arch	Benefit
D7971	Excision of pericoronal gingiva	Benefit
D7972	Surgical reduction of fibrous tuberosity	Benefit
D7980	Sialolithotomy	Benefit
D7981	Excision of salivary gland, by report	Benefit
D7982	Sialodochoplasty	Benefit
D7983	Closure of salivary fistula	Benefit
D7990	Emergency tracheotomy	Benefit
D7991	Coronoidectomy	Benefit
D7995	Synthetic graft - mandible or facial bones, by report	Benefit
D7996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report	Not A Benefit
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	Benefit
D7999	Unspecified oral surgery procedure, by report	By Report
Orthodontics		
D8010	Limited orthodontic treatment of the primary dentition	Not A Benefit
D8020	Limited orthodontic treatment of the transitional dentition	Not A Benefit
D8030	Limited orthodontic treatment of the adolescent dentition	Not A Benefit
D8040	Limited orthodontic treatment of the adult dentition	Not A Benefit
D8050	Interceptive orthodontic treatment of the primary dentition	Not A Benefit
D8060	Interceptive orthodontic treatment of the transitional dentition	Not A Benefit
D8070	Comprehensive orthodontic treatment of the transitional dentition	Not A Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition (primary dentition, cleft)	Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition (primary dentition, FGM)	Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition (mixed dentition, cleft)	Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition (mixed dentition, FGM)	Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition (malocclusion)	Benefit

CDT-4 Codes	Procedure Code Description	
D8080	Comprehensive orthodontic treatment of the adolescent dentition (permanent dentition, cleft)	Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition (permanent dentition, FGM)	Benefit
D8090	Comprehensive orthodontic treatment of the adult dentition	Not A Benefit
D8210	Removable appliance therapy	Benefit
D8220	Fixed appliance therapy	Benefit
D8660	Pre-orthodontic treatment visit	Benefit
D8670	Periodic orthodontic treatment visit (as part of contract)	Benefit
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Benefit
D8690	Orthodontic treatment (alternative billing to a contract fee)	Not A Benefit
D8691	Repair of orthodontic appliance	Benefit
D8692	Replacement of lost or broken retainer	Benefit
D8999	Unspecified orthodontic procedure, by report	By Report
Adjunctives		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	Benefit
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Benefit
D9211	Regional block anesthesia	Global
D9212	Trigeminal division block anesthesia	Global
D9215	Local anesthesia	Global
D9220	Deep sedation/general anesthesia - first 30 minutes	Benefit
D9221	Deep sedation/general anesthesia - each additional 15 minutes	Benefit
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	Benefit
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	Benefit
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	Benefit
D9248	Non-intravenous conscious sedation	Benefit
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	Global
D9410	House/Extended care facility call	Benefit
D9420	Hospital call	Benefit
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Benefit
D9440	Office visit - after regularly scheduled hours	Benefit
D9450	Case presentation, detailed and extensive treatment planning	Not A Benefit
D9610	Therapeutic drug injection, by report	Benefit
D9630	Other drugs and/or medicaments, by report	Not A Benefit
D9910	Application of desensitizing medicament	Benefit
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Not A Benefit
D9920	Behavior management, by report	Not A Benefit
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	Benefit
D9940	Occlusal guard, by report	Not A Benefit
D9941	Fabrication of athletic mouth guard	Not A Benefit
D9950	Occlusion analysis - mounted case	Benefit
D9951	Occlusal adjustment - limited	Benefit
D9952	Occlusal adjustment - complete	Benefit
D9970	Enamel microabrasion	Not A Benefit
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	Not A Benefit
D9972	External bleaching - per arch	Not A Benefit
D9973	External bleaching - per tooth	Not A Benefit
D9974	Internal bleaching - per tooth	Not A Benefit
D9999	Unspecified adjunctive procedure, by report	By Report

Federally Required Adult Dental Services (FRADS)

The following procedure codes will continue as reimbursable procedures for Medi-Cal beneficiaries 21 years of age and older beginning July 1, 2009

*Please note: The CDT-4 procedure codes marked with an asterisk (D0220, D0230, D0250, D0260, D0290, D0310 and D0330) are only payable for Medi-Cal beneficiaries age 21 and older who are not otherwise exempt when the procedure is appropriately rendered in conjunction with another FRADS.

Table 1

CDT-4 Code	CDT-4 Code Description
D0220*	Intraoral - periapical first film
D0230*	Intraoral - periapical each additional film
D0250*	Extraoral - first film
D0260*	Extraoral - each additional film
D0290*	Posterior - anterior or lateral skull and facial bone survey film
D0310*	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0322*	Tomographic survey
D0330*	Panoramic film
D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report
D2910	Recement inlay
D2920	Recement crown
D2940	Sedative filling
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint

CDT-4 Code	CDT-4 Code Description
D5988	Surgical splint
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6930	Recement fixed partial denture
D6999	Unspecified fixed prosthodontic procedure, by report
D7111	Coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue - soft (all others)
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greaterthan 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	D7465 Destruction of lesion(s) by physical or chemical method, by report
D7490	Radical resection of mandible with bone graft
D7510	Incision and drainage of abscess - intraoral soft tissue
D7520	Incision and drainage of abscess - extraoral soft tissue
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone

CDT-4 Code	CDT-4 Code Description
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrostomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy
D7876	Arthroscopy - surgical: discectomy
D7877	Arthroscopy - surgical: debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical - per sextant or quadrant
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report
D7955	Repair of maxillofacial soft and hard tissue defect
D7971	Excision of pericoronal gingiva
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia - each additional 15 minutes
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9241	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	Non-intravenous conscious sedation
D9410	House/Extended care facility call
D9420	Hospital call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic drug injection, by report
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report
D9999	Unspecified adjunctive procedure, by report

Table 2: Allowable Procedure Codes for Pregnant Women

CDT-4 Code	CDT-4 Code Description
D0120	Periodic oral evaluation
D0150	Comprehensive oral evaluation - new or established patient
D1110	Prophylaxis - adult
D1204	Topical application of fluoride (prophylaxis not included) – adult
D1205	Topical application of fluoride (including prophylaxis) - adult
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant
D4920	Unscheduled dressing change (by someone other than treating dentist)
D9951	Occlusal adjustment - limited

ACCESS DENTAL

2

Healthy Families Program

A description of Access Dental Plan's Healthy Families Program, including procedures and copayments.

THE HEALTHY FAMILIES PROGRAM (HFP) PROVIDES HEALTH, DENTAL AND VISION COVERAGE for uninsured low-income children (under 19 years of age) up to 250 percent of the Federal poverty level. The program uses Federal, State and County funds to provide health care coverage to uninsured children of lower income working Californians who are ineligible for Medi-Cal.

Unlike the Medi-Cal program, Healthy Families Program members have some minimal copayments to meet for certain services. The PCD must collect these copayments when delivering services. The benefits and copayments for the Healthy Families Program are listed below.

The Healthy Families Program (HFP) has made changes to the program. Based on the HFP income categories, there will be copayments and $1500 annual maximum amounts for applicable covered benefit services.

Reimbursement for Copayments

American Indians and Alaskan Native children are exempt from all HFP copayments.

In order to receive reimbursement for copayment amounts for services to American Indians and Alaskan Native children, providers are encouraged to use ADA claim forms or ***Access*** Dental encounter forms to report these services and request payment for these copayment amounts. This chapter contains a current list of procedure codes and description for the Healthy Families Program.

The HFP has increased copayments for applicable covered services for members who are in Income Categories B & C. Members in the income category A shall pay no more than $5.00 copayment for applicable covered services as described in this benefit

description section. If you have any questions regarding copayments, please call the Plan's Member Services Department at 888-849-8440, Monday through Friday from 8:00AM to 6:00PM.

The Healthy Families Scope of Dental Benefits is available by request, or can be reviewed online at www.mrmib.ca.gov.

Review criteria for prior authorization has been adopted from Medi-Cal Dental Program. This criteria is applied with covered benefits, limitations and exclusions of the Healthy Families program.

For prior authorization requirements, please refer to your individual contract agreement.

Dental Plan Covered Benefits Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.

The HFP has increased copayments for applicable covered services for members who are in Income Categories B & C. This copayment increase does not apply to members in Income Category A.

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
Diagnostic and Preventive Care Services	Initial and periodic oral examinations, Consultations, including specialist consultations, Topical fluoride treatment, Preventive dental education and oral hygiene instruction, Roentgenology (x-rays), Prophylaxis services (cleanings), Space Maintainers, Dental sealant treatments.	No copayment	No copayment
Restorative Dentistry (Fillings)	Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries, Micro filled resin restorations which are noncosmetic, Replacement of a restoration, Use of pins and pin build-up in conjunction with a restoration, Sedative base and sedative fillings.	No copayment	No copayment
Oral Surgery	Extractions, including surgical extractions, Removal of impacted teeth , Biopsy of oral tissues, Alveolectomies, Excision of cysts and neoplasms, Treatment of palatal torus, Treatment of mandibular torus, Frenectomy, Incision and drainage of abscesses, Post-operative services, including exams, suture removal and treatment of complications, Root recovery (separate procedure).	No copayment, except • $5 copayment for the removal of impacted teeth for a bony impaction • $5 copayment per root recovery	No copayment, except • $10 copayment for the removal of impacted teeth for a bony impaction • $10 copayment per root recovery
Endodontic	Direct pulp capping, Pulpotomy and vital pulpotomy, Apexification filling with calcium hydroxide, Root amputation, Root canal therapy, including culture canal, Retreatment of previous root canal therapy, Apicoectomy, Vitality tests.	No copayment, except • $5 copayment per canal for root canal therapy or retreatment of previous root canal therapy • $5 copayment per root for an apicoectomy	No copayment, except • $10 copayment per canal for root canal therapy or retreatment of previous root canal therapy • $10 copayment per root for an apicoectomy
Periodontics	Emergency treatment, including treatment for periodontal abscess and acute periodontitis, Periodontal scaling and root planing, and subgingival curettage, Gingivectomy, Osseous or muco-gingival surgery.	No copayment, except • $5 copayment per quadrant for osseous or muco-gingival surgery	No copayment, except • $10 copayment per quadrant for osseous or muco-gingival surgery
Crown and Fixed Bridge	Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel, Related dowel pins and pin build-up, Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, Recementation of crowns, bridges, inlays and onlays, Cast post and core, including cast retention under crowns, Repair or replacement of crowns, abutments or pontics.	No copayment, except • $5 copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. • $5 copayment per pontic. • The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.	No copayment, except • $10 copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. • $10 copayment per pontic. • The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
Removable Prosthetics	Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, Office or laboratory relines or rebases, Denture repair, Denture adjustment, Tissue conditioning, Denture duplication, Stayplates.	No copayment, except: ▪ $5 copayment for a complete maxillary or mandibular denture ▪ $5 copayment for partial acrylic upper or lower denture with clasps ▪ $5 copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles ▪ $5 copayment for removable unilateral partial denture ▪ $5 copayment for reline of upper, lower or partial denture when performed by a Laboratory ▪ $5 copayment for denture duplication	No copayment, except: ▪ $10 copayment for a complete maxillary or mandibular denture ▪ $10 copayment for partial acrylic upper or lower denture with clasps ▪ $10 copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles ▪ $10 copayment for removable unilateral partial denture ▪ $10 copayment for reline of upper, lower or partial denture when performed by a Laboratory ▪ $10 copayment for denture duplication
Other Benefits	Local anesthetics, Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure, Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of licensure, Emergency treatment, palliative treatment, Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.	No Charge	No Charge
Orthodontia Services	Not a Healthy Families Program covered benefit. Services are provided to members under the age of 19 through the California Children's Services Program (CCS) if the Member meets the eligibility requirements for medically necessary orthodontia coverage.	Not applicable	Not applicable
Deductibles	**No deductibles will be charged for covered benefits.**		
Annual Maximums	**No Annual Maximum.**		
Lifetime Maximums	**No lifetime maximum limits on benefits apply under this plan.**		

*Benefits are provided if the plan determines the services to be medically necessary.

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
DIAGNOSTIC AND PREVENTATIVE				
120	Periodic oral evaluation	Once every 6 months	$0	$0
140	Limited oral evaluation	Problem focused evaluation, for a specific problem and or a dental emergency, trauma, acute infection, etc. Benefit only if no other treatment (except x-rays) is rendered during the visit	$0	$0
145	Oral evalution for a patient under three years of age and counseling with primary caregiver	Once every 6 months	$0	$0
150	Comprehensive oral evaluation		$0	$0
210	Intraoral-complete series including bitewings	Once every 24 consecutive months	$0	$0
220	Intraoral-periapical-first film		$0	$0
230	Intraoral periapical-each additional film		$0	$0
240	Intraoral-occlusal film		$0	$0
270	Bitewing-single film		$0	$0
272	Bitewings-two films	Once every 6 months Bitewings- are allowed Once every 6 months in conjunction with periodic examinations Isolated bitewing or periapical films are allowed on an emergency or episodic basis.	$0	$0
273	Bitewings-three films			
274	Bitewings-four films			
277	Vertical bitewings-7 to 8 films			
330	Panoramic film	Once every 24 consecutive months	$0	$0
350	Photograph 1st		$0	$0
350	Photograph each additional (up to 7)		$0	$0
460	Pulp vitality tests		$0	$0
473	Histopathologic examinations		$0	$0
1110*	Prophylaxis – includes scaling of unattached tooth surfaces & polishing – adult (13 yrs and up)	Once every 6 months	$0	$0
1120*	Prophylaxis – children through age 12			
1203	Topical application fl excluding prophy-child			
1204	Topical application fl excluding prophy-adult			
1206	Topical fluoride varnish			
1330	Oral hygiene instruction		$0	$0
1351	Sealant – per tooth	Permanent 1st and 2nd molars only/once every 36 months	$0	$0
1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	Permanent 1st and 2nd molars only/once every 36 months Not a benefit in conjunction with other restorative services	$0	$0
1510	Space maintainer – fixed unilateral	Must have adequate space to allow normal eruption of permanent tooth not a benefit for congentially missing teeth	$0	$0
1515	Space maintainer-fixed bialateral			
1525	Space maintainer-removeable-bilateral			
1550	Re-cementation of space maintainer	Once every 6 months	$0	$0
1555	Removal of fixed space maintainer		$0	$0

* NOTE AGE RESTRICTIONS

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
RESTORATIVE DENTISTRY				
2140**	AMALGAM – ONE SURFACE PRIMARY OR PERMANENT	AMALGAM, COMPOSITE RESIN, ACRYLIC, SYNTHETIC OR PLASTIC RESTORATIONS ARE COVERED FOR THE TREATMENT OF CARIES LESIONS ONLY. POSTERIOR RESINS ARE OPTIONAL TREATMENTS AND WILL BE DOWN GRADED TO AN AMALGAM FILLING. PLEASE REFER TO THE OPTIONAL TREATMENTS POLICY IN THIS PROVIDER MANUAL.	$0	$0
2150**	AMALGAM – TWO SURFACES PRIMARY OR PERMANENT			
2160**	AMALGAM – THREE SURFACES PRIMARY OR PERMANENT			
2161**	AMALGAM – 4 OR MORE SURFACES PRIMARY OR PERMANENT			
2330	ANTERIOR RESIN RESTORATION. ANY COMPOSITES, WHICH DO NOT MEET 2335 CRITERIA, ARE TO BE BILLED AS 2330. EXAMPLE: F, B, I, ETC.			
2331	ANTERIOR RESIN RESTORATION. ANY COMPOSITES WHICH, DO NOT MEET 2335 CRITERIA, ARE TO BE BILLED AS 2330. EXAMPLE: ML, F, B, DF, DL, MF, I, ETC.			
2332	ANTERIOR RESIN RESTORATION. ANY COMPOSITES WHICH, DO NOT MEET 2335 CRITERIA, ARE TO BE BILLED AS 2330. EXAMPLE: DFL, MFL, ETC.			
2335	COMPOSITE FILLING MUST MEET THE FOLLOWING CRITERIA TO BE BILLED AS 2335: A) INCLUDE INCISAL AND ONE OR MORE OTHER SU RFACES B) INCLUDE BOTH MESIAL AND DISTAL, WITH OR WITHOUT OTHER SURFACE			
2391	RESIN-BASED COMPOSITE – ONE SURFACE, POSTERIOR			
2392	RESIN-BASED COMPOSITE – TWO SURFACES, POSTERIOR			
2393	RESIN-BASED COMPOSITE – THREE SURFACES, POSTERIOR			
2394	RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES, POSTERIOR			
CROWNS				
THE COST OF PRECIOUS METALS USED IN ANY FORM OF DENTAL BENEFITS IS THE RESPONSIBILITY OF THE MEMBER				
2542*	ONLAY - METALLIC - TWO SURFACES	FOR CHILDREN 12 YEARS AND OLDER (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) ONCE EVERY 36 MONTHS. ONLY IF A FILLING CAN NOT BE PLACED, AND NO MORE THAN 5 UNITS PER ARCH	$5.00	$10.00
2543*	ONLAYS - METALLIC - THREE SURFACES			
2544*	ONLAY – METALLIC FOUR OR MORE SURFACES			
2710*	CROWN – RESIN – LABORATORY	FOR CHILDREN UNDER 12 YEARS OLD ONCE EVERY 36 MONTHS	$0	$0
2720*	CROWN - RESIN WITH HIGH NOBLE METAL	FOR CHILDREN 12 YEARS AND OLDER (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) ONCE EVERY 36 MONTHS. ONLY IF A FILLING CAN NOT BE PLACED, AND NO MORE THAN 5 UNITS PER ARCH	$5.00	$10.00
2721*	CROWN - RESIN WITH PREDOMINANTLY BASE METAL			
2722*	CROWN - RESIN WITH NOBLE METAL			
2740*	CROWN – PORCELAIN/CERAMIC SUBSTRATE			
2750*	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL			
2751*	CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL			
2752*	CROWN – PORCELAIN FUSED TO NOBLE METAL			
2780*	CROWN - 3/4 CAST HIGH NOBLE METAL			

* NOTE AGE RESTRICTIONS

** PAYMENT WILL BE BASED ON THE TOOTH TYPE (PRIMARY/ PERMANENT) AS INDICATED ON THE CONTRACTED FEE SCHEDULE.

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
2781*	CROWN – ¾ PREDOMINANTLY BASE METAL	FOR CHILDREN 12 YEARS AND OLDER (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) ONCE EVERY 36 MONTHS. ONLY IF A FILLING CAN NOT BE PLACED, AND NO MORE THAN 5 UNITS PER ARCH	$5.00	$10.00
2782*	CROWN - 3/4 CAST NOBLE METAL			
2783*	CROWN - 3/4 PORCELINA/CERAMIC			
2790*	CROWN – FULL CAST HIGH NOBLE METAL			
2791*	CROWN – FULL CAST PREDOMINANTLY BASE METAL			
2792*	CROWN – FULL CAST NOBLE METAL			
2794*	CROWN - TITANIUM			
2910	RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION		$0	$0
2920	RECEMENT CROWN		$0	$0
2930	PREFAB STAINLESS STEEL CROWN PRIMARY TOOTH		$0	$0
2931*	PREFAB STAINLESS STEEL CROWN PERMANENT TOOTH	FOR CHILDREN UNDER 12 YEARS OLD	$0	$0
2932	PREFABRICATED RESIN CROWN	ANTERIOR TEETH ONLY ONE IN 12 MONTHS FOR PRIMARY TEETH ONE IN 36 MONTHS FOR PERMANENT TEETH	$0	$0
2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	ONE IN 12 MONTHS FOR PRIMARY TEETH ONE IN 36 MONTHS FOR PERMANENT TEETH WILL BE DOWNGRADED TO PREFAB STAINLESS STEEL CROWN (2930)	$0	$0
2934	PRE-FAB ESTHETIC COATED SSC - PRIMARY TOOTH	ONE IN A 12 MONTHS WILL BE DOWNGRADED TO PREFAB STAINLESS STEEL CROWN (2930)	$0	$0
2940	PROTECTIVE RESTORATION	PAID AS 9110	$0	$0
2950	CORE BUILDUP, INCLUDING ANY PINS.	FEE IS INCLUDED UNDER CROWNS	$0	$0
2951	PIN RETENTION PER TOOTH IN ADDITION TO RESTORATION		$0	$0
2952	CAST POST AND CORE IN ADDITION TO CROWN		$0	$0
2953	EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH	ONE IN LIFETIME PER TOOTH TO BE PERFORMED IN CONJUNCTION WITH D2952 AND IS NOT PAYABLE SEPARATELY	$0	$0
2954	PREFAB POST AND CORE IN ADDITION TO CROWN		$0	$0
2955	POST REMOVAL (NOT IN CONJUNCTION WITH ENDODONTIC THERAPY)		$0	$0
2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	ONLY IN CONJUNCTION WITH ALLOWABLE CROWN OR ON ROOT CANAL TREATED PERMANENT TEETH	$0	$0
2970	TEMPORARY CROWN (FRACTURED TOOTH)	ONE IN LIFETIME PER TOOTH FOR PERMANENT TEETH ONLY. THIS PROCEDURE IS LIMITED TO THE PALLIATIVE TREATMENT OF TRAUMATIC INJURY ONLY AND SHALL MEET THE CRITERIA FOR A LABORATORY PROCESSED CROWN (D2710-D2792) NOT A BENEFIT ON THE SAME DATE OF SERVICE AS: A. PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN- MINOR PROCEDURE (D9110) B. OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS) - NO OTHER SERVICES PERFORMED (D9430)	$0	$0
2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK	ONE IN 36 MONTHS	$0	$0
2980	CROWN REPAIR – BY REPORT		$0	$0

* NOTE AGE RESTRICTIONS

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
3110	PULP CAP, DIRECT, EXCLUDING FINAL RESTORATION		$0	$0
3220	THERAPEUTIC PULPOTOMY, EXCLUDING FINAL RESTORATION		$0	$0
3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH	ONE PER TOOTH A BENEFIT FOR PERMANENT TOOTH OR OVER-RETAINED PRIMARY TEETH WITH NO PERMANENT SUCCESSOR. THIS PROCEDURE IS FOR THE RELIEF OF ACUTE PAIN PRIOR TO CONVENTIONAL ROOT CANAL THERAPY AND IS NOT A BENEFIT FOR ROOT CANAL THERAPY VISITS. NOT A BENEFIT ON THE SAME DATE OF SERVICE WITH ANY ADDITIONAL SERVICES ON THE SAME TOOTH.	$0	$0
3222	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT		$0	$0
3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESOTRATION)	ONE PER PRIMARY TOOTH NOT A BENEFIT: A. FOR A PRIMARY TOOTH NEAR EXFOLIATION. B. WITH A THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) (D3220), SAME DATE OF SERVICE, SAME TOOTH. C. WITH PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH (D3221), SAME DATE OF SERVICE, SAME TOOTH.	$0	$0
3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESOTRATION)	ONE PER PRIMARY TOOTH NOT A BENEFIT: A. FOR A PRIMARY TOOTH NEAR EXFOLIATION. B. WITH A THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) (D3220), SAME DATE OF SERVICE, SAME TOOTH. C. WITH PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH (D3221), SAME DATE OF SERVICE, SAME TOOTH	$0	$0
3310	ROOT CANAL, ANTERIOR, EXCLUDING FINAL RESTORATION		$5.00 PER CANAL	$10.00 PER CANAL
3320	ROOT CANAL, BICUSPID, EXCLUDING FINAL RESTORATION			
3330	ROOT CANAL, MOLAR, EXCLUDING FINAL RESTORATION			
3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS	TO BE PERFORMED IN CONJUNCTION WITH ENDODONTIC PROCEDURES AND IS NOT PAYABLE SEPARATELY	$0	$0
3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY, ANTERIOR	RETREATMENT. ONLY IF SIGNS OF ABSCESS FORMATION PRESENT. NOT FOR REMOVAL OF SILVER POINTS, OVERFILLS, UNDERFILLS, OR BROKEN INSTRUMENTS WITHOUT PATHOLOGY.	$5.00 PER CANAL	$10.00 PER CANAL
3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY, BICUSPID			
3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY, MOLAR			
3351	APEXIFICATION/RECALCIFICATION/PULPAL REGENERATION - INITIAL VISIT	THE APEXIFICATION PROCEDURE MAY BE REPEATED AT SIX-MONTH INTERVALS, AFTER THE INITIAL APEXIFICATION SESSION WITH PAYMENT ALLOWED FOR EACH TREATMENT.	$0	$0
3352	APEXIFICATION/RECALCIFICATION/PULPAL REGENERATION - INTERIM			
3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT			

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
3354	PULPAL REGENERATION – (COMPLETION OF REGENERATIVE TREATMENT IN AN IMMATURE PERMANENT TOOTH WITH A NECROTIC PULP); DOES NOT INCLUDE FINAL RESTORATION.		$0	$0
3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR		$5.00 PER CANAL	$10.00 PER CANAL
3421	APICOECTOMY/PERIRADICULAR SURGERY – BICUS FIRST ROOT			
3425	APICOECTOMY/PERIRADICULAR SURGERY – MOLAR SECOND ROOT			
3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)	A BENEFIT FOR PERMANENT TEETH ONLY. NOT A BENEFIT: A. TO THE ORIGINAL PROVIDER WITHIN 90 DAYS OF ROOT CANAL THERAPY. B. TO THE ORIGINAL PROVIDER WITHIN 24 MONTHS OF A PRIOR APICOECTOMY/ PERIRADICULAR SURGERY, SAME ROOT. C. FOR 3RD MOLARS, UNLESS THE 3RD MOLAR OCCUPIES THE 1ST OR 2ND MOLAR POSITION OR IS AN ABUTMENT FOR AN EXISTING FIXED PARTIAL DENTURE OR REMOVABLE PARTIAL DENTURE WITH CAST CLASPS OR RESTS. ONLY PAYABLE THE SAME DATE OF SERVICE AS PROCEDURES D3421 OR D3425. THE FEE FOR THIS PROCEDURE INCLUDES THE PLACEMENT OF RETROGRADE FILLING MATERIAL AND ALL TREATMENT AND POST TREATMENT RADIOGRAPHS.	$5.00	$10.00
3430	RETROGRADE FILLING – PER ROOT		$0	$0
3450	ROOT AMPUTATION – INCLUDING ANY ROOT REMOVAL		$0	$0
	PERIODONTICS			
4210	GINGIVECTOMY/GINGIVOPLASTY – PER QUADRANT	CO-PAYMENT, MUST INCLUDE POST SURGICAL VISITS	$0	$0
4211	GINGIVECTOMY/GINGIVOLPLASTY – PER TOOTH	NOT IN CONJUNCTION WITH CROWN PREPARATION	$0	$0
4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	5 QUADRANTS IN 12 MONTHS	$0	$0
4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT		$0	$0
4260	OSSEOUS – MUCO – GINGIVAL SURGERY PER QUADRANT		$5.00	$10.00
4261*	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) – ONE TO THREE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	FOR PATIENTS AGE 13 OR OLDER - ONCE PER QUADRANT EVERY 36 MONTHS NOT WITHIN 30 DAYS FOLLOWING PERIODONTAL SCALING AND ROOT PLANING (D4341 AND D4342) FOR THE SAME QUADRANT	$5.00	$10.00
4341	PERIODONTAL SCALING AND ROOT PLANING FOUR OR MORE TEETH PER QUADRANT	UP TO 5 QUADRANTS IN 12 MONTH PERIOD. A BENEFIT TO TREAT ABSCESS OR ACUTE PERIODONTITIS	$0	$0
4342	PERIODONTAL SCALING AND ROOT PLANING ONE TO THREE TEETH PER QUADRANT		$0	$0

* NOTE AGE RESTRICTIONS

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
4910	PERIODONTAL MAINTENANCE *(PERIODONTAL RECALL (PERIODONTAL PROPHYLAXIS) FOLLOWING ACTIVE PERIODONTAL THERAPY AFTER THREE MONTHS (INCLUDES ANY EXAMINATION EVALUATION, CURETTAGE, ROOT PLANNING AND/OR POLISHING AS MAY BE NECESSARY.)*	ONCE EVERY 6 MONTH IF THERE IS NO HISTORY OF PROPHYLAXIS WITHIN 6 MONTH	$0	$0
4920*	UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST)	FOR PATIENTS AGE 13 OR OLDER ONCE PER PATIENT PER PROVIDER	$0	$0
	PROSTHETICS			
5110	COMPLETE DENTURE – UPPER	ONCE EVERY 36 MONTHS FOR CHILDREN 16 YEARS AND OLDER	$5.00	$10.00
5120	COMPLETE DENTURE – LOWER			
5130	IMMEDIATE DENTURE – UPPER			
5140	IMMEDIATE DENTURE – LOWER			
5211	UPPER PARTIAL-RESIN BASED WITH CONVENTIONAL CLASPS, RESTS & TEETH		$5.00	$10.00
5212	LOWER PARTIAL-RESIN BASED WITH CONVENTIONAL CLASPS, RESTS & TEETH		$5.00	$10.00
5213	UPPER PARTIAL-CAST METAL RESIN BASED WITH CONVENTIONAL CLASPS, RESTS & TEETH	ONCE EVERY 36 MONTHS FOR CHILDREN 16 YEARS AND OLDER	$5.00	$10.00
5214	LOWER PARTIAL-CAST METAL RESIN BASED WITH CONVENTIONAL CLASPS, RESTS & TEETH		$5.00	$10.00
5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)		$5.00	$10.00
5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)		$5.00	$10.00
5410	ADJUST COMPLETE DENTURE – UPPER		$0	$0
5411	ADJUST COMPLETE DENTURE – LOWER		$0	$0
5421	ADJUST PARTIAL DENTURE – UPPER		$0	$0
5422	ADJUST PARTIAL DENTURE – LOWER		$0	$0
5510	REPAIR BROKEN COMPLETE DENTURE BASE		$0	$0
5520	REPLACE MISSING/BROKEN T-COMPL. DENT- EACH T.		$0	$0
5610	REPAIR RESIN DENTURE BASE		$0	$0
5620	REPAIR CAST FRAMEWORK		$0	$0
5630	REPAIR OR REPLACE BROKEN CLASP		$0	$0
5640	REPLACE BROKEN TEETH – PER TOOTH		$0	$0
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE		$0	$0
5660	ADD CLASP TO EXISTING PARTIAL DENTURE		$0	$0
5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)		$0	$0
5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)		$0	$0
5710	REBASE COMPLETE MAXILLARY DENTURE	ONE IN 12 MONTHS FREQUENCY LIMIT APPLIES TO DENTURE RELINE	$0	$0
5711	REBASE COMPLETE MANDIBULAR DENTURE	ONE IN 12 MONTHS FREQUENCY LIMIT APPLIES TO DENTURE RELINE	$0	$0
5720	REBASE MAXILLARY PARTIAL DENTURE	ONE IN 12 MONTHS FREQUENCY LIMIT APPLIES TO DENTURE RELINE	$0	$0

* NOTE AGE RESTRICTIONS

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
5721	REBASE MANDIBULAR PARTIAL DENTURE	ONE IN 12 MONTHS FREQUENCY LIMIT APPLIES TO DENTURE RELINE	$0	$0
5730	RELINE COMPLETE UPPER DENTURE – CHAIRSIDE	ONE PER ARCH IN ANY 12 CONSECUTIVE MONTHS	$0	$0
5731	RELINE COMPLETE LOWER DENTURE – CHAIRSIDE			
5740	RELINE UPPER PARTIAL DENTURE – CHAIRSIDE			
5741	RELINE LOWER PART DENTURE – CHAIRSIDE			
5750	RELINE COMPLETE UPPER DENTURE – LABORATORY	ONE PER ARCH IN ANY 12 CONSECUTIVE MONTHS	$5.00	$10.00
5751	RELINE COMPLETE LOWER DENTURE – LABORATORY			
5760	RELINE UPPER PARTIAL DENTURE – LABORATORY			
5761	RELINE LOWER PARTIAL DENTURE – LABORATORY			
5820	INTERIM PARTIAL DENTURE (UPPER)	A BENEFIT ONLY IF USED AS ANTERIOR SPACE MAINTAINER IN CHILDREN	$0	$0
5821	INTERIM PARTIAL DENTURE – (LOWER)			
5850	TISSUE CONDITIONING, MAXILLARY	LIMITED TO TWO PER DENTURE	$0	$0
5851	TISSUE CONDITIONING, MANDIBULAR			
5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT - DENTURE DUPLICATION	ONE DENTURE DUPLICATION PER LIFETIME	$5.00	$10.00
BRIDGES				
PONTIC				
6210*	PONTIC - CAST HIGH NOBLE METAL	ONE PER 36 MONTHS CO-PAYMENT PER UNIT WHEN NECESSARY FOR PATIENTS (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) 16 YEARS OLD OR OLDER AND WHOSE ORAL HEALTH PERMITS, FOR ANTERIOR TEETH ONLY. UP TO 5 UNITS ALLOWED PER ARCH. OPTIONAL WHEN PROVIDED WITH A PARTIAL DENTURE ON SAME ARCH OR WHEN ABUTMENT TEETH ARE DENTALLY SOUND.	$5.00	$10.00
6211*	PONTIC - CAST PREDOMINANTLY BASE METAL			
6212*	PONTIC - CAST NOBLE METAL			
6214*	PONTIC - TITANIUM			
6240*	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL			
6241*	PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL			
6242*	PONTIC - PORCELAIN FUSED TO NOBLE METAL			
6245*	PONTIC - PORCLAIN/CERAMIC			
6251*	PONTIC - PONTIC RESIN PREDOMINANTLY BASE METAL			
6252*	PONTIC - RESIN WITH NOBLE METAL			
RETAINER				
6545*	RETAINER – CAST METAL RESIN BOND FIX PROSTH.	ONE PER 36 MONTHS CO-PAYMENT PER UNIT WHEN NECESSARY FOR PATIENTS (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) 16 YEARS OLD OR OLDER AND WHOSE ORAL HEALTH PERMITS, FOR ANTERIOR TEETH ONLY. UP TO 5 UNITS ALLOWED PER ARCH. OPTIONAL WHEN PROVIDED WITH A PARTIAL DENTURE ON SAME ARCH OR WHEN ABUTMENT TEETH ARE DENTALLY SOUND.	$5.00	$10.00
6610*	ONLAY - CAST HIGH NOBLE METAL, TWO SURFACES			
6611*	ONLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES			
6612*	ONLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES	ONE PER 36 MONTHS CO-PAYMENT PER UNIT WHEN NECESSARY FOR PATIENTS (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) 16 YEARS OLD OR OLDER AND WHOSE ORAL HEALTH PERMITS, FOR ANTERIOR TEETH ONLY. UP TO 5 UNITS ALLOWED PER ARCH. OPTIONAL WHEN PROVIDED WITH A PARTIAL DENTURE ON SAME ARCH OR WHEN ABUTMENT TEETH ARE DENTALLY SOUND.	$5.00	$10.00
6613*	ONLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES			
6614*	ONLAY - CAST NOBLE METAL, TWO SURFACES			
6615*	ONLAY - CAST NOBLE METAL, THREE OR MORE SURFACES			
6720*	CROWN - RESIN WITH HIGH NOBLE METAL			
6721*	CROWN - RESIN WITH PREDOMINANTLY BASE METAL			
6722*	CROWN - RESIN WITH NOBLE METAL			

* NOTE AGE RESTRICTIONS

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
6930	RECEMENT BRIDGE		$0	$0
6970	CAST POST AND CORE, IN ADDITION TO RETAINER		$0	$0
6972	PREFABRICATED POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE REATINER BASE METAL POST; INCLUDES CANAL PREPARATION	ONE IN LIFETIME ONLY IN CONJUNCTION WITH ALLOWABLE RETAINERS ON ROOT CANAL TREATED PERMANENT TEETH	$0	$0
6973	CORE BUILDUP FOR RETAINER, INCLUDING ANY PINS	INCLUDED IN THE FEE FOR RESTORATIVE AND FIXED PROSTHODONTIC PROCEDURES AND IS NOT PAYABLE SEPARATELY	$0	$0
6976	EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH	TO BE PERFORMED IN CONJUNCTION WITH D6970 AND IS NOT PAYABLE SEPARATELY	$0	$0
6977	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	TO BE PERFORMED IN CONJUNCTION WITH D6972 AND IS NOT PAYABLE SEPARATELY	$0	$0
6980	BRIDGE REPAIR, BY REPORT		$0	$0
	ORAL SURGERY			
7111	CORONAL REMNANTS - DECIDUOUS TOOTH		$0	$0
7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT		$0	$0
7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH AND INCLUDING ELEVATION OF FLAP IF INDICATED		$0	$0
7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE		$0	$0
7230	REMOVAL OF IMPACTED TOOTH PART BONY		$5.00	$10.00
7240	REMOVAL OF IMPACTED TOOTH - COMPLETE BONY		$5.00	$10.00
7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	ONE IN LIFETIME PER TOOTH A BENEFIT WHEN THE REMOVAL OF ANY IMPACTED TOOTH REQUIRES THE ELEVATION OF A MUCOPERIOSTEAL FLAP AND THE REMOVAL OF SUBSTANTIAL ALVEOLAR BONE COVERING MOST OR ALL OF THE CROWN	$5.00	$10.00
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS REQUIRING CUTTING OF SOFT TISSUE AND BONE AND CLOSURE		$5.00	$10.00
7251	CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL		$5.00	$10.00
7270	TOOTH REIMPLANTATION/STABILIZATION		$0	$0
7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)		$0	$0
7286	BIOPSY OF ORAL TISSUE - SOFT		$0	$0
7310	ALVEOPLASTY IN CONJUNCTION WITH EXTRATIONS - PER QUADRANT		$0	$0
7311	ALVEOPLASTY IN CONJUNCTION WITH EXTRATIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT		$0	$0
7320	ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRATIONS - PER QUADRANT		$0	$0
7321	ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRATIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT		$0	$0
7410	EXCISION OF BENIGN LESION UP TO 1.25 CM		$0	$0
7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM		$0	$0

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
7450	Removal of benign-odontogenic. cyst or tumor lesion diameter up to 1.25cm		$0	$0
7451	Removal of benign-odontogenic. cyst or tumor lesion diameter greater than 1.25cm		$0	$0
7460	Removal of benign nonodontogenic. cyst or tumor lesion diameter up to 1.25cm		$0	$0
7461	Removal of benign nonodontogenic. cyst or tumor lesion diameter greater than 1.25cm		$0	$0
7472	Removal of palatal torus		$0	$0
7473	Removal of mandibular torus		$0	$0
7473	Removal of mandibular torus		$0	$0
7510	Incision and drainage of abscess - intraoral soft tissue		$0	$0
OTHERS				
7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Will be downgraded to 7510	$0	$0
7520	Incision and drainage of abscess - extraoral		$0	$0
7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Will be downgraded to 7520	$0	$0
7960	Frenulectomy – also known as (frenectomy or frenotomy) – separate procedure not incidental to another procedure		$0	$0
9110	Palliative (emergency) treatment of dental pain – minor	Benefit only if no other treatment (except x-rays) is rendered during the visit	$0	$0
9210	Local anesthesia not in conjunction with operative or surgical procedures		$0	$0
9215	Local anesthesia in conjunction with operative or surgical procedures		$0	$0
9220	General anesthesia - first 30 minutes	A benefit only with authorized surgical procedure	$0	$0
9221	General anesthesia - each additional 15 minutes		$0	$0
9230	Administration of nitrous oxide / anxiolysis, analgesia		$0	$0
9241	Intravenous conscious sedation/analgesia – first 30 minutes	A benefit only with authorized surgical procedure.	$0	$0
9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	Includes intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring		
9248	Non-intravenous conscious sedation	includes non-intravenous administration of sedativeand/or analgesic agent(s) and appropriate monitoring	$0	$0
9310	Consult diag. Svc by nontreat practitioner	Benefit only if no other treatment (except x-rays) is rendered during the visit	$0	$0
9420	Hospital call		$0	$0

CDT CODE	PROCEDURE DESCRIPTION		CO-PAY (A)	CO-PAY (B/C)
9430	OFFICE VISIT DURING REGULAR HOURS-NO OTHER SERVICES		$0	$0
9440	OFFICE VISIT – AFTER REGULAR SCHEDULED HOURS		$0	$0
9920	BEHAVIOR MANAGEMENT		$0	$0
9930	COMPLICATIONS, POST SURGICAL, UNUSUAL, BY REPORT		$0	$0
9999	UNSPECIFIED ADJUNCTIVE PROCEDURE BY REPORT		$0	$0
ANNUAL MAXIMUMS		NO ANNUAL MAXIMUM		

Please use the following code to report missed or broken appointments.
Statement for broken appointment.

777	BROKEN APPOINTMENT	WITHOUT 24 HOUR NOTIFICATION	$5.00	$10.00

ACCESS DENTAL

3

Commercial Managed Care Program

A description of Access Dental Plan's Commercial Managed Care Program coverage, including procedures and copayments.

THE BENEFITS AND COPAYMENTS FOR COMMERCIAL MANAGED CARE COVERAGE are shown on the following pages. ***Access*** Dental Plan provides group dental benefits to employers and union groups. Under the prepaid Commercial Managed Care Program, members have a copayment for certain services. The PCD must collect the copayment at the time of delivery of service.

Review criteria for claims processing has been adopted from the Medi-Cal dental program provider manual. This criteria is applied with covered benefits, limitations, and exclusions of ***Access*** Dental Plan's Commercial Managed Care Program.

Copayment

Access Dental Plan offers several commercial product copayment schedules (plans 100, 200, 300, 400, 500, and 600) which are included in this chapter. These copayments are amounts that should be collected by the provider from the members at the time of delivery of service.

If ***Access*** Dental Plan offers a commercial product that provides a "Custom" copayment schedule that is less than the amount set forth on the lowest regular copayment schedule which is DMO-300, then the provider shall collect from the member the amount set forth in "Custom Copayment" schedule and submit a claim to ***Access*** Dental Plan for the difference between the amount charged to the member and the amount set forth in the DMO-300 copayment schedule.

Provider must refer to member's identification card to determine member's copayment schedule. You may contact our Provider Relations department or visit our website to obtain the copayment schedule.

Benefits Plan Summary

The following lists are allowed dental benefits the member can obtain through the Plan when the services are necessary and consistent with professionally recognized standards of practice, subject to the exceptions and limitations listed here:

◆ *Diagnostic and Preventive Benefits*

Description

- Benefit includes:
- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Radiographs (x-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type.

Limitations

Radiographs (x-rays) is limited as follows:
- Bitewing x-rays in conjunction with periodic examinations are limited to one series of two or four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis
- Full mouth x-rays in conjunction with periodic examinations are limited to once every 60 consecutive months

Panoramic film x-rays are limited to once every 60 consecutive months
Prophylaxis services (cleanings) are limited to one every six month period.
Dental sealant treatments are limited to un-restored permanent first and second molars for children under the age of 14 years.

◆ *Restorative Dentistry*

Description

Restorations include:
- Amalgam or composite resin for the treatment of caries
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations

Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam or composite resin; any other restoration such as a crown is considered optional.
- Composite resin on posterior teeth are optional.

Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary

◆ *Oral Surgery*

Description

Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation

The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

◆ *Endodontic*

Description

Endodonitcs benefits include:

- Direct and indirect pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited re-treatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

<u>Limitations</u>

Root canal therapy, including culture canal, is limited as follows:

- Re-treatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or re-treatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

◆ *Periodontics*

<u>Description</u>

Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy

<u>Limitation</u>

Periodontal scaling and root planing, and subgingival curettage are limited to four (4) quadrant treatments in any 12 consecutive months.

◆ *Crown and Fixed Bridge*

<u>Description</u>

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal.
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

<u>Limitation</u>

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every 60 consecutive months, except when the crown is no longer functional as determined by the Plan.
- Only acrylic crowns and stainless steel crowns are a benefit for children under 16 years of age. If other types of crowns are chosen as an optional

benefit for children under 16 years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers are considered optional.

The fixed bridge benefit is limited as follows:
- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 16, it is considered optional dental treatment. If performed on a member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

◆ *Removable Prosthetics*

<u>Description</u>

The removable prosthetics benefit includes:
- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, and clasps
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Stayplates

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within 60 consecutive months, unless:
  - It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  - The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within 60 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture
- Implants are considered an optional benefit
- Stayplates are a benefit for the replacement of an extracted anterior tooth during the healing period. Limited to (1) per arch in any 12 consecutive months.

Description

Other dental benefits include:

- Local anesthetics
- Oral sedation. For children under 6 years of age when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed for children under 13 years of age in a dental office by a practitioner acting within the scope of their licensure
- Emergency treatment, palliative treatment
- Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

◆ *Exclusions and Limitations*

The following dental Benefits are excluded under the plan:

1. Treatment which: a) is not included in the list of Covered Services and Supplies; b) is not Dentally Necessary; or c) is Experimental in nature.
2. Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
3. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the policy.
4. Replacement of a lost or stolen appliance including but not limited to, full or partial dentures, space maintainers and crowns and bridges.
5. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
6. Missed dental appointments.
7. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
8. Treatment for a jaw fracture.
9. Services or supplies provided by a dentist, dental hygienist, denturist or doctor who is: a) a close relative or a person who ordinarily resides with You or an Eligible Dependent; b) an employee of the employer; c) the employer.
10. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
11. Services and supplies obtained while outside the United States, except for Emergency Care.
12. Services or supplies resulting from or in the course of your or your Eligible Dependent's regular occupation for pay or profit for which you or your Eligible Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify Us of all such benefits.
13. Any Charges which are:
    a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a

governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and supplies.

b. Not imposed against the person or for which the person is not liable.

c. Reimbursable by Medicare Part A and Part B. If an Eligible Person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her Benefits under this policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for Eligible Persons insured under employers who notify Us that they employ 20 or more employees during the previous business year, this exclusion will not apply to an actively at work employee and/or his or her spouse who is age 65 or older if the employee elects coverage under this policy instead of coverage under Medicare.

14. Services and supplies provided primarily for cosmetic purposes.
15. Services and supplies which may not reasonably be expected to successfully correct the Eligible Person's dental condition for a period of at least three years, as determined by Us.
16. Orthodontic services, supplies, appliances and orthodontic-related services, unless an orthodontic rider was included in the policy.
17. Extraction of asymptomatic, pathology-free third molars (wisdom teeth).
18. Therapeutic drug injection.
19. Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
20. General anesthesia or intravenous/conscious sedation.
21. Excision of cysts and neoplasms
22. Osseous or muco-gingival surgery
23. Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes.
24. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The covered charge for the services is based on the single dental procedure code that accurately represents the treatment performed.
25. Replacement of stayplates.

26. Dispensing of drugs not normally supplied in a dental office.
27. Malignancies.
28. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
29. The cost of precious metals used in any form of dental Benefits.
30. Implant-supported dental appliances, implant placement, maintenance, removal and all other services associated with dental implants.
31. Dental services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonably should have known that an Emergency Care situation did not exist.
33. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.

Limitations of Other Coverage:

1. This dental coverage is not designed to duplicate any Benefits to which Members are entitled under government programs, including CHAMPUS, Medi-Cal or Workers' Compensation. By executing an enrollment application, a Member agrees to complete and submit to the Plan such consents, releases, assignments, and other documents reasonably requested by the Plan or order to obtain or assure CHAMPUS or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.

2. Benefits provided by a pediatric dentist are limited to children under six years of age following an attempt by the assigned Primary Care Dentist to treat the child and upon Prior Authorization by Access Dental Plan, less applicable Copayments.

DHMO Benefits and Copayments

The benefits shown below are performed as deemed appropriate by the attending Primary Care Dentist subject to the limitations and exclusions of the program. Enrollees should discuss all treatment options with their Primary Care Dentist prior to services being rendered.

The text that appears in italics below is specifically intended to clarify the delivery of benefits under the Access Dental Plan.

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D0415	Collection of microorganisms for culture and sensitivity	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D0425	Caries susceptibility tests	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures				$50.00	$50.00	$50.00
D0460	Pulp vitality tests	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D0470	Diagnostic casts	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report				No Cost	No Cost	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report				No Cost	No Cost	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report				No Cost	No Cost	No Cost
PREVENTIVE D1000-D1999							
D1110	Prophylaxis cleaning - adult –1 per 6 month period limited to 2 per 12 month period	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
	Additional Prophylaxis cleaning –adult				$45.00	$45.00	$45.00
D1120	Prophylaxis cleaning - child -–1 per 6 month period limited to 2 per 12 month period	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
	Additional Prophylaxis cleaning – child				$35.00	$35.00	$35.00
D1203	Topical application of fluoride (prophylaxis not included) - child -to age14, –1 per 6 month period limited to 2 per 12 month period	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D1204	Topical application of fluoride (prophylaxis not included) – adult – limited to 2 per 12 month period				No Cost	No Cost	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients, limited to 2 per 12 month period				No Cost	No Cost	No Cost
D1310	Nutritional counseling for control of dental Disease	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease				No Cost	No Cost	No Cost
D1330	Oral hygiene instructions	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D1351	Sealant - per tooth -limited to un-restored permanent molars to age 14 thru age 15	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent molars thru age 15	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D1510	Space maintainer - fixed – unilateral	$150.00	$125.00	$75.00	$70.00	$25.00	$10.00
D1515	Space maintainer - fixed – bilateral	$150.00	$125.00	$75.00	$70.00	$25.00	$10.00
D1520	Space maintainer – removable – unilateral				$80.00	$25.00	$10.00
D1525	Space maintainer – removable – bilateral				$80.00	$25.00	$10.00
D1550	Re-cementation of space maintainer	No Cost	No Cost	No Cost	$15.00	$5.00	$0.00
D1555	Removal of fixed space maintainer				$15.00	$5.00	$0.00

RESTORATIVE D2000-D2999

Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures. Access allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment. There is an additional copayment of $125 per unit for treatment plans with 7 or more units. There is an additional copayment of $75 per unit for porcelain on molars. Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals. Replacement of crowns requires the existing restoration to be 5+ years old.

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D2140	Amalgam - one surface, primary or permanent	$25.00	$10.00	No Cost	$8.00	No Cost	No Cost
D2150	Amalgam - two surfaces, primary or permanent	$25.00	$10.00	No Cost	$12.00	No Cost	No Cost
D2160	Amalgam - three surfaces, primary or permanent	$25.00	$10.00	No Cost	$18.00	No Cost	No Cost
D2161	Amalgam - four or more surfaces, primary or Permanent	$25.00	$10.00	No Cost	$22.00	No Cost	No Cost
D2330	Resin-based composite - one surface, anterior	$35.00	$25.00	$15.00	$22.00	No Cost	No Cost
D2331	Resin-based composite - two surfaces, anterior	$35.00	$25.00	$15.00	$26.00	No Cost	No Cost
D2332	Resin-based composite - three surfaces, anterior	$35.00	$25.00	$15.00	$30.00	No Cost	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$35.00	$25.00	$15.00	$55.00	No Cost	No Cost
D2390	Resin-based composite crown, anterior				$65.00	$35.00	No Cost
D2391	Resin-based composite – one surface, posterior				$65.00	$55.00	$45.00
D2392	Resin-based composite – two surfaces, posterior				$75.00	$65.00	$55.00
D2393	Resin-based composite – three surfaces, posterior				$85.00	$75.00	$65.00
D2394	Resin-based composite – four or more surfaces, posterior				$95.00	$85.00	$75.00
D2510	Inlay – metallic – one surface				$200.00	$165.00	$90.00
D2520	Inlay – metallic – two surfaces				$200.00	$165.00	$90.00
D2530	Inlay – metallic – three or more surfaces				$200.00	$165.00	$90.00
D2542	Onlay – metallic – two surfaces				$200.00	$165.00	$90.00
D2543	Onlay – metallic – three surfaces				$200.00	$165.00	$90.00
D2544	Onlay – metallic – four or more surfaces				$200.00	$165.00	$90.00
D2610	Inlay – porcelain/ceramic – one surface				$200.00	$165.00	$90.00
D2620	Inlay – porcelain/ceramic – two surfaces				$200.00	$165.00	$90.00
D2630	Inlay – porcelain/ceramic – three or more surfaces				$200.00	$165.00	$90.00
D2642	Onlay – porcelain/ceramic – two surfaces				$200.00	$165.00	$90.00
D2643	Onlay – porcelain/ceramic – three surfaces				$200.00	$165.00	$90.00
D2644	Onlay – porcelain/ceramic – four or more surfaces				$200.00	$165.00	$90.00
D2650	Inlay – resin-based composite – one surface				$200.00	$165.00	$90.00
D2651	Inlay – resin-based composite – two surfaces				$200.00	$165.00	$90.00
D2652	Inlay – resin-based composite – three or more surfaces				$200.00	$165.00	$90.00
D2662	Onlay – resin-based composite – two surfaces				$200.00	$165.00	$90.00
D2663	Onlay – resin-based composite – three surfaces				$200.00	$165.00	$90.00

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D2664	Onlay – resin-based composite – four or more surfaces				$200.00	$165.00	$90.00
D2710	Crown – resin-based composite (indirect)				$185.00	$50.00	$40.00
D2712	Crown - ¾ resin-based composite (indirect)				$185.00	$50.00	$40.00
D2720	Crown – resin with high noble metal				$200.00	$165.00	$90.00
D2721	Crown – resin with predominantly base metal				$200.00	$95.00	$60.00
D2722	Crown – resin with noble metal				$200.00	$95.00	$60.00
D2740	Crown – porcelain/ceramic substrate				$395.00	$240.00	$225.00
D2750	Crown - porcelain fused to high noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2751	Crown - porcelain fused to predominantly base metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2752	Crown - porcelain fused to noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2780	Crown - ¾ cast high noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2781	Crown - ¾ cast predominantly base metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2782	Crown - ¾ cast noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2783	Crown - ¾ porcelain/ceramic	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2790	Crown - full cast high noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2791	Crown - full cast predominantly base metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2792	Crown - full cast noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D2794	Crown – titanium				$200.00	$165.00	$90.00
D2799	Provisional crown				No Cost	No Cost	No Cost
D2910	Recement inlay, onlay or partial coverage restoration	No Cost	No Cost	No Cost	$20.00	No Cost	No Cost
D2915	Recement cast or prefabricated post and core	No Cost	No Cost	No Cost	$20.00	No Cost	No Cost
D2920	Recement crown	No Cost	No Cost	No Cost	$20.00	No Cost	No Cost
D2930	Prefabricated stainless steel crown – primary tooth	$125.00	$75.00	$50.00	$75.00	$15.00	No Cost
D2931	Prefabricated stainless steel crown – permanent tooth	$125.00	$75.00	$50.00	$75.00	$15.00	No Cost
D2932	Prefabricated resin crown				$85.00	$25.00	$15.00
D2933	Prefabricated stainless steel crown with resin window				$75.00	$20.00	$10.00
D2940	Protective restoration	$50.00	$25.00	$15.00	$20.00	$5.00	No Cost
D2950	Core buildup, including any pins	$100.00	$100.00	$50.00	$80.00	$15.00	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost	No Cost	No Cost	$15.00	$10.00	No Cost
D2952	Cast post and core in addition to crown – includes canal preparation	$100.00	$75.00	$50.00	$110.00	$35.00	No Cost
D2953	Each additional indirectly fabricated post – same tooth				$80.00	$25.00	No Cost
D2954	Prefabricated post and core in addition to crown - base metal post; includes canal preparation	$100.00	$75.00	$50.00	$95.00	$20.00	No Cost
D2955	Post removal (not in conjunction with endodontic therapy)				$40.00	$10.00	No Cost
D2957	Each additional prefabricated post – same tooth				$70.00	$15.00	No Cost
D2960	Labial veneer (resin laminate) – chairside				$250.00	$250.00	$250.00
D2970	Temporary crown (fractured tooth)				$20.00	$5.00	$5.00
D2971	Additional procedures to construct new crown under existing partial denture framework				$60.00	$28.00	$19.00
D2980	Crown repair, by report				$30.00	$15.00	$10.00

ENDODONTICS D3000-D3999

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D3110	Pulp cap - direct (excluding final restoration)	$35.00	$25.00	$10.00	$5.00	No Cost	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	$35.00	$25.00	$10.00	$5.00	No Cost	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$35.00	$25.00	$10.00	$45.00	No Cost	No Cost
D3221	Pulpal debridement, primary and permanent teeth				$50.00	$10.00	$5.00
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development				$75.00	$15.00	$8.00
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)				$60.00	$20.00	$5.00
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)				$60.00	$20.00	$5.00
D3310	Root canal - anterior (excluding final restoration)	$250.00	$175.00	$125.00	$125.00	$55.00	$45.00
D3320	Root canal - bicuspid (excluding final restoration)	$325.00	$250.00	$175.00	$215.00	$120.00	$90.00
D3330	Root canal - molar (excluding final restoration)	$425.00	$350.00	$275.00	$365.00	$250.00	$205.00
D3331	Treatment of root canal obstruction; non-surgical access				$80.00	$55.00	$45.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth				$80.00	$55.00	$45.00
D3333	Internal root repair of perforation defects				$80.00	$55.00	$45.00
D3346	Retreatment of previous root canal therapy – anterior	$400.00	$340.00	$280.00	$155.00	$85.00	$60.00
D3347	Retreatment of previous root canal therapy – bicuspid	$475.00	$400.00	$330.00	$245.00	$150.00	$105.00
D3348	Retreatment of previous root canal therapy – molar	$570.00	$485.00	$400.00	$395.00	$380.00	$220.00
D3351	Apexification/recalcification /pulpal regeneration – initial visit	$170.00	$140.00	$115.00	$80.00	$75.00	$70.00
D3352	Apexification/recalcification /pulpal regeneration – interim visit	$75.00	$65.00	$50.00	$55.00	$50.00	$45.00
D3353	Apexification/recalcification – final visit	$250.00	$215.00	$175.00	$55.00	$50.00	$45.00
D3354	Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration.				$75.00	$15.00	$8.00
D3410	Apicoectomy/periradicular surgery – anterior	$345.00	$295.00	$240.00	$155.00	$60.00	No Cost
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$375.00	$315.00	$260.00	$165.00	$70.00	No Cost
D3425	Apicoectomy/periradicular surgery – molar (first root)	$425.00	$360.00	$295.00	$175.00	$80.00	No Cost
D3426	Apicoectomy/periradicular surgery – bicuspid (each additional root)	$140.00	$120.00	$95.00	$100.00	$50.00	No Cost
D3430	Retrograde filling – per root				$75.00	$60.00	No Cost
D3450	Root amputation – per root				$85.00	No Cost	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy				$75.00	$30.00	No Cost

PERIODONTICS D4000-D4999

Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D4210	Gingivectomy or gingivoplasty -four or more contiguous teeth or bounded teeth spaces per quadrant	$275.00	$225.00	$150.00	$160.00	$130.00	$80.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$275.00	$225.00	$150.00	$95.00	$80.00	$50.00
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant				$160.00	$130.00	$80.00
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant				$95.00	$80.00	$50.00
D4245	Apically positioned flap				$175.00	$125.00	$75.00
D4249	Clinical crown lengthening – hard tissue				$150.00	$125.00	$75.00
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant				$390.00	$285.00	$185.00
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant				$310.00	$230.00	$145.00
D4263	Bone replacement graft – first site in quadrant				$240.00	$210.00	$200.00
D4264	Bone replacement graft – each additional site in quadrant				$85.00	$70.00	$60.00
D4270	Pedicle soft tissue graft procedure				$235.00	$205.00	$195.00
D4271	Free soft tissue graft procedure (including donor site surgery)				$235.00	$205.00	$195.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)				$90.00	$45.00	$45.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant limited to 4 quadrants during any 12 consecutive months	$150.00	$150.00	$125.00	$55.00	$25.00	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant limited to 4 quadrants during any 12 consecutive months	$75.00	$75.00	$65.00	$40.00	$20.00	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis				$55.00	$25.00	No Cost
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report				$60.00	$60.00	$60.00
D4910	Periodontal maintenance -limited to 1 treatment each 6 month period 2 treatments each 12 month period.	$25.00	$15.00	$5.00	$45.00	$15.00	No Cost
D4910	Periodontal maintenance – additional per 12 month period				$55.00	$55.00	$55.00

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600

PROSTHODONTICS D5000-D5899 (removable)

For all listed dentures and partial dentures, copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The member must continue to be eligible, and the service must be provided at the Primary Care Dentist's facility where the denture was originally delivered. Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months. Replacement of a denture or a partial denture requires the existing denture to be 5+ years old unless due to loss of a natural functioning tooth. Replacement will be a benefit only if the existing denture is unsatisfactory and cannot be made satisfactory.

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$475.00	$425.00	$375.00	$395.00	$160.00	$125.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$475.00	$425.00	$375.00	$445.00	$210.00	$170.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$475.00	$425.00	$375.00	$445.00	$210.00	$170.00
D5410	Adjust complete denture – maxillary	$35.00	$30.00	$20.00	$18.00	$10.00	No Cost
D5411	Adjust complete denture – mandibular	$35.00	$30.00	$20.00	$18.00	$10.00	No Cost
D5421	Adjust partial denture – maxillary	$35.00	$30.00	$20.00	$18.00	$10.00	No Cost
D5422	Adjust partial denture – mandibular	$35.00	$30.00	$20.00	$18.00	$10.00	No Cost
D5510	Repair broken complete denture base	$75.00	$50.00	$35.00	$55.00	$20.00	$15.00
D5520	Replace missing or broken teeth -complete denture (each tooth)	$75.00	$50.00	$35.00	$35.00	$10.00	$5.00
D5610	Repair resin denture base	$75.00	$50.00	$35.00	$55.00	$20.00	$15.00
D5620	Repair cast framework	$75.00	$50.00	$35.00	$55.00	$20.00	$15.00
D5630	Repair or replace broken clasp	$75.00	$50.00	$35.00	$55.00	$20.00	$15.00
D5640	Replace broken teeth - per tooth	$75.00	$50.00	$35.00	$45.00	$10.00	$5.00
D5650	Add tooth to existing partial denture	$75.00	$50.00	$35.00	$45.00	$10.00	$5.00
D5660	Add clasp to existing partial denture	$75.00	$40.00	$35.00	$55.00	$10.00	$5.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)				$180.00	$135.00	$75.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)				$180.00	$115.00	$75.00
D5710	Rebase complete maxillary denture				$105.00	$55.00	$35.00
D5711	Rebase complete mandibular denture				$105.00	$55.00	$35.00
D5720	Rebase maxillary partial denture				$105.00	$55.00	$35.00
D5721	Rebase mandibular partial denture				$105.00	$55.00	$35.00
D5730	Reline complete maxillary denture (chairside)	$125.00	$75.00	$50.00	$60.00	$20.00	No Cost
D5731	Reline complete mandibular denture (chairside)	$125.00	$75.00	$50.00	$60.00	$20.00	No Cost
D5740	Reline maxillary partial denture (chairside)	$125.00	$75.00	$50.00	$60.00	$20.00	No Cost
D5741	Reline mandibular partial denture (chairside)	$125.00	$75.00	$50.00	$60.00	$20.00	No Cost
D5750	Reline complete maxillary denture (laboratory)	$150.00	$125.00	$100.00	$95.00	$60.00	$35.00
D5751	Reline complete mandibular denture (laboratory)	$150.00	$125.00	$100.00	$95.00	$60.00	$35.00
D5760	Reline maxillary partial denture (laboratory)	$150.00	$125.00	$100.00	$95.00	$60.00	$35.00
D5761	Reline mandibular partial denture (laboratory)	$150.00	$125.00	$100.00	$95.00	$60.00	$35.00
D5820	Interim partial denture (maxillary) -limited to 1 in any 12 consecutive months	$125.00	$100.00	$75.00	$125.00	$75.00	$45.00
D5821	Interim partial denture (mandibular) -limited to 1 in any 12 consecutive months	$125.00	$100.00	$75.00	$125.00	$75.00	$45.00
D5850	Tissue conditioning, maxillary	$75.00	$75.00	$50.00	$30.00	No Cost	No Cost
D5851	Tissue conditioning, mandibular	$75.00	$75.00	$50.00	$30.00	No Cost	No Cost

MAXILLOFACIAL PROSTHETICS D5900-D5999 - Not Covered

IMPLANT SERVICES D6000-D6199 - Not Covered

PROSTHODONTICS D6200-D6999, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture)

Access allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment. There is an additional copayment of $125 per unit for treatment plans with 7 or more units. There is an additional copayment of $75 per unit for porcelain on molars. Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals. Replacement of a crown, pontic, requires the existing bridge to be 5+ years old.

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D6210	Pontic - cast high noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6211	Pontic - cast predominantly base metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6212	Pontic - cast noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6214	Pontic – titanium				$200.00	$165.00	$90.00
D6240	Pontic - porcelain fused to high noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6241	Pontic - porcelain fused to predominantly base metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6242	Pontic - porcelain fused to noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6245	Pontic – porcelain/ceramic				$395.00	$240.00	$225.00
D6250	Pontic – resin with high noble metal				$200.00	$165.00	$90.00
D6251	Pontic – resin with predominantly base metal				$200.00	$165.00	$90.00
D6252	Pontic – resin with noble metal				$200.00	$165.00	$90.00
D6253	Provisional pontic				No Cost	No Cost	No Cost
D6254	interim pontic				No Cost	No Cost	No Cost
D6600	Inlay – porcelain/ceramic, two surfaces				$200.00	$165.00	$90.00
D6601	Inlay – porcelain/ceramic, three or more surfaces				$200.00	$165.00	$90.00
D6602	Inlay – cast high noble metal, two surfaces				$200.00	$165.00	$90.00
D6603	Inlay – cast high noble metal, three or more surfaces				$200.00	$165.00	$90.00
D6604	Inlay – cast predominantly base metal, two surfaces				$200.00	$40.00	No Cost
D6605	Inlay – cast predominantly base metal, three or more surfaces				$200.00	$40.00	No Cost
D6606	Inlay – cast noble metal, two surfaces				$180.00	$100.00	$40.00
D6607	Inlay – cast noble metal, three or more surfaces				$185.00	$100.00	$40.00
D6608	Onlay – porcelain/ceramic, two surfaces				$200.00	$165.00	$90.00
D6609	Onlay – porcelain/ceramic, three or more surfaces				$200.00	$165.00	$90.00
D6610	Onlay – cast high noble metal, two surfaces				$200.00	$165.00	$90.00
D6611	Onlay – cast high noble metal, three or more surfaces				$200.00	$165.00	$90.00
D6612	Onlay – cast predominantly base metal, two surfaces				$200.00	$40.00	No Cost
D6613	Onlay – cast predominantly base metal, three or more surfaces				$200.00	$40.00	No Cost
D6614	Onlay – cast noble metal, two surfaces				$180.00	$100.00	$40.00
D6615	Onlay – cast noble metal, three or more surfaces				$190.00	$100.00	$40.00
D6710	Crown – indirect resin based composite				$200.00	$165.00	$90.00
D6720	Crown - resin with high noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6721	Crown - resin with predominantly base metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6722	Crown – resin with noble metal				$200.00	$165.00	$90.00
D6740	Crown – porcelain/ceramic				$395.00	$240.00	$225.00
D6750	Crown - porcelain fused to high noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6751	Crown - porcelain fused to predominantly base metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6752	Crown - porcelain fused to noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6780	Crown - ¾ cast high noble metal				$200.00	$165.00	$90.00

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D6781	Crown - ¾ cast predominantly base metal				$200.00	$165.00	$90.00
D6782	Crown - ¾ cast noble metal				$200.00	$165.00	$90.00
D6783	Crown - ¾ porcelain/ceramic				$200.00	$165.00	$90.00
D6790	Crown - full cast high noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6791	Crown - full cast predominantly base metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6792	Crown - full cast noble metal	$375.00	$350.00	$275.00	$200.00	$165.00	$90.00
D6794	Crown – titanium				$200.00	$165.00	$90.00
D6930	Recement fixed partial denture	No Cost	No Cost	No Cost	$25.00	No Cost	No Cost
D6940	Stress breaker				$50.00	No Cost	No Cost
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated				$110.00	$35.00	No Cost
D6972	Prefabricated post and core in addition to fixed partial denture retainer base metal post; includes canal preparation	$100.00	$75.00	$50.00	$95.00	$20.00	No Cost
D6973	Core buildup for retainer, including any pins	$100.00	$75.00	$50.00	$80.00	$15.00	No Cost
D6976	Each additional indirectly fabricated post – same tooth				$80.00	$25.00	No Cost
D6977	Each additional prefabricated post – same tooth				$70.00	$15.00	No Cost
D6980	Fixed partial denture repair, by report				$70.00	$15.00	$10.00

ORAL AND MAXILLOFACIAL SURGERY D7000-D7999

Includes preoperative and postoperative evaluations and treatment under a local anesthetic. Removal of asymptomatic third molars is not covered unless pathology exists. Biopsy of oral tissue does not include pathology laboratory services.

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D7111	Extraction, coronal remnants -deciduous tooth	$15.00	$10.00	No Cost	$10.00	No Cost	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$15.00	$10.00	No Cost	$14.00	$5.00	No Cost
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$115.00	$105.00	$95.00	$55.00	$25.00	$15.00
D7220	Removal of impacted tooth - soft tissue	$115.00	$105.00	$95.00	$70.00	$50.00	$25.00
D7230	Removal of impacted tooth -partially bony	$175.00	$150.00	$125.00	$95.00	$70.00	$50.00
D7240	Removal of impacted tooth -completely bony	$175.00	$150.00	$125.00	$120.00	$90.00	$70.00
D7241	Removal of impacted tooth -completely bony, with unusual surgical complications	$175.00	$150.00	$125.00	$140.00	$110.00	$90.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$115.00	$105.00	$95.00	$45.00	No Cost	No Cost
D7251	coronectomy – intentional partial tooth removal	$175.00	$150.00	$125.00	$140.00	$110.00	$90.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth				$130.00	$85.00	$50.00
D7280	Surgical access of an unerupted tooth				$120.00	$90.00	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption				$120.00	$90.00	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth				No Cost	No Cost	No Cost
D7286	Biopsy of oral tissue - soft - does not include pathology laboratory procedures	$150.00	$100.00	$100.00	$40.00	No Cost	No Cost
D7287	Exfoliative cytological sample collection				$50.00	$50.00	$50.00
D7288	Brush biopsy – transepithelial sample collection				$50.00	$50.00	$50.00
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$130.00	$110.00	$90.00	$100.00	$50.00	No Cost

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D7311	Alveoloplasty in conjunction with extractions – one to three teeth	$105.00	$85.00	$70.00	$100.00	$50.00	No Cost
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$195.00	$165.00	$135.00	$120.00	$70.00	No Cost
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth	$160.00	$135.00	$110.00	$120.00	$70.00	No Cost
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm				No Cost	No Cost	No Cost
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm				No Cost	No Cost	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)				$100.00	No Cost	No Cost
D7472	Removal of torus palatinus	$515.00	$435.00	$360.00	$100.00	No Cost	No Cost
D7473	Removal of torus mandibularis	$485.00	$415.00	$340.00	$100.00	No Cost	No Cost
D7510	Incision and drainage of abscess -intraoral soft tissue	$75.00	$55.00	$25.00	$30.00	$10.00	No Cost
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)				$30.00	$15.00	$10.00
D7520	Incision and drainage of abscess – extraoral soft tissue				$30.00	$10.00	No Cost
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)				$30.00	$15.00	$10.00
D7960	frenulectomy – also known as (frenectomy or frenotomy) – separate procedure not incidental to another procedure	No Cost	No Cost	No Cost	$40.00	$20.00	No Cost
D7963	Frenuloplasty				$40.00	$20.00	No Cost
D7970	Excision of hyperplastic tissue – per arch				$80.00	$55.00	$50.00

ADJUNCTIVE GENERAL SERVICES D9000-D9999

Bleaching services are limited to one bleaching tray and gel for 2 weeks of self-treatment. General anesthesia or IV sedation is only a covered service when administered by the treating dentist in conjunction with a covered oral surgery or periodontal surgery

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$50.00	$25.00	$15.00	$20.00	$5.00	$5.00
D9210	Local anesthesia not in conjunction with operative or surgical procedures				No Cost	No Cost	No Cost
D9211	Regional block anesthesia	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D9212	Trigeminal division block anesthesia	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost	No Cost	No Cost	No Cost	No Cost	No Cost
D9220	Deep sedation/general anesthesia – first 30 minutes				$165.00	$165.00	$165.00
D9221	Deep sedation/general anesthesia – each additional 15 minutes				$80.00	$80.00	$80.00
D9230	Administration of nitrous oxide/anxiolysis, analgesia -limited to children under 13 years of age	$25.00	$22.00	$18.00	$15.00	$15.00	$15.00
D9241	Intravenous conscious sedation/analgesia – first 30 minutes				$165.00	$165.00	$165.00
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes				$80.00	$80.00	$80.00
D9248	Non-intravenous conscious sedation (Oral Sedation) – limited to children under 6 years of age	$30.00	$25.00	$22.00	$15.00	$15.00	$15.00

CDT CODE	PROCEDURE DESCRIPTION	DMO 100	DMO 200	DMO 300	DMO 400	DMO 500	DMO 600
D9310	Consultation (diagnostic service provided by a dentist or physician other than practitioner providing treatment)	$50.00	$35.00	$25.00	No Cost	No Cost	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$15.00	$10.00	No Cost	$5.00	$5.00	$5.00
D9440	Office visit - after regularly scheduled hours	$15.00	$10.00	$10.00	$35.00	$25.00	$20.00
D9450	Case presentation, detailed and extensive treatment planning				No Cost	No Cost	No Cost
D9910	Application of desensitizing medicament				$15.00	$15.00	$15.00
D9940	Occlusal guard, by report				$105.00	$100.00	$95.00
D9942	Repair and/or reline of occlusal guard				$60.00	$50.00	$40.00
D9951	Occlusal adjustment, limited	$25.00	$10.00	No Cost	$55.00	$35.00	$20.00
D9952	Occlusal adjustment – complete				$105.00	$55.00	$40.00
D9972	External bleaching – per arch				$125.00	$125.00	$125.00
D9999	Broken appointment (less than 24 hour notice)				Not to Exceed $25.00	Not to Exceed $25.00	Not to Exceed $25.00

Provider Responsibilities

A discussion of the responsibilities of each provider.

EACH MEMBER WHO JOINS ACCESS DENTAL PLAN SELECTS A PRIMARY CARE DENTIST (PCD) who is responsible for providing or coordinating all dental care for that member. This includes but is not limited to specialty referrals and coordination of services. Both Primary Care Dentists and Participating Specialists have certain responsibilities to ensure care provided to ***Access*** members is provided under the appropriate requirements including covered benefits and referrals.

PCD Responsibilities

Primary Care Dentists are responsible to:

- Provide or coordinate all dental care for the member.
- Perform an initial dental assessment within 120 days of a member's eligibility date.
- Provide 24-hour emergency service, seven days a week. In the event that dentist is unable to provide emergency service and member contacts ***Access.*** Plan will refer member to another provider and deduct the cost of treatment from PCD.
- The provider shall employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.
- When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice.
- Provide dental services to members during normal working hours, and during such other hours as may be necessary in order to keep patient appointment schedules on a current

basis. (Dentist shall not differentiate by days or time of day when professional services are rendered to members.)

- Obtain prior authorization, when required, for any specialty referral or supplemental payment.
- Provider compliance with accessibility parameters shall be routinely monitored by ***Access*** through member and provider surveys, facility site audits, review of complaints and PCD transfer tracking. Corrective actions shall be implemented as needed, and monitored for effectiveness.
- Complete and return the quarterly provider survey within 10 days of mailing. (Surveys are mailed quarterly with the patient roster.)
- Refer patients who have California Children's Services (CCS) eligible conditions to ***Access***. (Refer to Chapter 11 for more details.)
- Maintain dental records for five years from the date of service and make dental records available during regular business hours.
- Provide documentation within 5 days of receiving an acknowledgment letter from ***Access*** regarding a patient complaint. (Refer to Chapter 14 for more details.)
- Provide a complete copy of dental records including x-rays upon member request and ***Access***' request.
- Provide updated recredential information upon request by the ***Access*** Provider Relations Department. Recredentialing is a recurring process, repeated every three years to verify that licenses and certification remain current for each dentist.
- Provider has the right, and may contact the Provider Relations Department for all related items:
  - Review information submitted to support their credentialing application
  - Correct erroneous information
  - Receive the status of the credentialing or Recredentialing application, upon request
  - Receive notification of these rights.
- Provide monthly encounter information for all covered services, using an ***Access*** or ADA Encounter form. (Refer to Chapter 5 for more details.)
- Provide encounter reports to ***Access*** by the fifteenth of each month for services provided to members in the previous month to be eligible for Supplemental Payments. (Encounters received after the fifteenth day of the month for services rendered the previous month will not be used for calculations of encounter payments.)
- Participate in ***Access'*** Quality Management Program and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements.
- Arrange for coverage by another provider when necessary (vacation, illness, etc.)

- To ensure that dental records are protected and confidential in accordance with all Federal and State laws and the California Dental Practice Act.
- Provider should not use aggressive sales techniques to sell optional (non-covered) services or inadequately document the consent of the member for accepting optional services. (Refer to Chapter 19 for more details.)
- All covered dental services shall be provided in accordance with generally accepted dental practices and standards prevailing in the professional community at the time of treatment.
- As a participating network dentist, you will integrate specialty care into the member's course of dental treatment by referring to a specialist when necessary. To enhance continuity of patient care, the referrals need to be mailed to ***Access*** Dental in a timely manner.
- Inform the members of availability of free language assistance services for any linguistic need by calling the Plan's Member Services Representative at 1-800-70-SMILE. (Refer to Chapter 17 for more details.)

Updating Provider Information

Providers are required to inform *Access* of changes in their practice in writing. Providers must report changes in practice, such as name and address changes, the addition of rendering associates, registered dental hygienists, tax identification information or the sale of your practice.

Initial Dental Assessment

Primary Care Dentists are required to perform an initial dental assessment within 120 days of a member's enrollment unless the member has been treated within the last twelve (12) months by his/her Primary Care Dentist. To facilitate this process, ***Access*** sends a notification to every member explaining the initial assessment program.

Members are instructed to contact their PCD as soon as possible if they have not received treatment within the last twelve (12) months.

PCDs must ensure that initial assessment appointments are scheduled within 120 days of the member's enrollment in the Plan. **If the member misses or cancels the appointment, the PCD must contact the member at least twice to attempt to reschedule the appointment.**

Initial dental care assessments must include a dental history, clinical examination and radiographs as needed, in the judgment of the PCD. PCDs shall additionally discuss general disease prevention and follow-up treatments as necessary with members.

Once contacted by the patient, an initial or routine appointment must be provided **within three weeks.** ***Access*** providers are expected to provide necessary dental services within acceptable time frames recommended by DMHC and ***Access.***

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

- Further education and assistance to the provider
- Provider counseling
- Provider probation
- Suspension of new assignments
- Transfer of patients to another provider
- Contract termination for continuing noncompliance

Specialist Responsibilities

All specialty care must be authorized by *Access* and documented through a referral form that is initiated by the Primary Care Dentist (PCD). If a member requires additional specialty care beyond the scope of the services authorized, the member must be referred back to the PCD for a new referral. Specialists are responsible to:

- Provide specialty care to members.
- Ensure prior authorization has been obtained.
- Work closely with primary care dentists to enhance continuity of patient care.
- Specialist to send a notification to PCD upon completion of treatment.
- Collect any applicable patient copayment. [Note that Medi-Cal members do not pay any copayments for services.]
- Participate in ***Access'*** Quality Management Program and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements.
- Maintain dental records for five years from the date of service and make dental records available during regular business hours.
- To ensure that dental records are protected and confidential in accordance with all Federal and State laws and the California Dental Practice Act.
- Provide updated recredential information upon request by the ***Access*** Provider Relations Department. Recredentialing is a recurring process, repeated every three years to verify that licenses and certification remain current for each dentist.

- Provider has the right, and may contact the Provider Relations Department for all related items:
  - Review information submitted to support their credentialing application
  - Correct erroneous information
  - Receive the status of the credentialing or Recredentialing application, upon request
  - Receive notification of these rights.
- Inform the members of availability of free language assistance services for any linguistic need by calling the Plan's Member Services Representative at 1-800-70-SMILE. (Refer to Chapter 17 for more details.)
- Provide documentation within 5 days of receiving an acknowledgment letter from ***Access*** regarding a patient complaint. (Refer to Chapter 14 for more details.)
- Provide a complete copy of dental records including x-rays upon member request and ***Access***' request.
- Provide 24-hour emergency service, seven days a week. In the event that dentist is unable to provide emergency service and member contacts ***Access.*** Plan will refer member to another provider and deduct the cost of treatment from PCD.
- The provider shall employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.
- When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice.
- Provide dental services to members during normal working hours, and during such other hours as may be necessary in order to keep patient appointment schedules on a current basis. (Dentist shall not differentiate by days or time of day when professional services are rendered to members.)

ACCESS DENTAL

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Encounter Reporting Requirements

How to report encounter information and why it is required.

ENCOUNTER INFORMATION MUST BE REPORTED to reflect all services provided to ***Access*** members. Providers are encouraged to use an ADA claim form to report encounter information to ***Access***.

Encounter information is required for all benefit programs and is an important source of information regarding the quality of care that ***Access*** providers deliver to our members.

Encounter information for services provided during one month should be received by *Access* on the fifteenth (15th) of the following month.

Encounter information must be mailed to ***Access*** at:

Access Dental Plan
P.O. Box 659005
Sacramento, CA 95865-9005
Attn: Claims
(916) 922-5000, ext. 6012, or 1-800-270-6743, ext. 6012

Encounters must be received by ***Access*** Dental Plan by the fifteenth of each month for services provided to members in the previous month. Encounters received after the fifteenth day of the month for services rendered the previous month will not be considered for calculations of encounter payments.

Please note that for submission of claims and encounters under the **GMC** and **LAPHP** programs we are now accepting the CDT-4 ADA fourth edition codes, and will no longer accept the old Denti-Cal 3 digit codes. Should you have any questions please review Denti-Cal bulletin volume 23, number 41 from November 2007 or go to Denti-Cal's web site at: http://www.denti-cal.ca.gov/provsrvcs/manuals/sec5/Section_5.pdf.

Encounter information must include the program name to which it applies. A sample Encounter Form is provided at the end of this chapter.

- Encounter payments will be paid on a monthly basis to the provider. ***Access*** will reimburse the provider in the first week of each month for encounter payments which it has received from the dentist, by the fifteenth of the previous month.
- ***Access*** will monitor encounter mailing on a monthly basis and will contact provider offices that do not provide encounter information on a timely basis.
- Finally, ***Access*** will take the following actions if the provider's office does not submit the monthly encounter information on a regular basis:
  - Further education and assistance to the provider
  - Provider counseling
  - Provider probation
  - Suspension of new assignments
  - Transfer of patients to another provider

ACCESS DENTAL

CLAIM / ENCOUNTER FORM

Attending Dentist's Statement II ☐ GMC ☐ HFP ☐ LAPHP ☐ DHMO CHDP Patient? ○ Yes ○ No

Check one:
- ☐ Dentist's pre-treatment estimate
- ☐ Dentist's statement of actual services
- ☐ Encounter

Carrier name and address:

PATIENT SECTION

1. Patient Name First Mi Last
Relationship to employee ☐ self ☐ child ☐ spouse ☐ other______
Sex M. F.
4. Patient birth date MM DD YYYY
5. If full time student school city
6. Employee / Subscriber name and mailing address
7. Employee / Subscriber / CIN Soc. Sec. number
8. Employee / Subscriber birth date MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another plan of benefits? Dental______ Medical______
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of employer
14-a. Employee / subscriber name (if different than patient's)
14-b. Employee / subscriber soc. Sec. number
14-c. Employee / subscriber birth date MM DD YYYY
15. Relationship to patient ☐ self ☐ child ☐ spouse ☐ other________

DENTIST SECTION

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ **Signed (Patient, or parent if minor)** **Date**

I hear by authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

▶ **Signed (Insured person)** **Date**

16. Dentist name
17. Mailing address
City, State, Zip
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date Current series
22. Place of treatment Office Hosp. ECF Other
23. Radiographs or models enclosed? No Yes How Many

	No	Yes	If yes, enter brief description and dates.
24. Is treatment result of occupational illness or injury?			
25. Is treatment result of auto accident?			
26. Other accident?			
27. Are any services covered by another plan?			
28. If prosthesis, is this initial placement?			(If no, reason for replacement) prior — 29. Date of Placement
30. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed — Mos. treatment remaining

Identify missing teeth with "X"

FACIAL
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
A B C D E F G H I J
LINGUAL
UPPER RIGHT PRIMARY LEFT PERMANENT LOWER
LINGUAL
T S R Q P O N M L K
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
FACIAL

31. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Use charting system shown.

Tooth # or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.) Line No.	Date Service Performed Mo.	Day	Year	Procedure number	Fee	For administrative use only
		1						
		2						
		3						
		4						
		5						
		6						
		7						
		8						
		9						
		10						
		11						
		12						
		13						
		14						
		15						

32. Remarks for unusual services

I hear by certify that the procedures as indicated by date have been completed and that the fee submitted are the actual fees I have charged and intend to collect for those procedures.

▶ Signed (dentist) Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

MAIL TO: Access Dental Plan
P.O. Box 659005
Sacramento, CA 95865-9005

PHONE: LAPHP 888-414-4110
HFP 888-849-8440
GMC 916-646-2130
DHMO 866-650-3660

ACCESS DENTAL

6

Referrals

When a referral is required, how to complete a referral and ensure it can be acted on promptly.

REFERRALS ARE REQUIRED FOR SERVICES CONSIDERED TO BE SPECIALTY TREATMENTS. The following is a brief explanation of specialty guidelines of ***Access*** Dental Plan.

The Primary Care Dentist requesting the referral must submit an ***Access*** specialty referral form. Providers are given a supply of Specialty Referral forms to keep in their offices. To obtain additional supplies of the form, contact ***Access*** at:

(916) 563-6025, or
1-800-640-4466, or
Providerrelations@premierlife.com

Information provided by dental offices is key to authorizations. Decisions authorizing referrals for specialty services are based on information provided by your office to ***Access*** Dental Plan. ***Access'*** Dental Consultants make the final decisions regarding authorization for specialty services.

The Dental Consultant, who is a California licensed dentist, reviews all referral decisions requiring professional judgment, including all potential denials.

Referral Department will make decisions on authorizations based on the information provided by the referring provider. The accuracy of this information will be verified based on the written referral request submitted by the referring provider. **If the written referral request and supporting documentation does not substantiate the need for a referral, *Access* will charge the cost of the referral services back to the referring provider.**

Referrals are valid for 90 days from the date of approval by *Access*.

Regular Specialty Referrals

A regular (non-emergency) referral is obtained by **completing a referral form and mailing the form to *Access*. Documentation supporting the reasons for the referral must be included with the referral form.**

Access will respond to a referral request within five (5) business days from the date the request is received in our offices. The form should be mailed to:

> *Access* **Dental Plan**
> **P.O. Box 659005**
> **Sacramento, CA 95865-9005**
> **Attn: Specialty Referral**

Regular referrals must be mailed as soon as possible.

Determinations of referrals are based on submitted documentation and the benefit as outlined in Title 22, Title 10 and the Department of Health Care Services Medi-Cal Dental Program Manual of Criteria for Dental Services. A copy of the approved Specialty Referral form is sent to the specialist, the member and the PCD. In addition, the PCD and member receive a letter notifying them of the approval and advising them, when appropriate, that follow-up treatment needs to be performed by the PCD.

Specialty referrals may be denied for any of the following reasons:

- Lack of eligibility.
- Procedure not a benefit.
- Insufficient documentation.
- Dental necessity for procedure not evident.
- Poor prognosis or longevity questionable.
- Procedure requested is within the scope of the PCD.

Decisions resulting in denial, delay or modification of all or part of the requested dental services shall be communicated to the member in writing within two business days and to the member's treating provider within 24 hours of the decision.

Denial notification includes the rationale for the denial as well as the member's right to appeal the decision and the appeal process, including timeframes for submitting an appeal. Members are also advised of their right to seek a second or third opinion at no charge. The Referral/Case Management Coordinator assists the member in obtaining a second or third opinion.

When a referral for a member under the age of 21 is denied based on Medi-Cal benefits, the member's parent or legal guardian will be advised to seek assistance through the Child Health and Disability Program (CHDP), California Children's Services (CCS) or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

When a referral is denied because the services fall within the scope of the PCD, the member is instructed to return to their PCD for treatment.

Emergency Specialty Referrals

An emergency referral is available for patients requiring immediate treatment. An emergency referral may be requested by telephone with a fax confirmation to ***Access'*** Referral Department.

Emergency referrals telephone numbers:
916-563-6012 and 800-270-6743, ext. 6012.

Emergency referrals can be faxed to:
916-648-7741 or 877-648-7741.

Access will respond to an emergency referral request within seventy-two (72) hours from the time the request is received in our offices. If the request for emergency referral is approved, ***Access*** will contact the specialty provider to inform him/her of the patient's urgent need for treatment and authorization by ***Access***.

Access' Referral Department will make decisions on emergency authorizations based on the information provided by the referring provider. The accuracy of this information will be verified based on the written referral request submitted by the referring provider. **If the written referral request and supporting documentation does not substantiate the need for a referral, *Access* will charge the cost of the referral services back to the referring provider.**

While emergency specialty referrals do not require prior authorization, specialty providers are requested to notify ***Access*** prior to treating the member whenever possible. This is done to ensure that the provider understands ***Access'*** program and does not provide routine non-emergent dental services for which he or she may not be reimbursed.

Dental emergency (emergent) services are defined as follows:

> ***Those services required for alleviation of severe pain, severe swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions, which, if not immediately diagnosed and treated, would lead to disability or harm to the member.***

Timelines

In determining whether to approve, modify or deny requests by providers prior to, retrospectively, or concurrent with the provision of dental care services to members, ***Access*** follows the following processes:

1. Decision to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of dental care services to members shall be made in a timely manner appropriate to the nature of the member's condition, not to exceed five (5) business days from ***Access'*** receipt of the information reasonably necessary and requested by ***Access*** to make the determination.
2. In cases where the review is retrospective, the decision shall be communicated to the individual who received services within 30 days of the receipt of the information that is reasonably necessary to make the determination. This information shall also be communicated to the provider.
3. When the member's condition is such that the member faces an imminent and serious threat to his or her health including, but not limited to, loss of life, or other major bodily function, the decision to approve, modify or deny requests by providers shall be made in a timely manner appropriate for the nature of the member's condition, not to exceed 72 hours after ***Access'*** receipt of the information reasonably necessary and requested by ***Access*** to make the determination.
4. Decisions to approve, modify or deny requests by providers for authorization prior to, or concurrent with, the provision of dental care services to members shall be communicated to the requesting provider within 24 hours of the decision.
5. Except for concurrent review decisions pertaining to dental care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or a part of the requested dental services, shall be communicated to the member in writing within two business days of the decision. In the case of concurrent review, dental care shall not be discontinued until the member's treating provider has been notified of ***Access'*** decision, and a care plan has been agreed upon by the treating provider that is appropriate for the dental needs of that patient.
6. In the event that ***Access*** cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified above because ***Access*** has not received all the needed information, ***Access*** shall then notify the provider and the member in writing that ***Access*** cannot make a decision to approve, modify or deny the request for authorization within the specified timeframe and specify the information requested but not received. ***Access*** shall also notify the provider and the member of the anticipated date on which a decision may be rendered.

Specialty Referrals by Category

Specialty Referral for Periodontics

Policy: Primary Care Dentists (PCD) are expected to administer all phases of periodontal treatments with the exception of periodontal surgeries. Before a referral can

be authorized, a complete periodontal work-up must be completed by the PCD through a nonsurgical approach. After healing is completed, if the PCD determines that oral hygiene is acceptable and pocket depths are unmaintainable, a referral can be requested from ***Access.*** Surgeries must be done by a panel provider after authorization is received from ***Access***.

Procedure: When requesting a periodontist referral, the PCD must submit the following documentation:

1. Case history.
2. Areas or tooth numbers where surgery is required.
3. Pre-scaling pocket depth charting.
4. FMX.
5. A copy of the patient's chart indicating the dates on which periodontal services were rendered.
6. Documentation indicating the dates the PCD provided full mouth root planing for the member.
7. A post-scaling (3-6 months after initial root planing) pocket depth charting.
8. The PCD is responsible for providing the following treatments: root planing, diagnosis, x-rays, pocket depth charting, curettage, occlusal adjustment, prophylaxis, oral hygiene instructions and emergency abscess treatments.

Specialty Referral for Endodontics

Policy: Performing endodontic treatments on all teeth, including molar teeth is the responsibility of the PCD. Referral to an endodontist without prior authorization from ***Access***, is the financial responsibility of the PCD.

The PCD is responsible for providing all palliative emergency treatments on teeth, even teeth that might need treatment from an endodontist due to a complication. If, for any reason, the PCD determines that the palliative treatment must be done by an endodontist, the PCD must obtain an emergency treatment authorization from ***Access***. The PCD must thoroughly document the patient's chart regarding the condition and why therapy cannot be done at the PCD's office.

For ***Access*** to authorize the endodontic treatment, the following must exist:

1. The tooth must be critically important to the integrity of the oral condition of the patient.
2. Specific reasons must exist for making the treatments by the PCD contradictory (i.e. failure of an existing root canal, calcified canals indicated through

radiographs depicting an endodontic file in the blocked canal, broken instruments and periapical pathology remaining after standard therapy.)

Procedure: The following documents must be submitted with a referral request for referral to an endodontist:

1. Reason why the treatment cannot be performed at the PCD's office.
2. FMX, or bilateral bite wings and periapical x-ray of the affected tooth.
3. Prognosis of the tooth.
4. Documentation of the complication in the chart.
5. Date of the previous root canal, if applicable.
6. Symptoms.
7. Inadequate access to perform the procedure or lack of proper instruments to perform the procedure are not acceptable reasons for a referral to an endodontist.
8. All requests for referral to an endodontist are reviewed by the Dental Consultant to determine whether the financial responsibility lies with ***Access*** or with the PCD.

Specialty Referral for Oral Surgery

Policy: Oral surgery services are expected to be delivered by the PCD with exceptions for partial bony, full bony extractions, biopsies or any surgery on a patient whose physician will not allow the PCD to perform the procedure at the PCD's office (documentation from the physician is required.)

Procedure: Requests for a referral to an oral surgeon must be accompanied by a diagnostic x-ray completely depicting the apical area of the tooth. If radiographs are not sufficient to justify need, additional diagnostic material like photographs and/or a statement of justification must be presented.

1. Extractions of impacted teeth may be referred to an oral surgeon if there is an existing pathology.
2. Extraction of immature, erupting third molars, which are currently impacted, is not a covered benefit.
3. Extraction of impacted, asymptomatic teeth with no pathology is not a covered benefit.
4. Oral surgery procedures related to orthodontic treatments are not covered benefits under the Healthy Families Program.

Specialty Referral for Pedodontics

PCDs are responsible for providing all necessary pedodontic care to their assigned enrollees, so long as that care is within their clinical competency. Young children with complicated management problems may constitute an appropriate referral to a specialist if at least two documented attempts with date of attempts, have been made by the Dentist in treating the patient. Some Patients with special health care needs may be considered as exceptions to this policy. Cases of rampant caries or baby bottle syndrome are not reasons for referral unless the patient is demonstrating significant behavioral problems that the PCD cannot handle.

For HFP program members, approvals of pedodontic referrals will not be authorized for children ages 6 years and older.

For GMC and LAPHP programs members, approvals of pedodontic referrals will not be authorized for children ages 11 years and older.

Specialty Referral for Orthodontics

For GMC and LAPHP Orthodontic treatment is a benefit as long as requirements are met as outlined in the Medi-Cal Dental Program Provider Manual. The member must be under 21 years of age with permanent dentition and have average good oral health.

For HFP, orthodontic treatment is not a covered benefit. However, Orthodontic services are covered if a member meets the eligibility and scoring requirements for California Children's Services (CCS).

Referral Follow-up

When a referral to a specialist is authorized, the PCD must evaluate the need for follow-up with the patient after the specialty services have been provided. It is the responsibility of the PCD to schedule the patient for any appropriate follow-up treatment. When a referral to a specialist is denied, it is the responsibility of the PCD to evaluate the patient for an appropriate alternative treatment.

Case Management

All complex and special needs cases are referred to the ***Access*** Referral/Case Management Coordinator for case management. ***Access*** **case management provides valuable services to members and providers for complex cases.** Complex cases are those cases where the dental condition is compromised by a medical condition, and care needs to be coordinated between medical and dental providers. Special needs cases are those members with physical and/or mental handicaps who are in need of dental care from providers who have experience working with these patients.

Denial of Referral Due to Inadequate Information

If ***Access*** receives a referral form that lacks required information, the referral form is returned to the PCD with a listing of the missing information. The missing information must be included when the referral form is resubmitted to ***Access***. If the missing information is not submitted, ***Access*** cannot process the referral.

Second Opinion

Access members are entitled to a second opinion for their treatments. A request for a second opinion may also be submitted to ***Access*** by a participating PCD or any other participating provider such as a specialist, who is treating a member.

If a member requests a second opinion, your office should contact ***Access*** and request a referral to another provider. ***Access*** will then provide the member with an authorization to obtain a second opinion.

If a member is requesting a second opinion about care from his or her PCD, the second opinion shall be provided by an appropriately qualified dental provider of the member's choice within ***Access'*** network. An appropriately qualified health care professional means a primary care dentist, specialist, or other licensed health care provider who meets these requirements.

If a member is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the member's choice within ***Access'*** network of the same or comparable specialty. If the specialist is not within *Access'* network, ***Access*** shall incur the cost or negotiate the fee arrangements of that second opinion, beyond the applicable copayments paid by the member. If there is no participating ***Access*** provider within the network who is an appropriately qualified dentist, ***Access*** shall authorize a second opinion by an appropriately qualified dentist outside of ***Access'*** provider network. ***Access*** shall take into account the ability of the member to travel to the provider. The cost of obtaining the second opinion will be borne by ***Access***. Providers who are treating members also can request second opinions.

The reasons for a second opinion shall include, but are not limited to the following reasons:

- Member questions the reasonableness or necessity of the recommended procedures
- Member questions the diagnosis or plan of care for a condition that threatens loss of life, substantial impairment, including a serious chronic condition.

- The clinical indications are not clear, the provider is unable to diagnose the condition or the diagnosis is unclear due to conflicting test results and the Member requests additional diagnosis.
- The treatment plan in progress is not improving the dental condition of the member within an appropriate period of time given the diagnosis and the member requests a second opinion regarding the diagnosis or continuance of treatment.
- Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Access shall review the reasons for the request for a second opinion and provide an authorization or a denial in an expeditious manner. The second opinion will be rendered within 72-hours from receipt of request by ***Access*** where the member's condition poses imminent and serious threat to the member's life.

Access shall require the provider who is rendering the second opinion to provide the member and the initial provider with a consultation report, including any recommended procedures or tests that this second provider deems appropriate.

In the event that ***Access*** denies a request by a member or a treating provider for a second opinion, ***Access*** shall notify the member and the provider in writing of the reasons for the denial and shall inform the member and the provider of the right to file a grievance with ***Access***.

Members, providers, or public interested in obtaining the timeline for authorizing second dental opinions can contact ***Access*** at:

Access Dental Plan, Inc.
P. O. Box 659005
Sacramento, CA 95865-9005
Attn: Specialty Referrals

Completion of the Referral Form

The date of authorization of a specialty referral is the date from which the 90-day authorization period is calculated. An authorization will expire 90 days after this date. Services must be provided prior to expiration of the authorization. Additional documentation of the referral request may be required.

Access' Specialty Referral Form must be completed for all referral authorizations, including emergency referrals. Instructions for completing the form are shown below. A sample form that corresponds to the numbers on these instructions is included on the next page.

1. Check the box for the type of referral (routine or emergency) and the program coverage of the patient.
2. Complete patient information must be provided.
3. The requesting PCD must complete the provider information, including both the ***Access*** Dental Plan provider number and the provider license number.
4. The specific specialty referral must be indicated.
5. The inclusion of required documentation and x-rays (if any) must be noted.
6. The requesting PCD must complete the information, including procedure code and description of the service to be provided by the specialist and a statement regarding the need for a specialist.
7. The requesting PCD must sign and date the referral form.

SPECIALIST REFERRAL FORM

Mail to: Access Dental Plan – Referral Department
PO Box 659005 – Sacramento, CA 95865-9005
Telephone: 800-270-6743 x6012 Fax: 877-648-7741

PLEASE CHECK APPROPRIATE BOXES:

❶ ☐ **Routine Referral** ☐ **Emergency Referral**

☐ **GMC** ☐ **DHMO-Commercial Managed Care** ☐ **HFP** ☐ **LAPHP**

PATIENT INFORMATION		PRIMARY CARE DENTIST INFORMATION
Patient Name: ❷		Provider Name: ❸
Parent's Name (if minor):		Provider Office Number:
CIN Number:		Provider Phone Number:
Phone:	DOB:	Provider Fax Number:
Address:		Address:
City, State, Zip:		City, State, Zip:
Social Security Number (optional):		License Number:

REQUEST FOR REFERRAL: ❹ ☐ **Endodontist** ☐ **Pedodontist** ☐**Periodontist**
☐ **Oral surgeon** ☐ **Orthodontist** ☐ **Other**

ATTACHMENTS: ❺ ☐ **X-rays included:** ☐ **YES** ☐ **NO** **If yes, how many?________ (PLEASE ATTACH FILMS TO THIS FORM)**

PLEASE REFER TO THE ACCESS DENTAL SPECIALTY CARE GUIDELINES ON THE BACK OF THIS FORM FOR DETAILS REGARDING THE DOCUMENTATION REQUIRED TO PROCESS YOUR SPECIALTY REFERRAL.

DESCRIBE THE PROCEDURE AND REASON FOR SPECIALTY REFERRAL

❻	**PATIENT MUST BE ELIGIBLE FOR COVERAGE AT TIME OF SERVICE**
	SPECIALIST: PLEASE RETURN X-RAYS WHEN TREATMENT IS COMPLETED

IN MY PROFESSIONAL JUDGMENT THE TREATMENT LISTED REQUIRES A SPECIALIST: ☐ **YES** ☐ **NO**

REFERRING DENTIST SIGNATURE: ❼_________________________ **DATE:**_______________

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF APPROVAL.

FOR ACCESS DENTAL PLAN USE ONLY

Eligibility: ☐ Yes ☐ No Date: Initial:

PLEASE SEE ATTACHED RESPONSE TO SPECIALTY REFERRAL REQUEST FOR THE FOLLOWING

☐ Approved	Date:	Initial:
☐ Modified	Date:	Initial:
☐ Insufficient Information	Date:	Initial:
☐ Denied	Date:	Initial:

SPECIALTY CARE GUIDELINES FOR ALL PROGRAMS

Purpose:

To provide uniform guidelines of responsibility for General Dentists, to ensure that the level of specialized care provided by general practitioners is appropriate.

The general Dentist is responsible for providing routine emergency and after hours emergency care, diagnostic and treatment planning procedures, diagnostic therapy, and the coordination of multi-disciplined treatment as needed.

Policy:

It is the policy of Access Dental Plan that general dentists provide the complete range of dental treatments for which they are licensed. Patients are only referred to a specialist for treatment of conditions that are beyond the capability of the general practitioner.

Referral Department will make decisions on authorizations based on the information provided by the referring provider. The accuracy of this information will be verified based on the written referral request submitted by the referring provider. **If the written referral request and supporting documentation does not substantiate the need for a referral, *Access* will charge the cost of the referral services back to the referring provider.**

Endodontics

All routine endodontic procedures are the responsibility of the general Dentist. This includes initial treatment of root canal fillings for single and multi-canal teeth. The Dentist must also provide emergency pulpal, I & D, and bleaching treatment. Referrals may be made for complicated "tried and failed" cases, apicoectomies, and retro fillings.

Pedodontics

The general Dentist is responsible for the routine care of children of all ages. Routine care includes extractions, fillings, stainless steel crowns, pulpotomy, space maintainers, sealants, prophylaxis, and fluoride treatment. Young children with complicated management problems may constitute an appropriate referral to a specialist if at least two documented attempts with date of attempts, have been made by the Dentist in treating the patient. Some Patients with special health care needs may be considered as exceptions to this policy.

For HFP program members, approvals of pedodontic referrals will not be authorized for children ages 6 years and older.

For GMC and LAPHP programs members, approvals of pedodontic referrals will not be authorized for children ages 11 years and older.

Periodontics

The general Dentist is responsible for the diagnosis and maintenance of his/her patient's periodontal care. The Dentist must be adept at surveying the patient's periodontal situation and home care motivation. The Dentist is responsible for all non-surgical treatment including, but not limited to, prophylaxis, subgingival curettage, root planning, oral hygiene instruction, and minor occlusal adjustment.

Specialty referral procedures may include: gingival surgery, osseous surgery, complete occlusal equilibration and orthodontic appliances. All periodontal referrals must indicate that the following procedures have been performed by the general Dentist prior to the referral:

1. Complete exam
2. Full Mouth X-rays
3. Full periodontal examination
4. Full mouth root planning
5. Recall periodontic exam within 3-6 months from the date of the initial root planning.

Oral Surgery

The general Dentist is responsible for providing Oral Surgery for erupted and devastated dentition including surgical extractions, root sectioning and retrieval, soft tissue impaction, intra-oral I & D, and/or routine minor surgical procedures. THE PLAN will cover extractions of impacted teeth only with an existing pathology, immature, erupting third molars, which are currently impacted (usually on patients 18 years or younger) are not a covered benefit. Extraction of impacted, asymptomatic teeth with no pathology on adult patients is not a benefit of THE PLAN. Part and full bony symptomatic impactions, biopsies, and osseous re-contouring and patients requiring hospital dentistry and specialist involvement due to the medical problem, may be referred to an Oral Surgeon.

Anesthesia

The general Dentist is expected to be an expert in controlling pain through the use of relaxation techniques and local anesthesia.

Orthodontics

General Dentists are not expected to have extensive orthodontic training and are not required to provide this care. Not all Access Dental Plan members have orthodontic coverage. Member referrals will be expedited through the Dental Director's office to orthodontic offices within the panel. Please see your provider manual for Healthy Families Program requirements through the California Children's Services Program.

Other

An authorization for a second opinion.

ACCESS DENTAL

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Claims Processing and Provider Dispute Resolution Mechanism

How to submit a claim and challenge, appeal or request reconsideration of a denied or contested claim.

AFTER A PROVIDER DELIVERS TREATMENT to an ***Access*** member, the provider must complete a claim form and submit it to ***Access*** Dental Plan. **The claim form must include the name of the program under which the member is covered (HFP, GMC, LAPHP or Commercial Managed Care).**

Review criteria for claims processing has been adopted from the Medi-Cal dental program provider manual. This criteria is applied with covered benefits, limitations, and exclusions of ***Access*** Dental Plan's Programs.

Claims Processing

To ensure claims are processed accurately and timely, ***Access*** Dental providers must adhere to the following guidelines:

Claim Submission Instructions

The following sections describe ***Access*** Dental Plan's claims submission process. Please note that for submission of claims and encounters under the **GMC** and **LAPHP** programs we are now accepting the CDT-4 ADA fourth edition codes, and will no longer accept the old Denti-Cal 3 digit codes. Should you have any questions please review Denti-Cal bulletin volume 23, number 41 from November 2007 or go to Denti-Cal's web site at: http://www.denti-cal.ca.gov/provsrvcs/manuals/sec5/Section_5.pdf.

Notice and Proof of Claim

Written notice of a claim must be given to the Plan within 30 days after the occurrence or commencement of any covered service or supply, or as soon thereafter as reasonably possible, but no later than 180 days from the date of service. Claims shall be processed by ***Access*** for payment and paid within 45 days of receipt of a "clean" claim or receipt of all required documentation and information. Any appeals related to the adjudication of claims by the Plan must be submitted no later than 180 days from the date of the original / first Explanation of Payments related to that claim. Claims submitted more than 180 days after the date of service will not be considered for payment. Appeals submitted 180 days after the date of the original / first Explanation of Payments will not be considered by the Plan.

All claims and appeals must be sent to the Plan at:

Access Dental Plan
Claims Department
P. O. Box 659005
Sacramento, CA 95865-9005

Acknowledgment of Claims

Access will verify and acknowledge the receipt of each claim, whether complete or not and post the recorded date of receipt on ***Access***' website at www.premierlife.com. Once on the website, scroll over to the *Provider Services* menu item, where a drop down box will display. Click on Claims Acknowledgment on the drop down box, and an Acknowledgment login page will appear. To access your claim, enter your Office Phone # and the last 4 digits of your tax ID into the Acknowledgment login page. Once a claim has been posted on the site, it will remain there for 30 days. If you do not have internet access, you may also verify ***Access'*** receipt of your claim by contacting ***Access*** at
1-800-270-6743 ext. 6012.

Claim Submission Requirements

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by *Access*:

- All claims must be submitted to ***Access*** for payment for services no later than 180 days after the date of service.
- All claims must include the name of the program under which the member is covered (HFP, GMC, LAPHP or Commercial Managed Care) and all the information and documentation necessary to adjudicate the claim.

- For emergency services, please submit a standard claim form which must include all the appropriate information, including pre-operative x-rays and a detail explanation of the emergency circumstances.

Fee Schedules

The complete Fee Schedule for contracted providers is posted on ***Access*** Dental Plan's website at www.premierlife.com.

Claims Overpayment

The following sections describe the process that will be followed if ***Access*** determines that it has overpaid a claim.

Notice of Overpayment of a Claim

If ***Access*** determines that it has overpaid a claim, ***Access*** will notify the provider in writing through a separate notice clearly identifying the claim; the name of the patient, the date of service and a clear explanation of the basis upon which ***Access*** believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Contested Notice

If the provider contests ***Access***' notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to ***Access*** stating the basis upon which the provider believes that the claim was not overpaid. ***Access*** will process the contested notice in accordance with ***Access***' contracted provider dispute resolution process described in the section titled Provider Dispute Resolution Process.

No Contest

If the provider does not contest ***Access***' notice of overpayment of a claim, the provider must reimburse ***Access*** within 30 working days of the provider's receipt of the notice of overpayment of a claim. In the event that the provider fails to reimburse ***Access*** within 30 working days of the receipt of overpayment of the claim, ***Access*** is authorized to offset the uncontested notice of overpayment of a claim from the provider's current claim submissions.

Offsets to Payments

Access may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when; (1) the provider fails to reimburse ***Access*** within the timeframe set forth above, and (2) ***Access***' contract with the provider specifically authorizes ***Access*** to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, ***Access*** will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

Provider Dispute Resolution Process

Definition: A contracted or non-contracted provider dispute is a provider's written notice to ***Access*** challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

Dispute Resolution Process for Contracted Providers

Each contracted provider dispute must contain, at a minimum, the following information: provider's name; provider's license number, provider's contact information, and:

- If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from ***Access*** to a contracted provider: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.
- If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on the issue.

Access will resolve any provider dispute submitted on behalf of an enrollee **through Access**' Consumer Grievance Process**. A provider dispute submitted on behalf of an enrollee will not be resolved through Access**' **Provider** Dispute Resolution **Process**.

Sending a Contracted Provider Dispute to *Access*

Contracted provider disputes submitted to ***Access*** must include the information listed above for each contracted provider dispute. All contracted provider disputes must be sent to the attention of the Provider Dispute Resolution Mechanism Department at the following address:

Access Dental Plan
ATTN: Provider Dispute Resolution Mechanism Department
8890 Cal Center Drive
Sacramento, CA 95826

Time Period for Submission of Provider Disputes

- Contracted provider disputes must be received by ***Access*** within 365 days from ***Access***' action that led to the dispute (or the most recent action if there are multiple actions).
- In the case of ***Access***' inaction, contracted provider disputes must be received by ***Access*** within 365 days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
- **Contracted provider disputes that do not include all required information may be returned to the submitter for completion.** An amended contracted provider dispute which includes the missing information may be submitted to ***Access*** within thirty (30) working days of your receipt of a returned contracted provider dispute.

Acknowledgment of Contracted Provider Disputes

Contracted provider disputes will be acknowledged by ***Access*** within fifteen (15) working days of the date of receipt by ***Access***.

Contracted Provider Dispute Inquiries

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to the Provider Dispute Resolution Mechanism Department at: 1-800-270-6743 ext. 7013.

Instructions for Filing Substantially Similar Contracted Provider Disputes

Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted with a cover sheet for each batch describing each provider dispute.

Time Period for Resolution and Written Determination of Contracted Provider Disputes

Access will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments

If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, ***Access*** will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

Dispute Resolution Process for Non-Contracted Providers

Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

- If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from ***Access*** to the provider the following must be provided: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect.
- If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

The dispute resolution process for non-contracted providers is the same as the process for contracted providers.

ACCESS DENTAL

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Quality Improvement Program

The Quality Management Program (QMP) is designed to ensure that Access Dental Plan provides the highest quality dental care to all members with an emphasis on dental disease prevention and the provision of exceptional customer service to members.

As a licensed health care service plan in California, ***Access*** is regulated by the California Department of Managed Health Care (DMHC). The Department of Managed Health Care's policies and regulations require all plans to maintain a Quality Management Program. ***Access*** Dental Plan's QMP includes all policies and procedures used by ***Access*** to ensure the delivery of the highest level of service to its members. The QMP provides specific policies relating to member and provider grievances/appeals, monitoring of provider offices/patients and monitoring of dental care and services provided to ***Access*** members.

***Access*' dental providers are expected to participate in the quality management process by cooperating with all QMP activities, recommendations and corrective actions.** In addition, dental providers are encouraged to be actively involved with establishing dental policies, standards, practice guidelines and review criteria.

Quality Management Committee

As ***Access*'** governing body, the Board of Directors has ultimate oversight responsibility for monitoring and ensuring the delivery of the highest quality, cost effective dental care and services to ***Access*** members. The Board of Directors has delegated day to day QMP operational responsibilities to the Dental Director with oversight responsibilities delegated to the Quality Management Committee (QMC). The Dental Director, under the direction of Access' Chief Executive Officer (CEO), chairs the committee. The QMC includes the five following subcommittees:

1. Peer Review Subcommittee
2. Utilization Review Subcommittee

3. Dental Policy Subcommittee
4. Member Grievances/Appeals and Member Services Subcommittee
5. QI Studies and HEDIS Compliance Subcommittee. In addition to the QMC and subcommittees, ***Access*** Dental Plan maintains a Public Policy committee to provide a forum for member input and feedback to ***Access*** regarding company processes and policies.

Access' committees include staff representatives from key ***Access*** departments, and network and non-network providers representing primary care and specialty dentistry. Specific staff representatives are considered non-voting members on some committees to avoid conflict of interest. **Providers are voting members on all committees.** Following are some key areas of discussion for input and feedback from committee representatives:

- Making recommendations for dental policies standards, practice guidelines and review criteria;
- Managing dental care functions to ensure high quality, cost effective dental care;
- Reviewing individual cases and aggregate data to assess the level of quality care provided to members;
- Making recommendations for corrective actions when needed; and
- Conducting follow-up monitoring to ensure effectiveness of corrective actions.

Provider participation is an integral component of the QMC and its subcommittees. Providers are the primary decision-makers on quality issues relating to the delivery of dental care. To ensure adequate provider representation, ***Access*** provider committee members, receive compensation for their time. The Dental Director, with QMC approval, selects providers for participation on committees.

Becoming a Committee Member

Providers who are interested in becoming a member of ***Access*** Dental Plan's Public Policy committee, QMC and/or subcommittees may email or write to the Dental Director at the following address and phone number:

Access Dental Plan
Attn: Dental Director
8890 Cal Center Drive
Sacramento, CA 95826
1-800-70-SMILE

On-Site Audits

DMHC requires all licensed plans to monitor and assist providers through on-site visits to provider panel dental offices. ***Access*** performs such site visits regularly. Generally ***Access***' Dental Director and/or Dental Consultant visit the panel provider offices annually according to established enrollment thresholds. The frequency of the site visits may be higher for certain programs, such as Medi-Cal Managed Care Dental Programs. ***Access*** views the site visits of the provider offices as a way to assist providers in complying with regulations related to the operations of dental offices (OSHA, Dental Board of California, EPA, Department of Health Care Services, etc.)

During the site visit, ***Access***' Dental Director and/or Dental Consultant assess the provider offices:

- Accessibility
- Facility and Equipment
- Emergency Procedures and Equipment
- Sterilization and Infection Control
- Process Of Care Assessment through Dental Records

Once the site visit is completed, the Dental Director and/or Dental Consultant will provide a report of the assessment to the billing dental provider. When issues are identified the report will include opportunities for improvement. The Dental Director and/or Dental Consultant may also provide information to the dental provider on how to implement specific improvements. When the Dental Director and/or Dental Consultant observes severe deficiencies in an office which could jeopardize the health of the members, the provider will be required to implement improvements or changes in practice within a defined period of time. ***Access*** will work closely with the provider to achieve compliance with specified regulations.

Access believes that provider offices benefit from the consulting services of our Dental Director and/or Dental Consultant. These services are provided in a non-adversarial, professional manner, at no charge to the dental office, with respect for the dental provider's privacy and patient schedule.

CADP STRUCTURAL REVIEW EVALUATION MEASURES

Review Criteria	Reviewer Evaluation Measures
I. Accessibility	
A. 24 Hour Emergency Contact System?	Active after hours mechanism (Answering machine, answering service, cell phone, or pager) available for 24hour / 7 day a week contact or instructions. 1. Patients informed of emergency system for 24/7 access. 2. Inability to provide 24-hour access for dental emergencies is a departure from accepted standard of care.
B. Reasonable appointment scheduling for plan members?	The patients wait time to schedule an appointment should be reasonable and appropriate according to filed access standards (Individual to each Plan). 1. Urgent Appointments - Within 72 Hours 2. Non-urgent Appointments- Within 36 Business Days 3. Preventive Dental Care Appointments- Within 40 Business Days
C. Language Assistance Program and Documents?	Patients requiring Language Assistance can receive it. Confirm languages spoken in office- indicate in check box or via manual entry those languages spoken. Provider knows how to contact plan to obtain language assistance for patients needing translation and/or interpretation services. Provider knows to document a patient's refusal of assistance in the patient's treatment record.
II. Facility and Equipment	
A. Clean, safe neat and well-maintained	Verification made that facility and equipment are clean, safe and in good repair 1. There are no visible stains or significant scarring of furniture or floors. 2. There is no debris on floors or other areas, especially patient care, reception, infection control areas and laboratories. 3. Décor should be in good taste, easily cleaned and well maintained 4. For protection of everyone, employees and patients, lighting should be sufficient to allow safe ingress/egress and to maintain good vision without fatigue. 5. Dental equipment should be appropriate and in good working condition: a. No equipment with obviously broken parts, visible damage, temporary repairs or grossly torn upholstery. b. Current certification results for equipment requiring local, state or federal certification on file at the facility. (radiographic equip/ medical waste)
B. Compliance with mercury hygiene, safety regulations?	Compliance with mercury hygiene, safety regulations. 1. Amalgamators covered. 2. Bulk mercury and scrap amalgam stored in sealed, unbreakable containers.

CADP STRUCTURAL REVIEW EVALUATION MEASURES

Review Criteria	Reviewer Evaluation Measures
	3. Mercury spill kit.
C. Nitrous Oxide Recovery System?	Verification that nitrous oxide equipment is clean, safe and in good repair. 1. No visible cracking or destruction to hoses or nose piece. 2. Recovery System with connection to exhaust or suction system. Usually requires a minimum of four hoses for this to be accomplished. 3. Fail Safe mechanism present for correct delivery of gasses.
D. Lead Apron (with thyroid collar for patient)	There should be a lead apron present with a thyroid collar. The collar does not have to be attached to the apron, but must be used on all patients when exposing radiographs. Separate thyroid collar is acceptable.
III. Emergency Procedures and Equipment	
A. Written emergency protocols?	For fire and/or natural disasters: 1. A plan indicating escape routes and staff member's responsibilities, including calling for help. 2. Exits clearly marked with exit signs. 3. Emergency numbers posted (911, Fire, Ambulance and local 7-digit numbers in both front office and back office or lab). Written protocol for calling for help. Note: If office protocol entails only calling 911, this section does not apply and evaluation should be marked "N/A".
B. Medical emergency kit on-site?	Medical emergency kit should be easily accessible and labeled with an inventory of contents. All required drugs (per JADA 3/2002 article) are current. Staff should be aware of location of kit. Recommend staff in-service training for general use of contents.
C. Portable oxygen supply available?	Portable oxygen supply tank / ambu- bag for medical emergencies should be available. 1. Recommend tanks be maintained full and a positive pressure bag or ambu bag be available. 2. Recommend staff in-service training for use of emergency oxygen source. 3. Staff should be aware of and have access to location.

CADP STRUCTURAL REVIEW EVALUATION MEASURES

Review Criteria	Reviewer Evaluation Measures
IV. Sterilization and Infection Control	
A. Sterilization and infection control protocols followed?	Verify sterilization and infection control procedures are in place. Verify staff trained in sterilization and infection control procedures and protocols. Sterilization and infection control procedures shall conform to the Dental Board of California. (DPA Section 1680dd, January 1993)
B. Protocols posted for sterilization procedures?	Protocols conspicuously posted. Dental Board of California. (DPA Section 1005b23, January 2001)
C. Weekly biological (spore) monitoring of sterilizer?	Sterilization procedures shall be monitored weekly and recorded, by appropriate methods, as required by the Dental Board of California. (DPA Section 1005b14, January 2001)
D. All instruments and hand-pieces properly cleaned, sterilized, and stored?	1. Contaminated instruments are properly cleaned. a. Utility gloves used. b. Ultrasonic cleaning recommended. Solutions changed per manufacture's specifications. 2. Acceptable procedures for sterilization are: a. Storage of instruments shall be in sterile bags or packs that are sealed. There should be no evidence of moisture or torn bags. Instruments must remain in sealed, sterile bags or packs until ready for use. Once opened, all instruments must be rebagged and resterilized, regardless of whether they were used or not. b. Hand-pieces must be properly sterilized between patients and bagged until use. c. Instruments, which cannot be cold-sterilized, or autoclaved, must be disposable and must be disposed of immediately after use. d. High level disinfectant should be utilized only on instruments that cannot be subjected to other methods of sterilization
E. Log kept monitoring changing of Sterilization solution?	Maintain a written log indicating: 1. Acceptable EPA registered brand name of the cold sterilant (high-level disinfectant) tuberculocidal hospital disinfectant, utilized according to the manufacturer's recommendations for sterilization. 2. Indicate dates solution changed, and dates of expiration of fresh solution. 3. Indicate name of staff member making the change. (Dental Practice Act)

CADP STRUCTURAL REVIEW EVALUATION MEASURES

Review Criteria	Reviewer Evaluation Measures
F. Staff wears appropriate personal protective equipment?	1. Personnel shall always use protective gloves, masks, eyewear, coats or gowns during patient care. 2. Splattered masks and garments should be replaced as necessary. 3. Gloves must be changed between patients and before leaving the operatory.
G. Proper and adequate use of barrier techniques?	1. Verification made that hard surfaces in all operatories are disinfected between patients and at the end of each day. A Cal OSHA/EPA approved solution should be used. 2. Verification made that surfaces not capable of being disinfected by routine methods should be covered with impervious materials.
H. Hand-pieces and waterlines flushed appropriately?	Operatory unit water lines shall be flushed between each patient and in the morning before use, for an appropriate amount of time (per manuf. guidelines).
I. Infection control and cross contamination prevention procedures followed in the office and laboratory?	1. The pumice pan should be changed after each use and rag wheels should be sterilized after each use or discarded. 2. Impressions, dentures and other appliances going to and coming from the laboratory should be properly rinsed and disinfected.

CADP PROCESS OF CARE EVALUATION CRITERIA

Review Criteria	Reviewer Evaluation Measures
1. DOCUMENTATION	
A. Medical History	
1. Comprehensive information collection	General medical history with information pertaining to general health and appearance, systemic disease, allergies and reactions to anesthetics. Should include a list of any current medications and/or treatment. Proactive format is recommended. Name, telephone number of physician and person to contact in an emergency. Patient must sign and date all baseline medical histories.
2. Medical follow-up	Patient comments, DDS/DMD notes, or consultation with a physician should be documented in the chart.
3. Appropriate medical alert	Should be uniform and conspicuously located on the portion of the chart used during treatment and should reflect current history.
4. Doctor signature and date	Dentist must sign and date all baseline medical histories after review with patient.
5. Periodic update	Documentation of medical history updates at appropriate intervals. Must be signed by the patient and the provider. Acceptable on medical history form or in the progress notes. Should reflect changes or no changes. Recommend update be done annually.
B. Dental History/Chief Complaint	Documentation of chief complaint and pertinent information relative to patient's dental history.
C. Documentation of Baseline Intra/Extra Oral Examination	
1. Status of teeth/existing conditions	Grid or narrative of existing restorations and conditions.
2. TMJ/Occlusal evaluation	Evidence of TMJ exam or evaluation of occlusion (classification) should be determined.
3. Prosthetics	Evaluation of existing appliance(s)(age, condition etc.), teeth replaced, clasps,etc.
4. Status of periodontal condition	a. Condition of gingival tissue, calculus, plaque, bleeding on probing, etc. b. Evidence of baseline probing should be documented (if indicated). c. Case type of perio conditions (Type I-IV) or (Normal, Gingivitis, or Slight, Moderate or Severe Periodontitis)
5. Soft tissue/oral cancer exam	a. Evidence that soft tissue /oral cancer exam was performed initially and periodically (at least annually) b. Note of any anatomical abnormalities

CADP PROCESS OF CARE EVALUATION CRITERIA

D. Progress Notes	
1. Legible and in ink	Provider should be reminded that progress notes are a legal document, all should be in ink, legible and should be in detail. Corrections should be made by lining-out. Documentation of any follow-up instructions to the patient or recommendations for future care. Documentation of patient leaving the practice and reasons, if known. Documentation if any records forwarded, etc.
2. Signed and dated by provider	All entries must be signed or initialed and dated by the treating provider. (Per CA. Dental Practice Act, Section 1683)
3. Anesthetics	Notation in progress notes as to the type and amount of anesthetic used; or notation "no anesthesia used" for applicable situations. (Including info on vaso-constrictors used, if any)
4. Prescriptions	Medications prescribed for the patient are documented and Sig., Rx, and Disp. in the progress notes or copies of all prescriptions are kept in the chart. Note an Rx given on phone. Recommended that dental lab prescriptions be documented in the progress notes or a copy kept in the chart.
II. QUALITY OF CARE	
A. Radiographs	
1. Quantity/Frequency	a. Adequate number of radiographs to make an appropriate diagnosis and treatment plan, per current FDA guidelines. b. Recall x-rays should be based on FDA guidelines. Depends on complexity of previous & proposed care, caries susceptibility, amount and type of treatment and time since last radiographic exposure. c. Whenever possible, radiographs should not be taken if recent acceptable films are available from another source (previous Dentist). d. Any refusal of radiographs should be documented.
2. Technical Quality	a. No overlapping contacts, or cone cuts that affect diagnostic value; periapical films should show apices. b. Good contrast, not over or underdeveloped; no chemical stains.
3. Mounted, labeled and dated	Recent radiographs must be mounted, labeled and dated for reviewing and comparison with past radiographs.
B. Treatment Plan	
1. Present and in ink	a. Comprehensive documentation of patient needs and treatment recommendations, all documentation in ink. b. Consistent with diagnosis and clinical exam findings. c. Alternative treatment plans and options should be documented with clear concise indication of what the patient has elected to have performed. d. Consultations and referrals should be noted when necessary.

CADP PROCESS OF CARE EVALUATION CRITERIA

2. Sequenced	Case should be sequenced in order of need and consistent with diagnostic and examination findings, and in compliance with recognized accepted professional standards. (Dental Practice Act, Section 1685) A possible sequence follows: a. Relief of pain, discomfort and infection. b. Prophylaxis and instructions in preventive care. c. Treatment of extensive caries and pulpal inflammation. Endodontic therapy. d. Periodontal treatment e. Replacement of missing teeth, or restorative treatment f. Placement of patient on recall schedule with documentation of progress notes.
3. Informed Consent	a. Documentation that treatment plan has been reviewed with the patient and that the patient understands the risks, benefits and alternatives to care. Patient should also understand the financial component of the treatment proposed. b. An appropriate form signed by the patient is recommended. Documentation that all patient's questions were answered. Evidence of a 'meeting of the minds'. c. Documentation of any refusal of recommended care.
III. TREATMENT OUTCOMES OF CARE	
A. Preventive Services	
1. Diagnosis	Documentation that prophylaxis was performed in a timely manner. Documentation of fluoride treatments planned or rendered, as appropriate to age of patient and caries incidence.
2. Oral Hygiene Instructions	Documentation of Home Care/ Oral Hygiene instructions given to patient.
3. Recall	Documentation of timely case appropriate recall of patient.
B. Operative Service	
1. Diagnosis	Recall and past radiographs used to evaluate proper diagnosis of caries and the need for treatment. Treatment performed in a timely manner.
2. Restorative Outcome and Follow-Up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
C. Crown and Bridge Services	
1. Diagnosis	Recall and past radiographs used to evaluate the need for treatment. Treatment performed in a timely manner.
2. Restorative Outcome and Follow-Up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.

CADP PROCESS OF CARE EVALUATION CRITERIA

D. Endodontic Services	
1. Diagnosis	Signs and symptoms documented (if need not evident on radiographs).
2. Rubber Dam Use	Evidence of rubber dam use on working x-rays and/or documentation of use in progress notes.
3. Endodontic Outcome and Follow-Up	a. Radiographic evaluation of treatment to determine that canal(s) is/are properly filled and well condensed. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment, no eivdence of extraction of recently completed endo. c. Documentation of final restoration. d. Recall follow-up recommend with PA x-ray.
4. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
E. Periodontal Services	
1. Diagnosis	Evidence that clinical examination including pocket charting and radiographs is available to determine proper type of treatment needed.
2. Treatment per visit	Rationale for more than 2 quadrants of scaling/root planing per visit should be documented.
3. Periodontal Follow-Up/Outcome	Recall follow-up recommended with radiographs or probing.
4. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
F. Prosthetic Services	
1. Diagnosis	Evaluation of form, fit, and function of existing prosthesis. Evaluation of need where no prosthesis exists.
2. Prosthetic Outcome and Follow-Up	a. Treatment was done in a timely manner, including necessary adjustments. b. Prognosis good for appropriate longevity.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
G. Surgical Services	
1. Diagnosis	Radiographic and/or soft tissue / clinical exam supports treatment rendered
2. Surgical Outcome and Follow-Up	a. Comprehensive documentation of treatment done, materials used, and any noteworthy occurrences during the procedure. b. Documentation of post-operative instructions to patient. c. Documentation of any needed post-operative care, including suture removal.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
IV. OVERALL PATIENT CARE	Overall care is clinically acceptable (to the extent that it is possible to determine by x-rays and available information.

ACCESS DENTAL

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Member Assignment to PCD

A discussion of how members are assigned to a PCD and the circumstances under which a PCD may request reassignment of the member to another PCD.

ASSIGNMENT OF ***Access*** MEMBERS TO A PRIMARY CARE DENTIST is the critical first step in establishing a successful relationship between patient and dentist and ensuring successful treatment outcomes.

Assignment of Member to PCD

Access assigns each member to a PCD. This assignment is done based on the following criteria:

- Member's request for a specific PCD.
- The nearest PCD to the residence of the member.

Please be aware that ***Access*** receives mid-month eligibility in all its programs. When a member is assigned mid-month upon member request, the dental office where the member is going to be assigned is contacted by telephone and the office personnel are informed of the assignment. The office will receive appropriate payments for that assignment for that month. However, the amount will be paid to the provider on the next month's check as an adjustment.

Member identification is discussed in detail, including a copy of a membership card, in Chapter 12.

Membership Lists to PCD

Access sends membership lists to PCDs at the beginning of the month, along with the capitation check. These lists show all the members assigned to a specific PCD for which capitation is being paid in that month.

If a member is requesting service and is not on the PCD's list or the PCD has a question regarding whether or not a member is assigned to him/her, the provider should call ***Access'*** Member Services Department or obtain the information from ***Access'*** website at www.premierlife.com to verify member assignment. The phone numbers for Member Services are as follows:

DHMO (Commercial Managed Care).. 866-650-3660
GMC (Geographic Managed Care).. 916-646-2130
HFP (Healthy Families Program)... 888-849-8440
LAPHP (Los Angeles Prepaid Health Plan).................................. 888-414-4110

Mid-Month Member Changes

Members who change their PCD in the middle of a month and require services prior to being included in the new PCD's membership list (and capitation calculation) may receive services from the new PCD. The new PCD will receive a pro-rated capitation amount, which is included in the following month's capitation check. However, the PCD should contact the Member Services Department to verify the change of PCD prior to providing services.

Reassignment of Member

A provider may submit a written request to reassign a member in cases of fraud or violence. The written request for reassigning a member may be for any of the following circumstances:

- Member is repeatedly verbally abusive to the provider, auxiliary or administrative staff or other Plan members.
- Member physically assaults the provider or staff person or another member or threatens another individual with a weapon on provider's premises. In this instance, the provider shall file a police report and file charges against the member.
- Member is disruptive to the provider's office operations.
- Member has allowed the fraudulent use of his/her coverage under the Plan, which includes his/her allowance of others to use his/her ***Access*** membership card to receive services from ***Access*** providers.
- Member has failed to follow prescribed treatment (including failure to keep established appointments). This shall not, in and of itself, be good cause for a request for member reassignment unless the provider can demonstrate that, as a result of the failure, the provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated under the Plan and the rate-setting assumptions.

Completion of the Transfer Form

A request to reassign a member must be submitted in writing by the provider. The request must include the reason for the reassignment, a narrative description of the encounters with the member that caused the provider to request member reassignment.

Upon receipt of the request, ***Access*** will contact the member to obtain the member's view on the reasons for the request for transfer. If the member concurs with the transfer, the transfer will be made. The provider will continue to be responsible for the dental care of the member until the effective date of the reassignment.

If the member does not wish to be reassigned, ***Access*** will not reassign the member. The provider has the right to request a review of this decision by the Dental Director.

A sample Transfer Request Form is included on the next page.

TRANSFER REQUEST FORM

Date:____________________ | Dental Office Name:____________________
Member Name:____________________ | Office Telephone #:____________________
Member ID #:____________________
Member Telephone #:____________________

GEOGRAPHIC MANAGED CARE	COMMERCIAL MANAGED CARE	HEALTHY FAMILIES PROGRAM	LOS ANGELES PREPAID HEALTH PROGRAM
❑ GMC	❑ DHMO	❑ HFP	❑ LAPHP

Reason For Request: All Provider Transfer Requests will be processed by the Plan within 30 days, from the date of receipt. All approved transfers will be result in the deletion of the member from the next month's roster. Providers will be notified by the Plan, in writing, of any denied requests.

- ❑ Member is repeatedly verbally abusive to the provider, auxiliary or administrative staff or other Plan members.
- ❑ Member physically assaulted the provider or staff person or another member or threatened another individual with a weapon on provider's premises. In this instance, the provider shall file a police report and file charges against the member.
- ❑ Member was disruptive to the provider's office operations.
- ❑ Member has allowed the fraudulent use of his/her coverage under the Plan, which includes his/her allowance of others to use his/her ***Access*** membership card to receive services from ***Access*** providers.
- ❑ Member has failed to follow prescribed treatment (including failure to keep established appointments). This shall not, in and of itself, be good cause for a request for member reassignment unless the provider can demonstrate that, as a result of the failure, the provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated under the Plan and the rate-setting assumptions.

Additional comments for transfer:____________________

____

PLEASE STATE THE MISSED APPOINTMENT DATES:____________________

Dentist's Signature:____________________ **Date:**____________________

PLEASE MAIL REQUEST TO: ACCESS DENTAL, P.O. BOX 659005, SACRAMENTO, CA 95865-9005
ATTENTION: CUSTOMER SERVICE DEPARTMENT

FOR ACCESS DENTAL PLAN OFFICE USE ONLY:
Person Receiving Complaint:____________________
Date of Action:____________________
Action Taken:____________________

____

ACCESS DENTAL

10

Continuation of Services with Terminated or Nonparticipating Provider

Upon request of a current or newly covered member, ***Access*** is required to provide for the completion of covered services for treatment of certain specified conditions if (a) the services were being provided by a terminated provider at the time of termination of the provider's contract, or (b) the covered services were being provided by a nonparticipating provider to a newly covered member at the time his or her coverage became effective. Members are entitled to continuation of services from such providers for the following circumstances and timeframes:

Acute Conditions: The duration of an acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration).

Newborn Children between Birth and Age 36 Months: ***Access*** shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the provider's contract or 12 months from the effective date of coverage for a newly covered member.

Surgery or Other Procedures: Performance of surgery or other procedure authorized by ***Access*** as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current members or 180 days from the effective date of coverage for newly covered members.

Access is not required to provide benefits that are not otherwise covered under the terms and conditions of the subscriber contract. This policy does not apply to a new member covered under an individual subscriber agreement.

Access is not required to provide for completion of covered services by a provider whose contract has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in Section 805(a)(6) of the Business and Profession Code, fraud or other criminal activity.

Members may request continuation of care by calling ***Access'*** Customer Service Department at 1-800-707-6453 during normal business hours or by sending a written request to ***Access***. ***Access*** may obtain copies of the member's dental records from the member's provider to evaluate the request.

The Dental Director (or his/her designee) will determine if the member is eligible for continuation of care under ***Access***' *Enrollee Block Transfers and Continuity of Care from Terminated or Non-Participating Providers* policy and the California Knox-Keene Act. The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

- Whether one of the circumstances described above, exists;
- Whether the requested services are covered by ***Access***; and
- The potential clinical effect that a change of providers would have on the member's treatment.

Access shall provide the member with the Dental Director's decision in writing within 5 business days of the receipt of the request and a copy of the member's dental record. The written notice shall inform the member how to file a grievance in the event the enrollee is dissatisfied with the decision.

Access requires the terminated or nonparticipating provider to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracted providers, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. ***Access*** is not required to continue the services with a provider if the provider does not accept the payment rates provided for in this paragraph.

The amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the member if receiving care from a provider currently contracted with or employed by ***Access***.

11

Calironia Children's Services (CCS)

A description of the California Children's Services (CCS) applicable to dental patients.

CALIFORNIA CHILDREN'S SERVICES (CCS) IS A PROGRAM which treats children under 21 years of age with certain physical limitations and diseases. The program is paid for by California taxpayers and offers medical care to children whose families cannot afford all or part of the needed care. **Patients must apply to CCS to become eligible for services under the CCS Program.**

CCS Eligibility for Dental Services

Orthodontic services are not a benefit through the Healthy Families Program. However if a patient meets eligibility requirements, orthodontic services may be provided by California Children Services.

CCS clients eligible for dental services through the CCS program include those who have been accepted for and are authorized to receive orthodontic services **by a CCS-paneled orthodontist**, as well as other clients with CCS-eligible conditions, such as:

- ♦ Medically handicapping malocclusion (one or more of the following conditions)
  - deep impinging overbite
  - crossbite of individual anterior teeth when destruction of soft tissue is present
  - severe traumatic deviations (for example, loss of premaxilla segment by burns or accident, the result of osteomyelitis; or other gross pathology
  - overjet of greater than 9 mm
  - mandibular protrusion of 3 mm or more
  - suspected need for orthognatic surgery

- combinations of the following conditions that appear to be medically handicapping:
  a) overjet
  b) overbite
  c) mandibular protrusion
  d) openbite
  e) ectopic eruption (excluding 3rd molars)
  f) anterior crowding
  g) posterior crossbite
- ♦ Cleft lip and/or palate (hard or soft)
- ♦ Congenital and/or acquired oral and craniofacial anomalies
- ♦ Complex congenital heart disease
- ♦ Seizure disorders
- ♦ Immune deficiencies
- ♦ Cerebral palsy
- ♦ Hemophilia and other blood dyscrasia
- ♦ Malignant neoplasms, including leukemia
- ♦ Rheumatoid arthritis
- ♦ Nephrosis
- ♦ Cystic fibrosis
- ♦ Organ transplants

Referrals for CCS Patients

If a dentist suspects a child has medically handicapping malocclusion or one of the other CCS eligible medical conditions listed above, the dentist must complete a CCS Orthodontic Screening Form. Only those cases meeting the requirements will be considered for referral. In addition, the dentist must specify the suspected CCS medical condition. It is very important that the dentist ensure the patient's information is complete.

The CCS Orthodontic Screening Form needs to be mailed to Access Dental, and not forwarded directly to your local CCS office, at the following address:

Access **Dental Plan**
Referral Department- CCS
P. O. Box 659005
Sacramento, CA 95865-9005

Upon receiving the form from the provider, Access will then refer the child to the local CCS program for determination of eligibility. For additional information, the provider may contact the Access Plan Liaison at:

(916) 563-6012, or

1-800-270-6743, ext. 6012

Upon referral, the Plan shall provide the applicant on behalf of the subscriber with a CCS one page (double-sided) informational flyer obtained form the state.

Access shall ensure continuity of care between the CCS providers and the referring Dentist.

Until eligibility for the CCS Program is established by the local CCS Program, and the extent that otherwise-covered services are not provided by the CCS Program once eligibility is established, ***Access*** shall be responsible for the delivery of all covered medically necessary health care and case management services for a subscriber referred to CCS. Once eligibility to CCS is established by the CCS Program for a subscriber:

- Dentist shall continue to provide covered primary care and all other medically necessary covered services other than those provided through the CCS Program for the CCS eligible condition.
- Dentist shall ensure the coordination of services between its primary care providers, the CCS specialty providers and the local CCS Program.
- The CCS Program shall authorize and pay for the delivery of medically necessary health care services to treat a subscriber's eligible condition. The CCS authorization, on determination of medical eligibility, shall be to CCS paneled providers and approved facilities, some of which may also be members of ***Access's*** network. Authorization normally cannot predate the initial referral to the local CCS Program in accordance with Title 22, CCR, and Section 42180. Claims for authorized services shall be submitted to the appropriate CCS office for approval of payment.

CCS-Approved Dental Providers

Dentists from every field of dentistry provide services for CCS clients. Prior to treating a CCS client, orthodontists and oral and maxillofacial surgeons must become CCS-paneled by the Children's Medical Services (CMS) Branch of the State Department of Health Services. Other dental providers (pediatric dentists, general dentists, endodontists, periodontists, and prosthodontists) are not required to be paneled. These non-paneled dental providers are listed as "approved providers" by the local CCS programs.

Providers may become an approved provider by contacting the local CCS administrator and offering to provide CCS dental services. Providers must complete a State Department of Health Services CCS *Panel Application* form. In addition, both CCS-paneled providers and approved providers must fill out a State Department of Health Services *Provider CGP Number Application* form to be compensated for the services they provide. Access encourages its providers to become "CCS-approved providers." This will ensure continuity of care for these children.

For further information on becoming a CCS-approved provider, or to receive the State Department of Health Services forms, contact the Children's Medical Services Branch at: (916) 322-8702.

Services unrelated to the CCS eligible condition continue to be benefits under the Medi-Cal Managed Care or Health Families Programs and are not covered by CCS. The Primary Care Dentist provides these benefits.

Access Dental HFP Orthodontic Pre-screening Form

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Patient	**Primary Care Provider**
Name:______________________	**Name:**______________________
CIN #:______________________	**Date:**______________________

- **Member must be in permanent dentition unless age 13 and older**
- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF THE CONDITION IS ABSENT.

CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS — **HLD Score**

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation) Indicate an 'X' if present and score no further ________
2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist) Indicate an 'X' if present and score no further ________
3. Deep impinging overbite WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE. TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT. Indicate an 'X' if present and score no further ________
4. Crossbite of individual anterior teeth WHEN **CLINICAL ATTACHMENT LOSS AND RECESSION OF THE GINGIVAL MARGIN ARE PRESENT .** Indicate an 'X' if present and score no further.. ________
5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.) Indicate an 'X' if present and score no further .... ________

6A. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm. Indicate an 'X' if present and score no further ________

THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

6B. Overjet equal to or less than 9 mm... .... ________

7. Overbite in mm.. ________

8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm..................... ________ **x 5 =** ________

9. Open bite in mm.. ________ **x 4 =** ________

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.

10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars) ________ (tooth numbers) ______ (total) **x 3 =** ________

11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE) ______ (maxilla) ________ (mandible) ______ (total) **x 5 =** ________

12. Labio-Lingual spread in mm .... ________

13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bi-lateral posterior crossbite)...Score 4 ________

TOTAL SCORE: ________

IF A PATIENT DOES NOT SCORE 26 OR ABOVE NOR MEETS ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS, HE/SHE MAY BE ELIGIBLE UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – SUPPLEMENTAL SERVICES (EPSDT–SS) EXCEPTION IF MEDICAL NECESSITY IS DOCUMENTED.

☐**EPSDT–SS EXCEPTION:** (Indicate with an 'X' and attach medical evidence and appropriate documentation for each of the following eight areas on a separate piece of paper IN ADDITION TO COMPLETING THE HLD SCORE SHEET ABOVE.)

DO NOT WRITE IN THIS AREA.

a) Principal diagnosis and significant associated diagnosis; and
b) Prognosis; and
c) Date of onset of the illness or condition and etiology if known; and
d) Clinical significance or functional impairment caused by the illness or condition; and
e) Specific types of services to be rendered by each discipline associated with the total treatment plan; and
f) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals; and
g) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care; and
h) Any other documentation which may assist the Department in making the required determinations.

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION
SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

6A **Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm:** Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and it's corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

6B **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.

7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)

8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).

9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.

13. **Posterior Unilateral Crossbite**: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERIAL CROSSBITE.**

ACCESS DENTAL

12

Member Identification

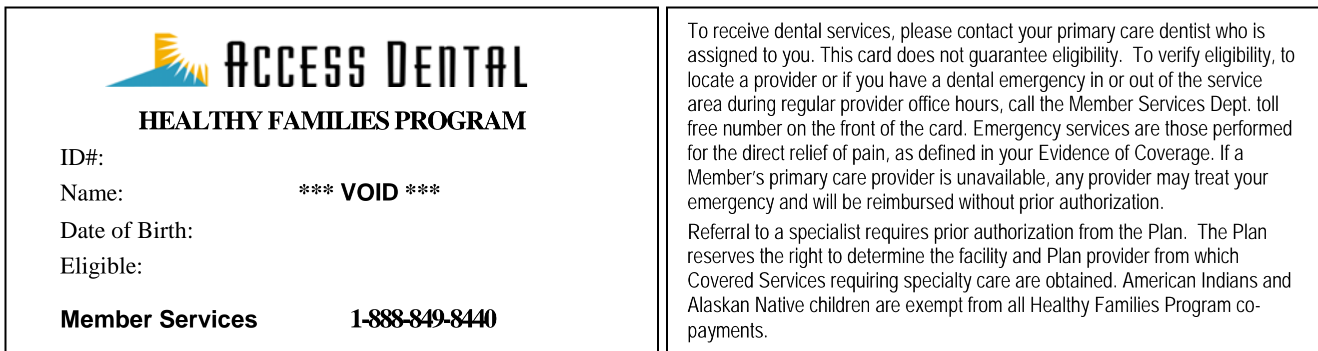
A description of how member identification is documented.

IDENTIFICATION OF ***Access*** DENTAL PLAN MEMBERS is accomplished through member identification cards issued by ***Access*** Dental Plan. Except for children, members must also show a photo identification card. In addition to the identification carried by members, ***Access*** provides each dental office with a listing of current members assigned to a PCD in that office.

Possession of an ***Access*** Dental Plan identification card does not guarantee eligibility for a specific month. Your office must check the ***Access*** issued computer listing to verify patient eligibility. If there is any question regarding current eligibility for coverage or assigned PCD, provider offices may contact ***Access*** Member Services at the following numbers:

DHMO (Commercial Managed Care).. 866-650-3660
GMC (Geographic Managed Care) 916-646-2130
HFP (Healthy Families Program).. 888-849-8440
LAPHP (Los Angeles Prepaid Health Plan)..................................... 888-414-4110

A copy of the ***Access*** identification card is shown below. Identification cards specify the program under which the individual is eligible. This sample is for the Healthy Families Program.



ACCESS DENTAL

HEALTHY FAMILIES PROGRAM

ID#:

Name: *** VOID ***

Date of Birth:

Eligible:

Member Services **1-888-849-8440**

To receive dental services, please contact your primary care dentist who is assigned to you. This card does not guarantee eligibility. To verify eligibility, to locate a provider or if you have a dental emergency in or out of the service area during regular provider office hours, call the Member Services Dept. toll free number on the front of the card. Emergency services are those performed for the direct relief of pain, as defined in your Evidence of Coverage. If a Member's primary care provider is unavailable, any provider may treat your emergency and will be reimbursed without prior authorization.

Referral to a specialist requires prior authorization from the Plan. The Plan reserves the right to determine the facility and Plan provider from which Covered Services requiring specialty care are obtained. American Indians and Alaskan Native children are exempt from all Healthy Families Program co-payments.

ACCESS DENTAL

13

Member Responsibilities

A description of members' responsibilities.

MEMBERS OF ***Access*** DENTAL PLAN HAVE CERTAIN RESPONSIBILITIES. These responsibilities ensure that all members participate in their own dental care and hygiene. Dental offices should be familiar with member responsibilities.

Access **Dental Plan members have the following responsibilities**:

- Knowing and understanding the rules and regulations of ***Access*** and abiding by them in the interest of quality dental care.
- Learning about their dental condition(s) and following prescribed treatment plans.
- Contacting his or her primary care dentist to make a dental appointment.
- Arriving at the office five to ten minutes before the scheduled appointment to allow time for filling out any necessary paper work.
- Calling the dentist and rescheduling an appointment at least 24 hours in advance if they cannot keep a scheduled appointment.
- Requesting individual counseling by the PCD to establish a healthy dental routine.
- Adopting positive lifestyle choices, such as brushing, flossing, checkups, good diet, avoiding tobacco, not biting hard foods, not opening containers with teeth and using fluoride.
- Attending classes held throughout the community addressing health education and promotion.
- Reading health education materials available at the dentist's office.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- File a complaint if your linguistic needs are not met.
- Always present your Member Identification Card when getting services.
- Treat all Access Dental Plan personnel and providers respectfully and courteously.

ACCESS DENTAL

14

Appeals and Grievances

A description of provider and member appeals and grievance processes.

PROVIDERS MAY APPEAL ADVERSE QUALITY DETERMINATIONS. Provider appeals are reviewed by the QMC or an appropriate subcommittee. **Members may appeal specialist referral denials, or providers may appeal on behalf of the member**.

Provider Appeals

Access Dental Plan maintains an effective provider appeals process whereby providers appeal decisions made by ***Access*** relating to the "Appealable Matters" described below.

Access' Dental Director is responsible for making recommendations to the QMC or appropriate subcommittee with regard to all adverse determinations. If the Dental Director determines that a provider should be administratively disciplined, the provider's file is forwarded to ***Access'*** QMC, or designated QMC subcommittee, which determines what action, if any, should be taken by ***Access***.

Appealable Matters

All *Access* network providers may appeal an adverse determination resulting in early termination of a provider contract arrangement relating to quality of care issues.

Appeals must be requested in writing and submitted to:

Access Dental Plan
Attn: Dental Director
P. O. Box 255039
Sacramento, CA 95865-5039
Grievancedept@premierlife.com

If a provider wishes to appeal an adverse decision, the written request for an appeal must include an identification of the grounds for an appeal and a clear and concise statement of the facts and issues in support of the appeal.

Member Appeals

Member appeals are submitted in writing to the ***Access*** office at 8890 Cal Center Drive, Sacramento, CA 95826. Appeals are forwarded to the Grievance/Appeals Coordinator who compiles all the information used in the initial review and any additional information received, and presents the case to the Member Grievances/Appeals & Member Services subcommittee at the next monthly meeting. This subcommittee reviews all available information and makes a determination. Only the Plan member and providers on this subcommittee make the determination.

Providers on the subcommittee determining member appeals must have no prior involvement in the decision and no vested interest in the case. The determination is communicated to the ***Access*** Dental Director and the Grievance/Appeals Coordinator who notifies the member and provider of the outcome, including their right to appeal to the State Department of Health Services.

Provider/ Member Complaints/Grievances

The main objective of the provider and member grievance process is to ensure an effective system for addressing and resolving complaints and grievances in a timely manner. In addition, the grievance process provides a mechanism for identifying systemic or provider trends that may be deleterious to patient care.

Complaints and grievances can be registered by phone, in writing or in person at the following address and phone number:

Access Dental Plan
Attn: Grievance Coordinator
P. O. Box 255039
Sacramento, CA 95865-5039

8890 Cal Center Drive
Sacramento, CA 95826

(916) 563-6013, or
1-800-270-6743, ext. 6013

All complaints will be handled expeditiously. Inquiries/complaints that concern quality of care are reviewed by the Dental Consultant.

Provider Follow-Up Documentation

In order for the Plan to investigate and resolve the member complaint, we require your office to submit the following information within 5 business days:

1. Copy of all the patient's treatment records.
2. Copy of the patient's signed consent.
3. Copy of all x-rays.
4. Copy of the patient's financial records.
5. Any comments your office my have regarding the patient's complaint.

A sample Grievance Form is provided per the Plan's threshold languages on the following pages.

GRIEVANCE FORM

GEOGRAPHIC MANAGED CARE	COMMERCIAL MANAGED CARE	HEALTHY FAMILIES PROGRAM	LOS ANGELES PREPAID HEALTH PROGRAM
❑ **GMC**	❑ **DHMO**	❑ **HFP**	❑ **LAPHP**

Access Dental Plan, Inc. ("The "Plan") takes very seriously problems raised by its enrollees and endeavors to reach solutions acceptable to all concerned. To facilitate these efforts, please provide us with the following information. If you need assistance in completing this form, please contact any Plan Member Services Representative at 1-800-707-6453 or any Plan provider representative.

Name: ____

Address: ____

City: ______________________________ State: __________ Zip Code:___________ Telephone: (_____) ______-____________

NATURE OF COMPLAINT (BE AS SPECIFIC AS POSSIBLE & USE THE BACK OF THIS FORM IF MORE SPACE IS NEEDED):

____

____

____

____

____

____

____

DATE OF INCIDENT GIVING RISE TO THIS COMPLAINT: ____

NAMES OF PLAN PERSONNEL INVOLVED IN INCIDENT: ____

____

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-800-707-6453) (TDD/TTY for the hearing impaired at 1-800-735-2929**) and use your health plan' s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free **telephone number (1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department' s Internet **Web site http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

PLEASE MAIL THIS FORM TO:

Grievance Department
Access Dental Plan
P. O. Box: 255039
Sacramento, CA 95865-5039

P l e a s e d o n o t w r i t e b e l o w t h i s l i n e – f o r P l a n u s e o n l y .

Name of Person Taking Complaint:______________________	Date Received:__________	Time Received:__________	Date/Time Logged:__________

FORMULARIO DE RECLAMO

SERVICIOS MÉDICOS ADMINISTRADOS GEOGRÁFICAMENTE	SERVICIOS MÉDICOS ADMINISTRADOS COMERCIALMENTE	PROGRAMA HEALTHY FAMILIES	PROGRAMA DE SALUD DE LOS ANGELES PAGADO
❑ **GMC**	❑ **DHMO**	❑ **HFP**	❑ **LAPHP**

Access Dental Plan, Inc. ("El "Plan") toma muy en serio todo problema planteado por sus miembros y se esfuerza por lograr soluciones aceptables para todos los interesados. Para facilitar estos esfuerzos, por favor proporcione la siguiente información. Si necesita ayuda para completar este formulario, comuníquese con algún representante de Servicios al Miembro del Plan al 1-800-707-6453 o con cualquier representante del proveedor del Plan.

Nombre: ____

Dirección: ____

Ciudad: ________________ Estado: __________ Código Postal:___________ Teléfono: (_____) ______- _____

NATURALEZA DE LA QUEJA (SEA LO MÁS ESPECÍFICO POSIBLE Y USE EL REVERSO DE ESTE FORMULARIO SI NECESITA MÁS ESPACIO):

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____

FECHA DEL INCIDENTE QUE OCASIONA ESTA QUEJA: ______________________________

NOMBRES DE LOS EMPLEADO DEL PLAN INVOLUCRADOS EN EL INCIDENTE: ______________________________

____

El Departamento de Atención Médica Supervisada de California es responsable de regular los planes de servicios médicos. Si tiene un reclamo contra su plan de salud, primero tiene que llamar por teléfono a su plan de salud al **(1-800-707-6453)** y usar el proceso de reclamo de su plan de salud antes de comunicarse con el departamento. La utilización de este procedimiento de reclamos no prohíbe ningún derecho o recurso potencial que pueda estar a su disponibilidad. Si necesita ayuda con un reclamo que implique una emergencia, un reclamo que su plan de salud no haya resuelto satisfactoriamente o un reclamo que haya permanecido sin solución por más de 30 días, puede llamar al departamento para solicitar asistencia. También puede ser elegible para una Revisión médica independiente (IMR, por sus siglas en inglés). Si usted es elegible para una IMR, el proceso de la IMR le proporcionará una revisión imparcial de las decisiones médicas tomadas por un plan de salud relacionado con una necesidad médica de un servicio o tratamiento propuesto, decisiones de cobertura para tratamientos experimentales o de investigación y disputas de pagos por servicios médicos urgentes o de emergencia. El departamento también tiene un número de teléfono gratuito **(1-888-HMO-2219)** y una línea **TDD (1-877-688-9891)** para personas con discapacidades auditivas y del lenguaje. **El sitio Web en Internet del departamento, http://www.hmohelp.ca.gov**, tiene formularios de quejas, formularios de solicitud de IMR e instrucciones en línea.

ENVÍE ESTE FORMULARIO POR CORREO A:

Grievance Department
Access Dental Plan
P. O. Box: 255039
Sacramento, CA 95865-5039

Por favor no escriba debajo de esta línea – para uso exclusivo del Plan.

Nombre de la persona que recibe la queja:________________	Fecha Recibido:__________	Tiempo Recibido:__________	Fecha/hora de registro:__________

ACCESS DENTAL

申訴表

區域管理保健	商業管理保健	健康家庭計劃	洛杉磯預付醫療計劃
❑ **GMC**	❑ **DHMO**	❑ **HFP**	❑ **LAPHP**

Access Dental Plan，Inc. （簡稱「計劃」）會非常認真地對待會員提出的問題並努力達成有關各方都能接受的解決方案。為促進相關工作，請向我們提供以下資訊。如果您在填寫此表格時需要協助，請致電 1-800-707-6453 聯絡計劃的任何會員服務代表或任何提供者代表。

姓名：____

地址：____

城市：____________________ 州：__________ 郵遞區號：___________ 電話：(_____) ______-__________ _____________

申訴性質（儘可能詳細說明，若需要更多填寫欄位，請使用此表格的背面）： ____

____

____

申訴起因事件發生的日期： ____

事件涉及的計劃員工的姓名： ____

加州醫療保健計劃管理局負責監管醫療保健服務計劃。
若您要申訴您的健康計劃，在聯絡加州醫療保健部門前，您應先致電您的健康計劃，電話：**1-800-707-6453**，并使用健康計劃的申訴程序。 使用此申訴程序並不會妨礙您享有任何可能的合法權利或補救措施。若您的申訴涉及急診，或健康計劃並未妥善解決或超過 30 天後仍未獲解決，可致電該部門尋求協助。您亦可申請獨立醫療審查 (Independent Medical Review，簡稱 IMR)。 若您符合 IMR 的申請資格，則 IMR 程序將對健康計劃就服務或治療方案之醫療必要性作出的醫療決定、就屬於試驗性或研究性治療作出的承保決定、以及涉及急診或緊急醫療服務的費用爭議作出公平的審查。
該部門亦為聽障或語障人士提供免費電話熱線 **(1-888-HMO-2219)** 及 **TDD 專線 (1-877-688-9891)。該部門的互聯網網站 (http://www.hmohelp.ca.gov)** 載有申訴表、IMR 申請表及在綫指導。

請將本表格郵寄至:

申訴部

Grievance Department
Access Dental Plan
P. O. Box: 255039
Sacramento, CA 95865-5039

請不要填寫此行下方的內容 – 僅供計劃使用。

申訴人姓名：____________________	**接收日期：**__________	**接收時間：**__________	**記錄日期／時間：**__________

ĐƠN KHIẾU NẠI

CHĂM SÓC CÓ QUẢN LÝ THEO KHU VỰC ĐỊA LÝ	CHĂM SÓC CÓ QUẢN LÝ THƯƠNG MẠI	CHƯƠNG TRÌNH HEALTHY FAMILIES	CHƯƠNG TRÌNH CHĂM SÓC SỨC KHỎE TRẢ TRƯỚC LOS ANGELES
❑ **GMC**	❑ **DHMO**	❑ **HFP**	❑ **LAPHP**

Access Dental Plan, Inc. ("Chương Trình") tiếp nhận rất nghiêm túc các vấn đề do hội viên của mình nêu ra và nỗ lực đạt được các giải pháp chấp nhận được đối với tất cả các bên liên quan. Để tạo điều kiện cho những nỗ lực này, vui lòng cung cấp cho chúng tôi thông tin sau đây. Nếu quý vị cần được hỗ trợ trong việc điền vào đơn này, vui lòng liên hệ bất kỳ Đại Diện Dịch Vụ Hội Viên Chương Trình nào qua số 1-800-707-6453 hoặc bất kỳ đại diện nào của nhà cung cấp trong Chương Trình.

Tên: ____

Địa chỉ: ____

Thành phố: ______________________ Tiểu bang: __________ Mã Zip:___________ Điện thoại: (_____) ______-_____

BẢN CHẤT CỦA ĐƠN KHIẾU NẠI (CÀNG CỤ THỂ CÀNG TỐT & SỬ DỤNG MẶT SAU CỦA ĐƠN NÀY NẾU CẦN THÊM CHỖ TRỐNG):

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NGÀY XẢY RA VỤ VIỆC DẪN ĐẾN ĐƠN KHIẾU NẠI NÀY: ______________________________

TÊN CỦA NHÂN VIÊN CHƯƠNG TRÌNH LIÊN QUAN ĐẾN VỤ VIỆC: ______________________________

____

Bộ Y Tế Điều Quản của Tiểu Bang California (DMHC) có trách nhiệm quy định các chương trình dịch vụ chăm sóc sức khỏe. Nếu có khiếu nại đối với chương trình bảo hiểm sức khỏe của mình, thì trước tiên quý vị nên gọi điện đến chương trình bảo hiểm sức khỏe của quý vị qua số **(1-800-707-6453)** và sử dụng quy trình giải quyết khiếu nại của chương trình bảo hiểm sức khỏe của quý vị trước khi liên lạc với bộ. Khi sử dụng quy trình giải quyết khiếu nại này, quý vị không bị mất các quyền hợp pháp hoặc biện pháp giải quyết có thể có dành cho cho quý vị. Nếu quý vị cần giúp giải quyết một khiếu nại liên quan tới trường hợp khẩn cấp, một khiếu nại chưa được chương trình bảo hiểm y tế của quý vị giải quyết thỏa đáng hoặc sau 30 ngày khiếu nại vẫn không được giải quyết, thì quý vị có thể gọi cho bộ để được giúp đỡ. Quý vị cũng có thể hội đủ điều kiện yêu cầu Đánh Giá Y Khoa Độc Lập (IMR). Nếu quý vị hội đủ điều kiện có một buổi IMR, quy trình IMR sẽ cung cấp một bản đánh giá không thiên vị về các quyết định y tế của một chương trình bảo hiểm y tế liên quan tới sự cần thiết về mặt y tế của dịch vụ hoặc biện pháp điều trị được đề nghị, các quyết định về bảo hiểm cho các biện pháp điều trị mang tính chất nghiên cứu hoặc thử nghiệm và các tranh chấp về việc thanh toán cho các dịch vụ y tế khẩn cấp và cấp cứu. Bộ cũng có một số điện thoại miễn phí **(1-888-HMO-2219)** và một đường dây **TDD (1-877-688-9891)** dành cho người khiếm thính và thiểu năng ngôn ngữ. Trang Web của bộ **http://www.hmohelp.ca.gov** có các mẫu đơn khiếu nại, các mẫu đăng ký IMR và các hướng dẫn trực tuyến.

HÃY GỬI MẪU ĐƠN NÀY ĐẾN:

Grievance Department
Access Dental Plan
P. O. Box: 255039
Sacramento, CA 95865-5039

Vui lòng không viết vào phần bên dưới dòng này – chỉ để Chương Trình sử dụng.

Tên của Người Tiếp Nhận Khiếu Nại:______________________ **Ngày Đã nhận:**__________ **Giờ Đã nhận:**__________ **Ngày/Giờ Đã Ghi Lại:**__________

ACCESS DENTAL

15

Emergency and Out-of-Area Care

Definition of emergency and out-of-area care and how to receive payment.

Emergency care is defined as those services required for alleviation of severe pain, severe swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions, which, if not immediately diagnosed and treated, would lead to disability or harm to the member.

Emergency services are exempt from prior authorization, but must be justified according to the following criteria:

> Any service classified as an emergency which would have been subject to prior authorization had it not been so classified, must be supported by a physician's or dentist's statement that describes the nature of the emergency; including relevant clinical information about the patient's condition and states why the emergency services rendered were considered to be immediately necessary. It must be comprehensive enough to support a finding that an emergency existed.

Emergency Care After Hours

During regular office hours, members may obtain care by contacting their PCD for emergency treatment. After business hours, members should contact their PCD through the after-hours emergency care phone number of their PCD.

Dentist shall provide directions to their patients on how to obtain emergency services 24 hours per day, seven days per week, including vacations and holidays. Urgent appointments should be scheduled within 24 hours and the patient should be informed that only the emergency would be treated at that time. This after-hours number must provide for a return call to the member within one hour.

The provider shall employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

Out of Area Emergency Care

Providers may be requested to provide emergency services to out-of-area members if contacted by the Plan. Such treatment provided to the member must be directly related to treatment of the emergency condition, as defined above. Providers who provide emergency treatment to members will submit a claim Access for the treatment, with accompanying documentation that verifies the emergency. Access will be responsible for the cost of the emergency treatment only.

Anti-Fraud Program and the Deficit Reduction Act of 2005

Pursuant to certain provisions of the Deficit and Reduction Act of 2005, ***Access*** has established a Fraud and Abuse Prevention and Detection Program. As part of this program, ***Access*** provides information to all employees, contractors, subcontractors and agents about the federal and State False Claims Acts; remedies available under these acts; and how employees and others can use them; and about whistleblower protections for individuals who report suspected false claims.

> **Abuse** is defined as practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2).
>
> **Fraud** is defined as the 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 constitutesfraud under applicable Federal or State law (42 CFR 455.2).

Federal False Claims Act (FCA)

Any person who does any of the following is liable for penalties under the Federal False Claims Act:

- ♦ Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;
- ♦ Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid;
- ♦ Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;

Examples of a False Claim:

Member fraud or misrepresentation includes, but is not limited to:

- ♦ Altering health records;
- ♦ Altering referral forms;
- ♦ Allowing another individual use of a Medicare or Access Dental Plan card for the purpose of obtaining benefits.

Provider fraud and abuse includes, but is not limited to:

- ♦ Falsification of provider credentials;
- ♦ Billing for services not provided;
- ♦ Double billing, upcoding, and unbundling; and

Remedies:

- ♦ Violation of the Federal False Claims Act is punishable by a civil penalty of not less than $5,500 and not more than $11,000, plus three (3) times the amount of damages that the government sustains because of the violation.
- ♦ A Federal False Claims action may be brought by the U.S Attorney General.
- ♦ An individual also may bring a qui tam action for violation of the Federal False Claims Act. This means the individual files a civil action on behalf of the government.
- ♦ An individual who files a qui tam action receives an award only if, and after, the government recovers money from the defendant as a result of the lawsuit. Generally, the court may award the individual between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the individual substantially contributed to the prosecution of the action.

- Under the Federal False Claims Act, the statute of limitations is six years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation was committed.

California False Claims Act:

The California False Claims Act is similar to the Federal False Claims Act. The California False Claims Act makes it illegal, among other things, for any individual to knowingly present or cause to be presented to a state employee a false claim for payment or approval, knowingly make, use, or cause to be made or used a false record or statement to get a false claim paid or approved by the State, or to conspire to defraud the State or any political subdivision by getting a false claim allowed or paid by the State (California Government Code Section 12650-12656).

- Violation of the California False Claims Act is punishable by a civil penalty of up to $10,000 for each false claim, plus three (3) times the amount of damages that the State sustains because of the violation.
- The California False Claims Act also allows individuals to file qui tam actions.

Whistleblower Protections:

The Federal and California False Claims Acts provide protection for individuals who report suspected false claims (whistleblowers).

- ***Access*** assures that whistleblowers will not be subjected to reprisal, harassment, retribution, discipline or discrimination by the company or any of its employees based on having made the report.
- Any employee or agent who engages in any such reprisal, harassment, retribution, discipline or discrimination against a good faith reporter may be subject to disciplinary action as deemed appropriate by ***Access***.
- Protection is also provided for employees who are discharged, demoted, suspended or discriminated against in retaliation for their involvement in false claims act cases.

Detecting Fraud and Abuse:

Access Dental Plan Departments identify potential member and provider fraud and abuse through various methods including, but not limited to, the review of following:

- ♦ Referrals, claims and utilization;
- ♦ Auditing/routine quality improvement audits;
- ♦ Provider billing patterns;
- ♦ Approvals or denials of health services to members;
- ♦ Complaints or grievances filed by members, providers or employees; specifically issues related to underutilization of services, refusal to refer and other treatment related issue.
- ♦ Member customer service inquiries; and
- ♦ Medical records, specifically for referral patterns and quality of care issues.

Plan personnel shall review all “red flags” or “red flag events,” or other situations suspected as potential fraudulent activity. Information regarding red flags and red flag events is provided for personnel as part of the fraud and abuse employee training sessions.

Reporting Fraud and Abuse:

Possible False Claims Act violations should be reported to ***Access*’** Fraud Officer for further investigation. The Fraud Officer can be contacted by phone at(916) 920-2500 or by mail at the following address: Anti-Fraud Officer, ***Access*** Dental Plan, P.O. Box 659010, Sacramento, CA 95865-9010.
You may report possible violations directly to the Federal Department of Health and Human Services. The Office of the Inspector General also maintains a hotline, which offers a confidential means for reporting vital information. The Hotline can be contacted:

Phone: 1-800-HHS-TIPS
Fax: 1-800-223-2164
Email: HHSTips@oig.hhs.gov
Mail: Office of the Inspector General
General HHS TIPS Hotline
P.O. Box 23489 Washington, DC 20026

ACCESS DENTAL

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Language Assistance Program

A description of the language assistance services for ***non-Medi-Cal members.***

ACCESS DENTAL PLAN maintains a comprehensive language assistance program, providing language assistance services for Limited English Proficient (LEP) members. This chapter describes the services ***Access*** provides and the Provider responsibilities related to the language assistance program.

Points of Contact

- Language assistance services are available to members at the following points of contact:

Access Member Service Line

- Members in all service areas contact the Member Service Line by calling the toll-free Member Service Line phone number provided on each member identification card (phone numbers differ based on dental program).
- Member Service Line is available between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday (holidays excluded).
- During non-business hours, a recorded message directs members to call (800) 870-4290 if they have an emergency. The 24 hour answering service initiates a call to ***Access'*** Interpreting Service if the member requires interpreting services.
- Bilingual staff who are proficient in English and non-English are able to facilitate customer service functions in English and non-English language.

Access Complaints/Grievances Department

- Members in all service areas contact the Complaints/Grievance Department by telephone, online, mail, or in person between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday (holidays excluded), at the Plan's headquarters located at:

  Access Dental Plan
  Complaints/Grievances Department
  8890 Cal Center
  Sacramento, CA 95826
  1-800 – 70 SMILE (707-6453)

- Members contacting the Complaints/Grievances Department by mail to report a grievance submit a letter or Grievance Form.
  - Grievance Forms translated into ***Access***' threshold languages are included in the Evidence of Coverage booklet and in the provider manual. Grievance Forms are also available in provider offices and online at the ***Access*** website: www.premierlife.com.
- Members contacting the Complaints/Grievances Department will be advised of their right to file a grievance with ***Access*** or the Department of Managed Health Care and seek an independent medical review. (IMR is not available to dental enrollees unless services of a physician are covered under the plan, so this IMR notice requirement will not apply under most dental plans).
- Members have the right to file a grievance if their linguistic needs are not met by the Plan and/or provider office.

Provider Offices

- Member demographic profile data will be disclosed to contracting providers upon request for lawful purposes, including language assistance and health care quality improvement purposes.
- Member demographic profile data will be disclosed to contracting providers upon request.
  - Members may request interpreting service for an appointment by contacting the ***Access*** Member Service Line.
  - The ***Access*** representative will schedule the appointment with the Interpreting Service.
- ***Access*** will retain financial responsibilities to provide language assistance services to the members.

Member Notice

- The Member Notice notifies members of the availability of free language assistance services and how to access the services.
- The Member Notice will be in English and ***Access***' threshold languages (Spanish and Chinese).
- The Member Notice will be sent with all vital documents, enrollment materials for new and renewing members, and other periodic member correspondences, such as brochures, newsletters, outreach, or marketing materials.

Translation Services

- Standardized vital documents will be translated into ***Access***' threshold languages at no charge to enrollees.
- For vital documents that are not standardized, but which contain enrollee-specific information, ***Access*** will provide the English version together with the Department-approved written notice of the availability of interpretation and translation services.
  - If a translation is requested, ***Access*** shall provide the requested translation within 21 days of the receipt of the request for translation.
- The threshold language identified by ***Access*** is Spanish and Chinese.
- Members can call the Plan Member Services Line to request translated documents.
- The following vital documents will be translated into ***Access***' threshold languages and are available to members upon request:

Standardized Vital Documents

- Welcome Packet
- Benefit and Copay Schedule
- Exclusions and Limitations
- Grievance Form
- Member Notification of Change in Primary Care Dentist
- Privacy Notice
- HIPAA-related forms

<u>Enrollee-specific Vital Documents</u>

- Explanation of Benefits
- Grievance Acknowledgment Letter
- Grievance Resolution Letter
- Referral
- Notice of Authorization

♦ Subscriber contracts, Evidence of Coverage booklets and other large disclosure forms and enrollee handbooks will not be translated in their entirety. A summary matrix, translated into the threshold languages, is available for LEP members. This matrix includes the following information:

- Major categories of benefits covered under the plan;
- Corresponding copayments and coinsurance;
- Exclusions and limitations; and
- Any applicable deductible and lifetime maximums.

Interpreting Services

♦ Interpreting services available at all points of contact, free of charge to members, are offered through the following:

- Bilingual ***Access***' staff members;
- Bilingual contracted providers and office staff; and
- Interpreting Service.

♦ Members can call the Plan's Member Services Line at 1-800 – 70 SMILE (707-6453) to request interpreter services. Interpreter services can be provided over the phone or arranged for a member's appointment, based on the member's request. If a member goes in for an appointment without first arranging for interpreter services, the provider may contact the Plan at the time of the appointment to arrange for phone interpreter services or face-to-face interpreter services (which would require the member to reschedule the appointment for a later time).

♦ Provider office staff shall offer interpreting services to LEP members, including when a member is accompanied by a family member or friend who has the ability to provide interpretation services. The offer of interpreting service, and the acceptance or denial by the member, shall be documented in the member record or file, as applicable.

- Provider directories identify contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff.

Contracting Providers

- Contracting providers must offer the language assistance services included in the provider contract, which are as follows:
  - Provider office will contact Access to obtain information regarding a member's language preference, as necessary.
  - Provider office will record member's language preference in the patient record.
  - The offer of interpreting service, and the acceptance or denial by the member, shall be documented in the member record or file, as applicable.
- ***Access*** will confirm the provider office's compliance with Language Assistance Program policies and procedures during provider office quality assurance audits. The following review criteria shall be assessed during the audits:
  - Staff is aware of free language services provided by Plan and the process for accessing services.
  - Limited English Proficient (LEP) members are offered interpreting services, even when member is accompanied by a family member or friend with ability to interpret. The offer of interpreting service, and acceptance or denial by member, is documented in patient record. Staff shall discourage the use of family members or friends as interpreters.
  - Member language preference recorded in patient record.
- Provider offices may have bilingual providers and/or office staff available to speak to members in non-English languages.
  - Bilingual office staff converse with members in the non-English language only to the extent necessary to facilitate administrative customer service functions.
  - Providers shall provide quarterly updates regarding any changes in the bilingual language capabilities of currently employed providers and/or office staff by submitting quarterly provider survey to ***Access***.
  - Provider directories shall identify contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff.
- Provider offices receive Grievance Forms translated into the threshold languages as part of the provider manual. The provider office will provide these for the member upon request.

- Access informs contracted providers that informational notices explaining how members may contact the plan, file a complaint, obtain assistance from the Department and seek an independent medical review are available in non-English languages through the Department's web site. (The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.)

ACCESS DENTAL

18

Prior Authorization

To ensure all non-emercency dental procedures are consistently evaluated for dental necessity and appropriateness.

With the exception of preventive dental care, all non-emergency dental procedures require prior authorization from ***Access***. Provider dentists may initiate authorization requests via the telephone, however, since hard copy supporting documentation is usually required to make a determination, ***Access*** encourages providers to submit requests via mail. To be approved, dental services must meet criteria for dental necessity/appropriateness and be a covered benefit of the Medi-Cal program or the Healthy Families program, as defined by Title 22 and Title 10, the Department of Health Services *Medi-Cal Manual of Criteria for Dental Services*, and the member's evidence of coverage. Title 22, California Code of Regulations, Section 51307, states that the outpatient and inpatient dental services which are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury, or defect are covered to the extent specified in Section 51307 when fully documented to be medically necessary.

Dental Necessity: The underlying principle of whether a service is reasonable and necessary is whether or not the requested service or item, which is a program benefit, is fully documented to be immediately necessary, is in accord with generally accepted standards of dental practice and is indispensable to the oral health of the beneficiary. Authorization shall be granted only for the lowest cost covered service appropriate to the presenting adverse condition.

Access follows the following procedures for prior authorizations:

- The PCD or specialist submits a request for authorization to ***Access*** via mail and must include diagnostic properly mounted and labeled X-rays.
- The authorization request is logged into the ***Access*** Dental MIS system and forwarded to the Referral/Case Management Coordinator for review.
- The Referral/Case Management Coordinator evaluates the request to determine the necessary documentation is complete and the requested procedure is a covered benefit as outlined in the member's evidence of coverage and the *Medi-Cal Manual of Criteria for Dental Services*.
- The Referral/Case Management Coordinator forwards the request to the Dental Director, or a licensed dentist consultant, to evaluate the request and determine dental necessity / appropriateness.
- Following approval, the dental provider and member are notified that the procedure has been approved according to the timeframes described in the *Review Timeframes/Communication* Policy and Procedure.
- If a specialist is performing the procedure, the member is advised that, when appropriate, follow-up treatment needs to be performed by the PCD.
- ***Access*** sends a reminder letter to the member within 60 days after the procedure has been approved if no claim has been received for the approved services.
- If the procedure is denied, the member and provider are notified as described in the Denials Policy and Procedure.

ACCESS DENTAL

19

Optional Treatment

To define the process related to optional treatment plans offered by providers and to establish clear procedures in terms of claims handling, quality managements, and implementation.

OPtio nal treatment is not an excluded benefit. It is an upgraded alternative procedure presented by the provider to satisfy the same function of the covered procedure and is chosen by the member. It is subject to the limitations and exclusions of the program. The optional treatment procedure should be appropriate for the clinical condition, be supported by the clinical finding and diagnosis or the member's dentist, and meet the clinical standards. Optional treatment may not be offered as an alternative procedure where prognosis is poor or guarded. It is inappropriate to present the covered treatment procedures as inadequate or of inferior quality.

When optional treatment is offered, the provider must fully inform the member in writing of the following:

- The recommended covered treatment
- The advantages and disadvantages of both the covered and the optional treatment
- All applicable fees

The member or guardian must verify his/her full understanding and sign a consent form for the treatment.

The member is responsible for any applicable copayments, and:

- ♦ If the provider has contracted fees for the covered procedure and optional procedure, the provider may charge the member the difference between the two fees;
- ♦ If the provider has a contracted fee for the covered procedure and there is no contracted fee for the optional procedure, the provider may charge the member the difference between the contracted fee for the covered procedure and the provider's usual and customary fee for the optional procedure; or
- ♦ If the provide does not have contracted fees for the covered procedure or optional procedure (e.g. capitated provider), the provider may charge the member the difference between his/her usual and customary fees for the covered and optional procedures.

"Contracted fee" refers to the provider's contracted fee schedule for the program in which the member is enrolled.

The member will not be responsible for any amounts in excess of those described above.

Access will make an allowance for optional treatment based on the provider's contract and associated fee for the covered procedure, if applicable.

Providers who do not offer amalgam restorations and use composite resin on posterior teeth as their basic office procedure must provide the posterior composite to ***Access***' members at the same copayment for the covered amalgam. The member cannot be charge for any amount in excess of the covered amalgam restoration.

Although some plans may provide coverage for Porcelain ceramic substrate crowns, members choosing to expedite the production of their crown and bypass the use of a lab, receiving a Cerec crown, will be subject to the optional treatment policy.

Procedures that are considered optional treatment are specific to benefit plans. Examples of Optional treatment include the following (except when the plan includes a coverage for the alternate procedure at a specified copayment(s)):

- Composite resin on posterior teeth, when the covered benefit is amalgam restoration.
- Porcelain ceramic crowns, Lava, Empress, Captek when the covered benefit is Porcelain fused to metal substrate or full cast crowns.
- Crowns when fillings are adequate.
- Crowns on children under the age of 12 years when the covered benefit is acrylic or stainless steel crowns.
- Fixed bridges when a partial could satisfactorily restore the case.
- Fixed bridges replacing missing posterior teeth when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial on the same arch.
- Treatments other than partial denture to replace missing bilateral posterior teeth.
- Any treatment specifically identified as optional in a specific benefit plan.

If coverage and/or copayment(s) for an alternative procedure is included in the member's program, the procedure is not considered optional treatment.

Compliance with these procedures will be monitored during the claims review process and through member grievances/appeals.

If a provider does not follow the standards defined in this policy and procedure, a corrective action plan may be implemented and monitored. Providers who do not comply with the corrective action plan may be subject to ***Access*** sanctions including, but not limited to, probation or termination.

ACCESS DENTAL

20

Infection Control

To ensure standard precautions are set in place to minimize the transmission of pathogens in the dental office.

Access shall require all providers to comply with the standard precautions and infection control measures as outlined and mandated by the Dental Board of California under California Code of Regulations (CCR) Title 16, Section 1005 and the California Division of Occupational Safety and Health (Cal-OSHA) under Title 8, Section 5193. ***Access*** shall verify providers' compliance with the regulation during the routine on-site audits

Definitions:

- **Standard precautions** - is a set of combined precautions that include the major components of universal precautions (designed to reduce the risk of transmission of blood borne pathogens) and body substance isolation (designed to reduce the risk of transmission of pathogens from moist body substances). Similar to universal precautions, standard precautions are used for care of all patients regardless of their diagnoses of personal infectious status.
- **Critical instruments** – are surgical and other instruments used to penetrate soft tissue or bone.
- **Semi-critical instruments and devices** – are surgical and other instruments that are not used to penetrate soft tissue or bone, but contact oral tissue.
- **Non-critical instruments and devices** – are instruments and devices that contact intact skin.

- **Low-level disinfection** – is the least effective disinfection process, kills some bacteria, viruses and fungi, but does not kill bacterial spores or mycobacterium tuberculosis var bovis, a laboratory test organism used to classify the strength of disinfectant chemicals.
- **Intermediate-level disinfection** – kills mycobacterium tuberculosis var bovis indication that many human pathogens are also killed, but does not necessarily kill spores.
- **High-level disinfection** – kills some, but not necessarily all bacterial spores. This process kills mycobacterium tuberculosis var bovis, bacteria, fungi, and viruses.
- All germicides must be used in accordance with intended use and label instructions.
- **Sterilization** – kills all forms of microbial life.
- **Personal Protective Equipment** - includes items such as gloves, masks, protective eyewear and protective attire (gowns/lab coats) which are intended to prevent exposure to blood and body fluids.
- **Other Potentially Infectious Materials (OPIM)** - means any one of the following: (A) human body fluids such as saliva in dental procedures and any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (B) any unfixed tissue or organ (other than intact skin) from a human (living or dead); (C) HIV-containing cell or tissue cultures, organ culture and blood, or other tissues from experimental animals.

Licensees shall comply with infection control precautions mandated by the California Division of Occupational Safety and Health (Cal-OSH).

All licensees shall comply with and enforce the following minimum precautions to minimize the transmission of pathogens in health care setting:

- Standard precautions shall be practice in the care of all patients.
- A written protocol shall be developed by the licensee for proper instrument processing, operatory cleanliness, and management of injuries.
- A copy of Title 16 section 1005 regulation shall be conspicuously posted in each dental office.

Personal Protective Equipment

- Health care workers shall wear surgical facemasks in combination with either chin length plastic face shields or protective eyewear when treating

patients whenever there is potential for splashing or spattering of blood or OPIM. After each patient and during patient treatment if applicable, masks shall be changed if moist or contaminated. After each patient, face shields and protective eyewear shall be cleaned and disinfected, if contaminated.

- Health care workers shall wear reusable or disposable protective attire when their clothing or skin is likely to be soiled with blood or OPIM. Gowns must be changed daily or between patients if it should become moist or visibly soiled. Protective attire must be removed when leaving laboratories or areas of patient care activities. Reusable gowns shall be laundered in accordance with Cal-OSHA Bloodborne Pathogens Standards. (Title 8, Cal. Code Regs., section 5193)

Hand Hygiene

- Health care workers shall wash contaminated or visibly soiled hands with soap and water and put on new gloves before treating each patient. If hands are not visibly soiled or contaminated an alcohol based hand rub may be used as an alternative to soap and water.
- Health care workers who have exudative lesions or weeping dermatitis of the hand shall refrain from all direct patient care and from handling patient care equipment until the condition resolves.

Gloves

- Medical exam gloves shall be worn whenever there is a potential for contact with mucous membranes, blood or OPIM. Gloves must be discarded upon completion of treatment and before leaving laboratories or areas of patient care activities. Healthcare workers shall perform hand hygiene procedures after removing and discarding gloves. Gloves shall not be washed before or after use.

Sterilization and Disinfection

- Reusable dental instruments used for invasive procedures, those procedures that penetrate the mucous membrane or skin, are cleaned of all visible debris and then sterilized by an autoclave device. FDA cleared chemical sterilants/disinfectants shall be used for sterilization of heat-sensitive critical items and for high-level disinfection of heat-sensitive semi-critical items.

- Dental Instruments sterilized by a heat or vapor method shall be packaged or wrapped before sterilization if they are not to be used immediately after being sterilized. These packages or containers shall remain sealed unless the instruments within them are placed onto a setup tray and covered with a moisture impervious barrier on the day the instruments will be used and shall be stored in a manner so as to prevent contamination.
- All high-speed dental hand pieces, low-speed hand piece components used intraorally, and other dental unit attachments such as reusable air/water syringe tips and ultrasonic scaler tips, shall be heat-sterilized between patients.
- Single use disposable instruments (e.g. prophylaxis angles, prophylaxis cups and brushes, tips for high-speed evacuators, saliva ejectors, air/water syringe tips) shall be used for one patient only and discarded.
- Needles shall be recapped only by using the scoop technique or a protective device. Needles shall not be bent or broken for the purpose of disposal. Disposable needles, syringes, scalpel blades or other sharp items and instruments shall be placed into sharps containers for disposal according to all applicable regulations.
- All biohazardous and sharp waste shall be handled and processed according to the California Medical Waste Guide.
- Proper functioning of the sterilization cycle shall be verified at least weekly through the use of a biological indicator (such as a spore test). Test results must be maintained for 12 months as required by the Dental Board of California.

Irrigation

- Sterile coolants/irrigants shall be used for surgical procedures involving soft tissue or bone. Sterile coolants/irrigants must be delivered using a sterile delivery system.

Facilities

- If items or surfaces likely to be contaminated are difficult to clean and disinfect they shall be protected with disposable impervious barriers.

- Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using a Cal-EPA registered, hospital grade low- to intermediate-level disinfectant after each patient. The low-level disinfectants used shall be labeled effective against HBV and HIV. Use disinfectants in accordance with the manufacturer's instructions. Clean all housekeeping surfaces (e.g. floors, walls, sinks) with a detergent and water or a Cal-EPA registered, hospital grade disinfectant.
- Dental unit water lines shall be anti-retractive. At the beginning of each workday, dental unit lines shall be purged with air, or flushed with water for at least two (2) minutes prior to attaching handpieces, scalers and other devices. The dental unit line shall be flushed between each patient for a minimum of twenty (20) seconds.
- All disposable, single use only, patient treatment items are disposed of as medical waste or solid waste depending upon their classification and according to applicable local, state, and federal environmental standards.

Lab Areas

- Splash shields and equipment guards shall be used on dental laboratory lathes. Fresh pumice and a disinfected, sterilized, or new ragwheel shall be used for each patient. Devices used to polish, trim or adjust contaminated intraoral devices shall be disinfected or sterilized.
- Intraoral items such as impressions, bite registrations, prosthetic and orthodontic appliances shall be cleaned and disinfected with an intermediate-level disinfectant before manipulation in the laboratory and before placement in the patient's mouth. Such items shall be thoroughly rinsed prior to placement in the patient's mouth.