Dear Doctor,

Thank you for joining our network to treat members under the Utah Medicaid Dental Services Program (Program). Delta Dental Insurance Company (Delta Dental) underwrites and administers this Program, which provides comprehensive dental benefits for eligible members.

This Provider Manual serves as a “how to” guide for you and your staff and includes the following:

- Important contact information
- How to verify members’ eligibility
- Instructions for claims processing and billing
- Policies and procedures
- Sample forms and more

This Manual will be revised from time to time. If you print a paper copy for your office, please check our website at deltadentalins.com/ut-medicaid periodically to ensure you have the most current version.

If you have any questions about the contents of the Provider Manual or participation in the Program, please call our toll-free provider number between 6 a.m. and 7 p.m., Mountain Time, Monday through Friday (excluding Utah State-approved holidays) at 866-616-1475.

Sincerely,

Daniel W. Croley, DMD
Vice President, Network Development
HEALTH INSURANCE PORTABILITY AND ACCOUNT AVAILABILITY ACT (HIPAA)

Consumer demand for protection of health information to retain privacy and deter identity theft led to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 — state and federal laws affecting how benefit-related information is handled.

Delta Dental incorporates HIPAA into its business practices, from the procedure code sets we use to our screening process for obtaining patient information through our toll-free telephone service. We believe that the privacy and protection of patient health information is crucial, and we appreciate your cooperation related to HIPAA requirements and to maintaining your patients’ right to privacy.
### IMPORTANT CONTACT INFORMATION

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<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Hours</th>
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<tbody>
<tr>
<td>Provider Customer Service Toll-Free*</td>
<td>866-616-1475</td>
<td>Monday – Friday, 6:00 a.m. to 7 p.m. Mountain time, excluding Utah state-approved holidays</td>
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<td>(also used to reach Provider Relations)</td>
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<tr>
<td>Member Customer Service Toll-Free*</td>
<td>866-467-4219</td>
<td>Monday – Friday, 6:00 a.m. to 7 p.m. Mountain time, excluding Utah state-approved holidays</td>
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<td>(also used to reach Provider Relations)</td>
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<td>* Secure interactive voice response system (IVR) is available 24 hours, 7 days a week</td>
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<tr>
<th>Service</th>
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<tr>
<td>Provider Dispute Toll-Free</td>
<td>866-275-1396</td>
</tr>
<tr>
<td>Fraud, Waste, and Abuse (Utah OIG)</td>
<td>855-403-7283</td>
</tr>
<tr>
<td>Provider Website</td>
<td>deltadentalins.com/ut-medicaid</td>
</tr>
</tbody>
</table>

**Delta Dental – Utah Medicaid Payer ID Numbers**

| Claims payer | #DDCA2 |

**Administrator and Correspondence**

| Delta Dental Insurance Company | Re: Utah Medicaid Dental Services | P.O. Box 1803 | Alpharetta, GA 30023 |

**Processing Inquiries: Claims, Referral Request and Prior Authorization**

| Delta Dental Insurance Company | Re: Utah Medicaid Dental Services | P.O. Box 1810 | Alpharetta, GA 30023 |

**Quality Management, Provider Dispute, Grievances, Appeals and Fair Hearing**

| Delta Dental Insurance Company | Re: Utah Medicaid Dental Services | P.O. Box 1860 | Alpharetta, GA 30023 |
### Table of Contents

**SECTION 1 OVERVIEW - UTAH MEDICAID PROGRAM** ................................................................. 7
- COST SHARING PROVISIONS ........................................................................................................ 7
- PROGRAM SERVICES ..................................................................................................................... 7
- NON-PROGRAM SERVICES AND/OR SPEND-UPS SERVICES ...................................................... 7
- PROVIDER WEBSITE .................................................................................................................. 7
- PROVIDER CUSTOMER SERVICE TOLL-FREE 866-616-1475 ....................................................... 7
- INTERPRETIVE SERVICES ............................................................................................................. 7
- NON-EMERGENCY MEDICAL TRANSPORTATION ....................................................................... 8
- PROVIDER ORIENTATION .......................................................................................................... 8
- PROVIDER ON-SITE VISITS .......................................................................................................... 8
- CHILDREN WITH SPECIAL HEALTH CARE NEEDS ...................................................................... 8
- UDOH MEDICAID PROGRAM ...................................................................................................... 9

**SECTION 2 CONTRACTED NETWORK PROVIDERS** ................................................................. 10
- BECOMING A CONTRACTED NETWORK PROVIDER ................................................................. 10
- CREDENTIALING ....................................................................................................................... 10
- RE-CREDENTIALING .................................................................................................................... 10
- NATIONAL PROVIDER IDENTIFIER ............................................................................................. 10
- COMPENSATION ........................................................................................................................ 11
- OTHER CONTRACTED PROVIDER REQUIREMENTS .................................................................... 11

**SECTION 3 ELIGIBILITY AND BENEFITS** .............................................................................. 12
- ELIGIBILITY VERIFICATION ....................................................................................................... 12
- MEMBER OPTIONS ..................................................................................................................... 13
- RESTRICTION PROGRAM ........................................................................................................... 13
- JUSTIFICATION REGARDING DENTAL CARE OUTSIDE OF THE APPROVED SERVICE AREA .... 13

**SECTION 4 PROVIDER RESPONSIBILITIES** ............................................................................ 14
- PROGRAM SERVICES .................................................................................................................. 14
- SPEND-UP SERVICES .................................................................................................................. 14
- NON-PROGRAM SERVICES ........................................................................................................ 14
- PRIOR AUTHORIZATIONS ............................................................................................................ 15
- VERIFICATION OF MEMBER ELIGIBILITY .................................................................................. 15
- APPOINTMENT SCHEDULING AND AVAILABILITY .................................................................... 15
- WAIT TIMES ............................................................................................................................... 16
- BROKEN APPOINTMENT ............................................................................................................ 16
- SPECIALTY REFERRAL PROCESS ............................................................................................... 16
- DENTAL RECORDS ...................................................................................................................... 16
- PROFESSIONAL CONDUCT ......................................................................................................... 17
- FRAUD, WASTE, AND ABUSE ..................................................................................................... 17
- PROVIDER DISPUTES ................................................................................................................. 18
Table of Contents

SECTION 5 PROCESSING CLAIMS ................................................................. 19
CLAIM SUBMISSION ................................................................................ 19
SUBMISSION OF DUPLICATE OR DIGITAL X-RAYS AND OTHER RECORDS ........................................... 19
DELTA DENTAL PROCESSING .................................................................. 20
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM ........................................... 20

SECTION 6 QUALITY MANAGEMENT .......................................................... 21
QUALITY OF CARE GUIDELINES ............................................................... 21
QUALITY ASSESSMENT AND PERFORMANCE ........................................... 25
COMPLAINTS AND APPEAL PROCESS ......................................................... 26

SECTION 7 COVERED SERVICES AND GUIDELINES ...................................... 34
DIAGNOSTIC SERVICES D0100-D0999 ...................................................... 35
PREVENTIVE SERVICES D1000-D1999 ...................................................... 36
RESTORATIVE SERVICES D2000-D2999 ...................................................... 37
ENDODONTIC SERVICES D3000-D3999 ...................................................... 39
PERIODONTIC SERVICES D4000-D4999 ...................................................... 40
PROSTHODONTIC SERVICES D5000-D5999 ............................................... 41
ORAL SURGERY SERVICES D7000-D7999 ................................................... 45
ORTHODONTIC SERVICES D8000-D8999 ................................................... 50
ADJUNCTIVE GENERAL SERVICES D9000-D9999 ..................................... 52

SECTION 8 SPECIALTY REFERRAL GUIDELINES .......................................... 55
ENDODONTICS REFERRAL GUIDELINES D3000-D3999 ................................ 56
PERIODONTICS REFERRAL GUIDELINES D4000-D4999 ................................ 57
ORAL SURGERY REFERRAL GUIDELINES D7000-D7999 ................................ 59
ORTHODONTIC REFERRAL GUIDELINES D8000-D8999 ................................ 60

SECTION 9 MEMBER RIGHTS AND PROTECTIONS ...................................... 63
MEMBER RIGHTS AND PROTECTIONS ....................................................... 63

SECTION 10 FORMS ....................................................................................... 65
Section 1 Overview - Utah Medicaid Program

The Utah Medicaid Program provides dental services to pregnant women and individuals eligible under Early Periodic Screening, Diagnosis and Treatment (EPSDT), also known as Child Health Evaluation and Care (CHEC).

COST SHARING PROVISIONS
There are no cost sharing provisions for this Program. No copayments shall be imposed for any covered services or office visits under this Program.

PROGRAM SERVICES
Covered services for the Program include diagnosis and preventive treatment; restorative, endodontic, periodontal and surgical procedures and extractions; orthodontic treatment, and complete and partial dentures. These covered dental services in accordance with benefits as defined in the Medicaid State Plan and State and Federal Law. Dental care services to members must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment. Dental services that are experimental, investigational, for temporomandibular joint disease or duplicate another provider’s services will not be covered under the Program.

See Section 7 Covered Services and Guidelines for details of each covered procedure code.

NON-PROGRAM SERVICES AND/OR SPEND-UP SERVICES
See Section 4 Provider Responsibilities for details about processing non-program services/spend-up services.

PROVIDER WEBSITE
deltadentalins.com/ut-medicaid is a user-friendly website specifically created to help providers locate Utah Medicaid Dental Services Program information. Delta Dental’s website fully complies with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy regulations and statutes.

PROVIDER CUSTOMER SERVICE TOLL-FREE 866-616-1475
Delta Dental’s toll-free Customer Service provides a convenient resource for providers and dental office staff to rapidly obtain information about all aspects of the Program, including covered services, eligibility, service limitations, prior authorizations and claim processing inquiries.

Business hours are from 6 a.m. to 7 p.m. Mountain time, excluding Utah state-approved holidays. Providers may also use our secure Interactive Voice Response system (IVR) during and after business hours to access routine information about the Program, member eligibility confirmation and participation information. Providers may refer members to the toll-free at 866-467-4219.

INTERPRETIVE SERVICES
Delta Dental promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic background. Participating providers must provide care with sensitivity, understanding and respect for each member’s culture, background and beliefs. Provider should advise members that Delta Dental provides oral interpretive services free of charge for all non-English languages. Delta Dental also offers face-to-face interpretive services at dental facilities with a minimum of 48 hours advance notice. For interpretive services, call Provider Customer Service department at 866-616-1475.
Interpretation Services:
- Phone interpretation in more than 150 languages
- TTY/TTD services for hearing impaired
- In-person interpreters at the enrollee’s appointment (mainly for those who communicate through American Sign Language)

Translation Services:
- Translation of vital enrollee documents
- Marketing and outreach materials in Spanish and other languages

Providers are encouraged to visit the CMS sponsored website Think Cultural Health www.thinkculturalhealth.org to learn more about cultural awareness.

Providers should encourage members to use professional services rather than relying on a family member or friend, though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

NON-EMERGENCY MEDICAL TRANSPORTATION
Medicaid may provide non-emergency medical transportation for eligible members on Traditional Medicaid services. Refer members to the Utah Department of Health to receive these benefits.
- Division of Medicaid and Health Care Financing 801-538-6155 or 1-800-662-9651
- Online information: https://medicaid.utah.gov/non-emergency-transportation

PROVIDER ORIENTATION
Delta Dental will conduct an in-person office orientation for all newly contracted providers/facilities. The orientation will address the following topics:
- General Program purposes and goals
- Program policies and procedures
- An overview of Program services and contract requirements
- Correct use of standard billing forms
- Other provider support services

An experienced, qualified representative conducts each orientation. Utah Medicaid network provider training orientations and re-orientations are included within our services.

PROVIDER ON-SITE VISITS
Upon request, we offer in-person office visits from a Delta Dental Provider Relations representative. These visits are to help providers and dental office staff better understand how to administer the Program’s policies and procedures, and/or any other dental office responsibilities related to this Program. To request an on-site visit, please call our toll-free number: 866-616-1475.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS
Delta Dental works with the Utah Department of Health and other plans to ensure that children with special health care needs status have access to:
- Comprehensive evaluation for the condition
Section 1 Overview - Utah Medicaid Program

- Pediatric subspecialty consultation and care appropriate to the condition
- Rehabilitative services provided by professionals with pediatric training
- Durable medical equipment appropriate for the condition
- Care coordination

For children with special health care needs who are determined to require a special mechanism to ensure direct access to a specialist for a course of treatment or regular care monitoring, Delta Dental will approve a standing referral or an approved number of visits after verifying that the specialist has the required skills to monitor the member’s preventive and primary dental care needs. When medically necessary for the member’s special health needs condition, Delta Dental will also work with other entities, as needed, to ensure timely access to coordinated multispecialty clinics. Qualifying special health needs conditions include, but are not limited to:

- Nervous system defects, such as spina bifida, sacral agenesis, and hydrocephalus
- Craniofacial defects, such as cleft lip and palate, and Treacher-Collins Syndrome
- Complex skeletal defects, such as arthrogryposis, osteogenesis imperfecta, and phocomelia
- Inborn metabolic disorders, such as phenylketonuria and galactosemia
- Neuromotor disabilities such as cerebral palsy and muscular dystrophy
- Complex seizure disorders
- Congenital heart defects
- Genetic disorders, such as chromosome disorders and genetic disorders
- Chronic illnesses, such as cystic fibrosis, hemophilia, rheumatoid arthritis, bronchopulmonary dysplasia, cancer, diabetes and nephritis
- Immune disorders
- Developmental disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

UDOH MEDICAID PROGRAM

The Utah Department of Health also administers a Medicaid Fee-for-Service Program, and are solely responsible for covering eligible Medicaid dental services for:

- Non-pregnant adults, Refugee Medicaid, Nursing Home Medicaid, or children who are covered by Foster Care Medicaid (unless child was previously enrolled in regular Medicaid, the Medicaid claims/payments would still be honored).
- Facility charges for hospital and ambulatory surgical centers.
- Medical and surgical services of a provider, including general anesthesia performed at a hospital or ambulatory surgical center.
- Emergency services provided in an emergency department (ED) of a hospital or an urgent care facility.
- Services performed at an Indian Health Services (IHS), tribal facility or Urban Indian Facility (UIF). Services performed at the state hospital or state developmental center.
Section 2  Contracted Network Providers

BECOMING A CONTRACTED NETWORK PROVIDER
As a prerequisite, a provider must first enroll with the state of Utah to be considered as a “known Utah Medicaid provider”. Then the provider must apply to and be approved by Delta Dental as a Utah Medicaid network provider. The contracting process is summarized below.
Upon request or as part of a recruitment initiative, Delta Dental offers and provides a prospective contracting provider an enrollment packet. After Delta Dental receives the completed enrollment documents, the Provider File Maintenance (PFM) staff will verify that all data fields have been completed prior to entering the information into Delta Dental’s system of record.

CREDENTIALING
Credentialing involves gathering and reviewing information from regulatory agencies, professional associations and educational institutions to ensure that the prospective network provider is legally qualified to practice dentistry. Delta Dental uses various credentialing criteria and guidelines to verify that the provider meets and maintains the standards for Program participation. Delta Dental verifies the following for each prospective contracting provider:
- Presence of acceptable professional liability (malpractice) insurance coverage
- All permits and registrations are current, including Drug Enforcement Administration, conscious sedation, oral conscious sedation, and general anesthesia
- Possession of certificates of specialty or proof of Board eligibility, as applicable
- The absence of negative actions taken by the State Board of Dental Examiners and/or the absence of adverse peer review cases or decisions for all principals and associates
- Curriculum vitae or work history
- Not included on UDOH Office of Inspector General’s (OIG’s) list of excluded providers

After the credentialing process has been completed and approved through the credentialing committee, Delta Dental mails a counter-signed Contracting Provider Agreement to the provider facility along with a welcome letter.

RE-CREDENTIALING
The credentialing process is repeated every three years to verify that licenses and certifications remain current for each provider and that there are no adverse circumstances presented that would prevent continued participation in the Program. Prior to expiration, Delta Dental’s automated system generates reporting and reminder letters with credentialing documents for completion. A Delta Dental credentialing specialist will contact the provider to initiate the re-credentialing process. The process should take no longer than 60 days to complete. The provider will be notified upon completion of the re-credentialing process.

NATIONAL PROVIDER IDENTIFIER
Contracted network providers must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 Code of Federal Regulations (C.F.R.), Part 162, Subpart D. (An NPI was required to be in place for most providers by May 23, 2007).
Section 2  Contracted Network Providers

COMPENSATION
Contracted providers receive compensation for covered services provided to Medicaid members in accordance with the terms and conditions of the Contracting Provider Agreement between Delta Dental and the provider. The compensation providers receive under the Agreement will be payment in full for all covered services.

OTHER CONTRACTED PROVIDER REQUIREMENTS
Contracted providers are encouraged to:

▶ Use online Provider Tools. Easy, free tools and services help providers save time and money. Providers can submit real-time claims, sign up for direct deposit, verify eligibility and review provider documents. Providers can also help save paper and resources by stopping paper documents and receiving email notices when new documents are ready to view online.

▶ Participate in member outreach. We’ll notify contracted providers about opportunities to participate in activities and events in their communities that help support current members and provide information for potential members.
Section 3  Eligibility and Benefits

ELIGIBILITY VERIFICATION

The eligibility information provided by Delta Dental reflects the eligibility information received by Delta Dental from the Utah Department of Health (UDOH). Eligibility for Program membership is determined on a month to month basis. Therefore, it is vital that prior to every appointment, providers verify eligibility before initiating treatment. Providers can also use Utah’s Eligibility Lookup Tool to verify coverage and plan enrollment for the member. https://medicaid.utah.gov/eligibility

The back of the card has helpful contact information and websites for both providers and members. Providers should always ask to see the member’s Medicaid card and Delta Dental membership card prior to providing treatment. Providers are required to make a good faith effort to verify each member’s identity and Program eligibility before providing treatment.

Here are samples of Medicaid and Delta Dental membership cards:
Section 3  Eligibility and Benefits

MEMBER OPTIONS
Medicaid members may change their plan once a year. Members have 90 days after they make their choice (or are assigned because they did not choose to change their plan). Under certain circumstances, members may change their plan after the 90 days and before the next open enrollment. Members can call a Health Program Representative (HPR) toll free at 866-608-9422 to change their plan.

RESTRICTION PROGRAM
Medicaid members who inappropriately utilize health care services may be referred to and enrolled in the Medicaid Restriction Program. This Program provides safeguards against inappropriate and excessive use of Medicaid services. Restriction Program members are identified for enrollment through:

- Quarterly review of member profiles to identify exceptional utilization of medical services
- Verbal and written reports of inappropriate use of services generated by one more health care providers. These reports are verified through a review of the member’s claim history by Medicaid staff and medical consultants.
- Referral from Medicaid staff

Members selected for enrollment in the Restriction Program are informed of the reasons, counseled in the appropriate use of health care services, assisted in selecting a primary care provider or Accountable Care Organization (ACO) and a particular pharmacy. These members must receive all health care services through either the assigned provider or health plan, or receive a referral from those providers, and all pharmacy services from the assigned pharmacy. With the exception of emergencies, Medicaid will only pay claims for services rendered by providers to whom the member has been appropriately referred. To verify if a member is in the Restriction Program use Utah’s Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility.

JUSTIFICATION REGARDING DENTAL CARE OUTSIDE OF THE APPROVED SERVICE AREA
Within the limits of the Program, necessary dental care outside of the approved service area may only be covered when the criteria below is met.

For emergency dental care, the criteria is as follows:
- When an emergency arises from accident, injury or illness
- Where the health of the individual would be endangered if care and services were postponed until it is feasible for the member to return to the approved service area
- Where the health of the individual would be endangered if the member undertook travel to return to approved service area

For non-emergency dental services; prior authorization required:
- When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the approved service area, including out of state services
- When a treatment plan has been proposed by the member’s attending provider outside the approved service area and the proposed plan has been received, reviewed and prior authorized by Delta Dental before the services are provided (Delta Dental may prior authorize such treatment plans only when the proposed treatment is not available from resources and facilities within the approved service area)

Except for emergency services, no other dental services are covered outside the United States.
Section 4 Provider Responsibilities

The following section outlines certain responsibilities of a contracted network provider, however contracted network providers must comply with responsibilities included in other sections of this manual and provisions agreed upon in their Provider Agreement with Delta Dental.

PROGRAM SERVICES
Contracted network providers must furnish covered Services to members in a manner consistent with the requirements of the Medicaid statutes, regulations, Centers for Medicare and Medicaid Services (CMS) pronouncements, Delta Dental's contractual obligations and policies and practices, as well as professionally recognized standards of dental health care. Contracted network providers must make services accessible and available to members when medically necessary. Network providers must also ensure that Covered Services are provided to members in a culturally competent manner, including those members with limited English proficiency or reading skills, diverse cultural or ethnic backgrounds, or physical or mental disabilities, to ensure that members receive effective communications that allow them to make decisions regarding treatment options, including the option of no treatment, and to ensure that instructions regarding follow-up care and training in self-care, if necessary, are delivered and understood.

SPEND-UP SERVICES
Medicaid members may choose to upgrade a covered service to a non-covered service if they assume the responsibility for the difference between the provider’s usual and customary fees for the non-covered service and the covered service. However, the only dental procedures they may choose to upgrade are:

1. A covered stainless steel crown (D2931) to non-covered porcelain or cast noble/high-noble/gold crown;
2. A covered anterior stainless steel crown (D2930) to non-covered anterior stainless steel crown with a toothcolored facing); or
3. Another covered dental procedure when authorized by the dental plan or through a hearing process.
4. Other covered dental procedures when authorized through CHEC, Utilization Review (UR), or Hearing processes.

NON-PROGRAM SERVICES
When a member requests a service not covered by Medicaid, such as a non-covered crown instead of a covered stainless steel crown, a network provider may bill the member when ALL conditions below are met:

1. Network provider has an established policy for billing all members for services not covered by a third party.
2. Member is advised prior to receiving a non-covered service that Medicaid will not pay for the service.
3. An agreement is made in writing, prior to treatment, between the provider and the member or the member’s legal representative that details the service and the amount to be paid by the member.
4. Member or legal representative agrees to be personally responsible for the payment.
5. Member must make the choice and provider cannot mandate or insist that a covered service be upgraded.

Unless all conditions are met, the network provider may not bill the member for the non-covered service, even if the provider chooses not to bill Delta Dental or Medicaid. Further, the member’s Medicaid identification card may not be held by the provider as guarantee of payment by the member, nor may any other restrictions be placed upon the member.
Section 4  Provider Responsibilities

The amount paid by the member must be limited to the difference between the provider’s regularly charged fee for the non-covered service and the network provider’s regularly charged fee for the covered dental service. For example, if the Medicaid fee for a stainless steel crown is $200, and the provider’s regularly charged fee is $250, and the member agrees to be responsible for a porcelain/ceramic crown instead, with a usual and customary fee of $800, the member would be responsible to pay the $550 difference.

Important note: In this example, the member is not responsible for the $50 difference between the provider’s regularly charged fee and the Medicaid fee for the stainless steel crown. This is because the provider would have accepted the Medicaid fee of $200 as payment in full and therefore cannot bill the member for the $50 difference.

PRIOR AUTHORIZATIONS

A prior authorization is a condition for reimbursement; however, it is not a guarantee of payment. Prior authorizations are valid for up to one year based on member’s eligibility, and are not transferable to another provider. If the member elects to change their network provider a new prior authorization must be requested.

Network providers are required to advise eligible members that they will be able to receive the approved treatment services upon receipt of authorization of a treatment plan.

Prior authorized and approved orthodontic treatment must be initiated before the loss of Program eligibility and completed within 36 months of the authorization date. See Section 7 Covered Services and Guidelines, as well as Section 8 Specialty Referrals for details on prior authorization process, including which procedure codes require prior authorization.

VERIFICATION OF MEMBER ELIGIBILITY

Providers are required to verify the member’s identity and eligibility prior to providing treatment (see Section 3 Eligibility and Benefits for details).

APPOINTMENT SCHEDULING AND AVAILABILITY

Providers are responsible for the following availability and appointment standards:

- Appointments for routine/non-urgent care must be available to members within 21 days.
- Appointments for urgent care that can be treated in a provider’s office must be available within the same day.
- Emergency care shall be available to members 24 hours a day, seven days a week. If provider’s office will be unavailable to provide emergency access 24 hours per day, seven days per week (including vacations and holidays), the contracted network primary care provider must make alternative arrangements in advance ensuring that emergency care will be available.
- Providers shall establish a system for contacting members who miss/break scheduled appointments to ensure completion of the member’s treatment plan.
- Provider shall be available to provide dental services to Enrollees at least 30 hours of each week, exclusive of nationally recognized holidays and at least 48 weeks of each year. He/she shall also provider 24 hour emergency service to enrollees each day of the week.
Section 4 Provider Responsibilities

WAIT TIMES
Members should not wait for more than 30 minutes beyond the designated appointment time to begin care. Provider must document when the member arrives for the appointment and when the provider sees the member. If a member is waiting for a scheduled appointment and the wait-time goes beyond 15 minutes, an explanation for the delay should be given to the member with the option of rescheduling the appointment.

BROKEN APPOINTMENT
The dental provider may bill a member for broken appointments providing that this policy is in writing and posted conspicuously in the office. This condition requires a written agreement with the member regarding broken appointments.

SPECIALTY REFERRAL PROCESS
In the event it is necessary to refer a member to a specialist for treatment, be sure to refer the member to a contracted Utah Medicaid network specialist. Please refer to Section 7 of this Manual (Covered Services and Guidelines) to review the codes that require a specialist. Providers may use Delta Dental’s Utah Medicaid Program Provider Directory to locate a contracted network specialist in the member’s area. If the provider cannot locate a network specialist, the provider may call the Provider Customer Service 866-616-1475 to facilitate a member referral to a specialist. Members can be treated by a general dentist for most Orthodontic, Endodontic or Oral Surgery procedures. Providers are responsible to verify which covered services require a specialist.

DENTAL RECORDS
Providers must keep and maintain all confidential records that are necessary to fully disclose the type and extent of services provided to a member for a minimum period of ten years from the date of service. A coherent dental record system with appropriate forms must be used. The member’s progress must be thoroughly documented and charted in his or her dental treatment records. The detailed record must reflect all aspects of member care, including ancillary services.

At a minimum, the dental record system must include the following:

- Legible, understandable, and organized progress notes
- Entries made in ink, signed and dated by the treating provider (please note that computerized treatment records are acceptable)
- Mounted radiographs (with date and member identification clearly marked) that are retained with each member’s record
- Recall system documentation for broken/missed appointments follow-up action taken and date of rescheduled appointment
- Treatment/procedures rendered, including, as appropriate, materials, bases, varnishes, medicaments, impressions, temporaries, arch, quadrant, area, tooth number, and/or surface(s)

Further, progress notes should adequately describe and document:

- Date(s) of service
- Amount and type of anesthetic with vasoconstrictor used or if a local anesthetic was not used
Section 4  Provider Responsibilities

- Any prescription given to member with the name of medication, quantity dispensed, and instructions for use
- Any necessary post-operative or follow-up instructions, including precautions and limitations
- Any specialty referral and documentation of results of the referral
- If applicable, any untoward event or complication during treatment that could reasonably affect prognosis or precipitate significant post-operative pain, infection, dysfunction, or disability (for such cases, appropriate documentation includes the notification of the member (or parent/guardian for a minor) and appropriate recommendations, which may include referring the member, rescheduling the member for a post-op appointment, or modifying the treatment plan or schedule)
- Any provision of appropriate emergency care and scheduling of needed follow-up for definitive care
- That treatment was provided in a timely manner consistent with the member’s individual dental needs and that appropriate treatment was rendered during each appointment
- Broken or missed appointments and follow-up by the office to reschedule
- Next scheduled visit and recall schedule, if not documented elsewhere in the chart
- Treatment plan(s) were completed or, if not, why treatment was not completed
- Identification of the treating provider (dentist/hygienist) by his or her signature or initials (if initials are used in a practice, each set must be unique within the office and there must be a legend available that accurately provides the full name of the treating dentist/hygienist)
- Summary of telephone communications with members or guardians, including attempts to schedule appointments, calls to cancel or reschedule appointments, and discussions relating to post-operative care and instructions

The use of electronic medical records must conform to the requirements of HIPAA and other federal and state laws. Subject to compliance with applicable federal and state privacy laws and professional standards regarding the confidentiality of dental records, providers must assist Delta Dental in achieving continuity of care for members through the maximum sharing of members’ dental records. Within 30 days of a written request by a member, providers must be able to provide copies of the member’s dental records to any other provider treating such member at no charge. Providers’ obligations regarding dental records are further defined in other sections of this Manual, as well as the Contracting Provider Agreement.

PROFESSIONAL CONDUCT

While performing the services described in the provider’s Contracting Provider Agreement, the provider agrees to:

- Comply with applicable state laws, rules, and regulations and UDOH’s requests regarding personal and professional conduct generally applicable to the service locations
- Otherwise conduct himself/herself in a business-like and professional manner

FRAUD, WASTE, AND ABUSE

Contracting network providers are subject to all state/federal laws and regulations relating to fraud, waste, or abuse in health or dental care. Providers must agree and cooperate with the following:

- DOH OIG and/or the Utah Medicaid Fraud Control Unit (MFCU) must be allowed to conduct private interviews with the provider and the provider’s employees, agents, contractors and members
Section 4 Provider Responsibilities

- Request for information from such entities must be complied with in the form and language requested.
- Providers and employees, agents and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultations, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigation.
- Compliance with all requirements will be at the provider’s own expense.
- Cooperate and assist UDOH and any state/federal agency that is charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, waste, and abuse.
- Provide originals and/or copies of any and all information, allow access to premises, and provide records to the OIG, UDOH, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services, Federal Bureau of Investigation, Utah Department of Insurance (UDI), the Utah Attorney General’s Medicaid Fraud Control Unit (MFCU), or other units of state/federal government, upon request and free of charge.
- If required records are included in another legal entity’s records, such as a hospital, the provider is responsible for obtaining a copy of these records.
- Report any suspected fraud, waste and abuse committed by Delta Dental or a member to the UDOH OIG at 855-403-7283.

You can also report waste, abuse and fraud by contacting the Utah Office of Inspector General (OIG). Here is their contact information:
- Telephone Number: 1-800-436-6184 (OIG Hotline)
- Website: oig.utah.gov

PROVIDER DISPUTES

Providers must mail all disputes, such as an appeal regarding claim processing, to the following address:

Delta Dental – Utah Medicaid
QM Department
P.O. Box 1860
Alpharetta, GA 30023

The Quality Management (QM) department is responsible for resolving all provider disputes. Providers may contact the QM department by mail at the above address or by calling toll-free: 866-275-1396. Standard appeals that are received orally must be followed up with a written signed appeal within five (5) business days from the date of the oral filing. Delta Dental accepts submitted provider disputes for claims that were submitted by the provider within one year of the Program’s original decision date. QM department will acknowledge receipt of a provider claim dispute within five (5) business days of receipt and resolve provider disputes within forty-five (45) calendar days of receipt of all reasonably relevant information.

Providers have the right to request a state fair hearing to dispute the decision made by the Program. More information regarding this process can be obtained by referencing the Utah Medicaid Provider Manual, Division of Medicaid and Health Financing; Administrative Review/Fair Hearing located at: https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf
Section 5  Processing Claims

CLAIM SUBMISSION

Claims must be submitted within 12 months of the date of service. **Here are several options for submitting claims:**

- **Provider Tools**
  Register your facility for secure Online Services account and use Provider Tools for fast, free services including:
  - Free real-time claims with digital attachments
  - Free real-time pre-treatment estimates with digital attachments
  - Current Utah members’ eligibility and benefits
  - Claim status and history
  - Sign up for direct deposit/electronic funds transfer (EFT)
  - Choose paperless documents with email alerts and more

Take the first easy step — register as a facility today at [deltadentalins.com/dentists](http://deltadentalins.com/dentists)

- **Electronic Claims Submission (i.e. through a clearinghouse)**
  Delta Dental – Utah Medicaid Claims Payer ID number: DDCA2
  Delta Dental also includes more information at deltadentalins.com/dentists/index.html. Electronic claims submission through a clearinghouse has many advantages, such as simplifying submission, fast notification of claim errors and possible integration with your practice management software programs. Providers should check with a vendor or their clearinghouse for pricing and more details.

- **Mail Claims and Prior Authorization to:**
  Delta Dental Insurance Company  
  Re: Utah Medicaid Dental Services  
  P.O. Box 1810  
  Alpharetta, GA 30023

**SUBMISSION OF DUPLICATE OR DIGITAL X-RAYS AND OTHER RECORDS**

Radiographic images and other supporting documentation will not be returned. Please do not submit original radiographic images. Radiographic image copies of diagnostic quality, including paper copies of digitized images, are acceptable.
Section 5  Processing Claims

DELTA DENTAL PROCESSING
Delta Dental makes decisions to approve, modify or deny requests based on the member’s benefit coverage and eligibility. Delta Dental pends requests only if we have not received all information reasonably necessary to make a decision to approve, modify or deny that request. Upon receipt of all information reasonably necessary and requested, Delta Dental will make a decision within the time frame specified by applicable regulations.

Only specific procedures require prior authorization for treatment. See Section 7 for processing guideline details, including if prior authorization is required. Prior authorizations are valid for up to 1 year based on member’s eligibility. A prior authorization is a condition for reimbursement; however, it is not a guarantee of payment. Prior authorized and approved orthodontic treatment must be initiated before the loss of Program eligibility and completed within 36 months of the authorization date.

For other authorized services, claim payment requires that:

- Services must be performed during the valid authorization period.
- A claim for payment must be submitted for payment no later than 120 days after the last services were performed; and
- The member must be eligible during the month in which procedure is actually performed.

Prior authorization is not transferable from one dental office to another. If a facility that received authorization is unable to complete the service, a provider from a different dental office cannot perform the service until a new treatment plan is authorized (unless it’s an emergency please call Provider Customer Service or see Section 4 for more details). To expedite processing of a prior authorization when the new provider is not in the same dental office as the provider who received the original authorization, the new provider must submit a new prior authorization request with an attached statement from the member indicating a change of provider.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM
As part of Delta Dental’s Quality Assessment and Performance Improvement (QAPI) Program, Delta Dental may require selected providers to obtain prior authorization for some or all dental services. Providers may be required to submit additional x-rays and/or documentation to substantiate the need for the treatment requested or to demonstrate that the quality of the treatment performed is consistent with generally accepted standards of care.

Providers may be randomly selected to obtain prior authorization or for special claims review as a result of utilization review or after consideration of other reasonable circumstances. Written notification will be sent to all selected providers at least 30 days in advance of prior authorization or special claims review requirements.
Section 6 Quality Management

Delta Dental is committed to continuous improvement in the service delivery and quality of clinical dental care provided to Utah Medicaid members. We maintain a comprehensive quality and utilization review Program designed to identify, evaluate and remedy problems relating to access to care, continuity and quality of care, utilization, and the cost of services. Our quality review program includes standards, policies and procedures for credentialing and re-credentialing providers and other health care professionals and facilities providing covered dental services to Utah Medicaid members. Peer review panels and committees are used to conduct quality of care and utilization review in accordance with applicable state and federal laws and regulations. All quality and utilization review forms, records and other information in Delta Dental’s possession are the property of Delta Dental and will remain confidential.

QUALITY OF CARE GUIDELINES
Quality of care guidelines apply to all contracted network providers. Quality of care guidelines are based on the American Dental Association’s Guidelines for the Assessment of Clinical Quality and Professional Performance and applicable standards from the Centers for Disease Control and Prevention and regulatory agencies.

Treatment Plan
All members should be presented with an appropriate written treatment plan containing an explanation of benefits and costs. A network provider must present various forms of alternate treatment to a member including covered and non-covered services. Under no circumstance may a contracted network provider deny a member covered services based on the member’s refusal to accept optional/noncovered treatment. The accepted treatment plan must be signed and dated by the member or his/her parent or guardian and the treating network provider.

Treatment Planning/Documentation Procedures
A member’s treatment should be based on the following sequence of care:
- Procedures for pain relief and discomfort, elimination of infection, irritations and trauma
- Treatment of active dental decay, necessary extractions, periodontal treatment, prophylaxis and oral hygiene instructions
- Final restorations and replacement of missing teeth
- Placement on an active recall system

Second Opinions
Members may request a second opinion if they disagree with or question the diagnosis and/or proposed treatment plan. Network providers should refer members to Delta Dental Member Customer Service department at 866-467-4219 for information about how to request a second opinion.

Access Standards
Accessibility standards will be monitored for the following to confirm contracted providers’ compliance:
- Routine/Non-urgent care appointments
  Appointments for routine or non-urgent care must be available to members within 21 days.
- Urgent care appointments
  Appointments for urgent care that can be treated in a provider’s office must be available in the same day.
Section 6 Quality Management

- **Emergency care, if needed, must be available 24 hours per day, seven days per week:**
  - Severe dental/oral pain, bleeding or swelling
  - Dental emergencies that risk life or disability without timely professional care

If a facility will be unavailable to provide emergency access 24 hours per day, seven days per week, the contracted primary care provider must make alternative arrangements in advance ensuring that emergency care will be available. A contracted provider who fails to do so may be held financially responsible for the cost of emergency care provided by a non-contracted provider. If this or other access standards are not met, Delta Dental reserves the right to close the facility to new Medicaid member enrollment.

**Recall, Failed or Cancelled Appointments**
Contracted providers should have an active recall system and an established system for contacting Medicaid members who fail to keep or cancel appointments. Per Utah Medicaid Program benefits limitations and exclusion, a contracted provider may charge for failed or cancelled appointments, if this policy is in writing and posted conspicuously in the office. A member’s failure to keep a recall or routine care appointment should be documented in the member’s record.

**Emergency Referrals**
Members who need emergency dental care are to be referred to the nearest network provider. If a network provider is not the closest provider, or the member is outside the State of Utah at the time, Delta Dental will locate a qualified U.S. provider in good standing with his or her state’s licensing board to provide covered dental services at no cost to the member. If the member is out of the area, Delta Dental will authorize payment for necessary covered services, unless we reasonably determine that the emergency services and care were never performed, or the member did not require emergency services and care (and should reasonably have known that an emergency did not exist).

**Continuity of Care**
The contracted network provider should refer a member to his/her current physician for any condition that may require active medical management. The referral should include any relevant evaluation made by the contracted provider. Copies of communications should be provided to the member and filed in the dental record. If the urgency for a referral does not permit a written communication, verbal referral to the physician is acceptable. Documentation should be made in the member’s record indicating the means of communication and the name of the person contacted at the physician’s office.

**Medical/Dental History**
A comprehensive medical and dental history must be completed and included in each member record. Medical history forms must be comprehensive; use a yes/no format and include information regarding the following:

- Chief complaint/reason for visit
- Systemic diseases or conditions, such as a cardiac condition, bleeding disorders, history of rheumatic fever, diabetes, hepatitis or joint replacements
- Allergies and/or emergency sensitivity to drugs (including anesthetics) or latex
- Current treating physician
Section 6 Quality Management

- All current medical services being rendered, including medications or prescribed drugs
- Prior use of stimulants including Phen-Fen/Redux
- Use or prior use of any Bisphosphonate medications such as Boniva or Fosamax
- Current blood pressure
- Nervous disorders
- Communicable diseases, including venereal disease, HIV/AIDS

Medical history forms must be signed and updated at least annually by the provider and the member or the member’s parent or guardian at initial and recall appointments. Medical alerts should be visually displayed in and/or on the chart. Alerts on the outside of the chart must be generic and guarded against viewing by non-entitled individuals.

Radiographic Images

- Radiographic image equipment must be inspected at regular intervals as required by regulation and/or as recommended by the manufacturer.
- Only licensed or certified personnel may be permitted to operate radiographic image equipment.
- Initial and recall radiographic images should be taken according to FDA/ADA guidelines. An attempt should be made to obtain copies of radiographic images taken within the last 12 months.
- Initial complete radiographic image series for adults/children must consist of sufficient diagnostic radiographic images, including bitewings, as necessary to view the entire dental arches and immediate supporting structures. Radiographic images must be mounted, identified and dated.
- Refusal of radiographic images must be documented in the dental record and initialed by the member. The member should be informed that the examination and diagnosis are not complete without radiographic images.
- Lead aprons with thyroid collars must be used for member protection.

Infection Control

Contracted network providers will comply with all applicable Centers for Disease Control and Prevention (CDC) guidelines and related federal and state regulations for sterilization and infection control in the dental office, as follows:

- Heat stable critical and semi-critical instruments and hand pieces shall be cleaned and sterilized before use by autoclaving, chemclaving or dry heat.
- Critical and semi-critical instruments and hand pieces sterilized by a heat or vapor method shall be packaged/wrapped before sterilization and remain so when stored.
- Proper functioning of heat sterilization equipment shall be verified at least weekly with a biological indicator (such as a spore test).
- Test results shall be logged and must be maintained for at least 12 months.
- All single use disposable instruments shall be used for one member only and then discarded.
- An FDA-approved sterilant should be used for cold sterilization according to the manufacturer’s directions.
- Universal barrier techniques shall be used and operatories disinfected between members.
- Before attaching hand pieces or other devices, dental unit lines will be purged or flushed for two minutes at the start of the workday and for twenty seconds between members.
Section 6 Quality Management

Gloves and Personal Protective Equipment
For the protection of staff and members, hands must be washed and gloved before treating each member. Delta Dental recommends gloves be changed in full view of the member. Providers, hygienists and chairside assistants must wear surgical masks and protective eyewear or a full face shield while treating members. Reusable or disposable protective attire shall be worn when clothing or skin is likely to be soiled with blood or potentially infectious materials. Gowns must be changed daily, or between members if they become moist or visibly soiled.

Informed Consent Process
The informed consent process includes the steps listed below:

- Diagnosis
- Inherent risks
- Reason for treatment
- Prognosis without treatment
- Nature of care and treatment
- Expectancy of success following treatment
- Alternative plans of treatment

The contracted network provider should manage expectations and accomplishment of the treatment plan in the long-term interests of the member. Each treatment plan should clearly indicate the planned step-by-step progression and the expected duration of the treatment.

A consent form, specific to the individual treatment plan, must be signed in ink by the member or his/her parent or guardian and the treating provider.

No matter how thorough the clinical examination, how accurate the diagnosis, or how rational the treatment plan, there may be times when a member refuses to accept part or all of a recommended treatment. There may also be times when the member requests treatment that, in the best judgment of the treating provider, may be inappropriate or injurious to the member’s dental health.

A member cannot be forced to comply with a recommended course of treatment. Similarly, a contracted network provider cannot be forced by the member to perform services that are not appropriate or are outside accepted standards of care. If this sort of disagreement occurs, the treating provider should make the member fully aware of the diagnosis and recommendations and record the member’s complete response in the member’s dental record.

Dental Records
Member dental records will be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive records should be comprehensive, legible and organized. Entries should be in ink and signed/dated by the treating provider or other licensed health professional who performed services. Member records requested by Delta Dental for grievance resolutions, second opinions or regulatory compliance must be available at no cost to Delta Dental, the Program or the member. Noncompliance with Program due dates for records may result in an administrative penalty of $50.00 or more. Continued non-compliance or refusal to provide records may result in disciplinary actions, up to and including termination. Please refer to section 4 of this Manual for additional information about dental records.
Section 6 Quality Management

QUALITY ASSESSMENT AND PERFORMANCE

Delta Dental has established and follows quality of care guidelines that include recommendations developed by organizations and specialty groups such as the American Academy of Pediatric Dentistry, the American Academy of Endodontists, the American Academy of Periodontists, the American Association of Oral Surgeons, and the ADA and its constituent (state) components. We apply these guidelines equally to general practice providers and specialists and use them to evaluate Utah Medicaid member care. Network providers shall comply with the standards and requirements of the Quality Assessment and Performance Improvement (QAPI) program established by Delta Dental in accordance with UDOH requirements and set forth in this provider manual.

Contracting network providers agree to comply with our Quality Assessment and Performance Improvement program requirements. Providers are required to integrate specialty care into the member’s course of dental treatment by making timely referrals to a specialist when necessary or appropriate. Providers may not impose any limitations on the acceptance or treatment of Utah Medicaid members not imposed on other members/patients. Providers are required to maintain the provider/member relationship with the Utah Medicaid member and shall be solely responsible to the member for dental advice and treatment.

Charts
Charts are designed to evaluate the process and quality of care rendered to Utah Medicaid members. As needed, a sample of charts will assess the quality of care delivered and will take into account both the process of care (as documented in the dental records) and the outcome of care, as represented by the current status of the member. All assessment and clinical review findings are discussed with the provider. Findings and recommendations are presented in an educational manner to inform and instruct the provider and facility staff of Program requirements and procedures and to ensure compliance with Utah Medicaid standards of care.

The provider is subsequently provided with a letter noting deficiencies, if any, an overall rating and any scheduled future assessments. If significant deficiencies are noted, corrective action may be required prior to implementation or renewal of the Contracting Provider Agreement.

Reviews
Delta Dental conducts quality of care reviews to assess the quality of care provided by providers. A quality of care review may result from multiple member complaints or an analysis of quality assessments, utilization reports or patterns of care or conduct observed during claims processing. The review may include selective oral examinations of Utah Medicaid members by regional consultants and/or a review of facilities (on-site) and detailed chart audits.

Corrective Action and Hearing Process
When specific cases of substandard quality of care are identified during the quality of care review process, a letter requesting corrective action will be mailed to the treating provider. Many forms of corrective action may be recommended, including but not limited to the following:

- A quality correction letter indicating the deficiency or deficiencies and requiring changes to be implemented within a maximum of 60 days. The seriousness of the deficiency or deficiencies noted will dictate the number of days that the provider has to implement the required changes.
Section 6 Quality Management

- Required prior authorization of claims and/or claims review.
- Post-treatment reviews of members by a regional dental consultant.
- Required attendance by the provider at training sessions or participation in continuing education programs.
- Restricted acceptance of new members until the provider has become compliant with all standards of care for a given amount of time.
- Recoupment of sums paid where billing discrepancies are found during reviews.
- Restriction of a provider’s authorized scope of services.
- Referral to the State of Utah Board of Dental Examiners and/or the U.S. Department of Justice, Attorney General’s Office.
- Termination of the Contracting Provider Agreement.

Notice of Proposed Corrective Action
Delta Dental will provide notice of the proposed corrective or adverse action at least 21 days prior to the effective date of the proposed action unless our dental director has initiated immediate action to avoid imminent danger to the health of a Utah Medicaid member. We will initiate the proposed or adverse action on the noted effective date if the provider does not request a hearing prior to the effective date of the proposed action.

The Notice of Action includes the following information:
- Proposed action to be taken
- Reason for the proposed action
- Effective date
- Requirement that the action be reported to the state Board of Dental Examiners.
- The right of the provider to request a hearing by submitting a written request to Delta Dental prior to the effective date of the proposed action (or within 21 days of the notice, if the dental director has taken immediate action)
- The procedures governing such hearings

Notification that failure of the provider to request a hearing within the time required constitutes a waiver of the provider’s right to a hearing, and Delta Dental will initiate the proposed action on the effective date.

COMPLAINTS AND APPEAL PROCESS

What is a Grievance?
Any expression of dissatisfaction (written or oral) made by the enrollee or the enrollee’s representative concerning Delta Dental or Utah Medicaid provider, with the exception of dissatisfaction with a Notice of Action. Delta Dental accepts grievances without limiting the time period between receipt and the date of the incident or action, which is the subject of the enrollee’s dissatisfaction.

Possible subjects for grievances include, but are not limited to:
- The quality of care or of the services provided;
- Benefits decisions and/or charges by a Plan provider;
- The provider’s facility and its appearance, policies, or allegations of rudeness by the provider or the office staff;
Section 6 Quality Management

- Appointment availability and/or an inability to contact or access care at a facility;
- The Plan and its policies, processes, staff or activities other than the Actions defined above; or
- Any failure by the Plan or a facility to respect the enrollee’s rights

Grievance Process
Enrollee someone acting on their behalf with enrollee’s approval, or Delta Dental provider may file a Grievance by:
- Calling Member Services at 1-866-467-4219 and asking to file a Grievance
- Sending a Grievance form or letter to the
  Delta Dental Insurance Company
  Quality Management Department,
  P.O. Box 1860,
  Alpharetta, GA 30023

Delta will log complaint and attempt to resolve the problem over the phone immediately. Phone call will be documented as a Grievance. The timeframe for closing a Standard Grievance and providing a decision is within 45 calendar days of receipt. However, after providing the enrollee written notification, Delta Dental may extend the Standard Grievance timeframe by 14 calendar days, if such an extension is required to get additional information and is in the enrollee’s best interest. Alternatively, the enrollee, the enrollee’s provider or another authorized agent may request a 14 calendar day extension.

Expedited (Quick) Grievance
A request by the enrollee or the enrollee’s representative for Delta Dental to investigate an issue and render an Expedited Grievance because the timeframe for a Standard Grievance could seriously jeopardize the enrollee’s life, health or ability to attain, maintain, or regain maximum function. The timeframe for an Expedited Grievance is as soon as possible, but no later than 3 business days of receipt. However, after providing the enrollee written notification, Delta Dental may extend the Expedited Grievance timeframe by 14 calendar days, if such an extension is required to get additional information and is in the enrollee’s best interest. Alternatively, the enrollee, the enrollee’s provider or another authorized agent may request a 14 calendar day extension.

What is an Appeal?
A request by the enrollee or the enrollee’s representative for the Plan to review or reconsider an Action.

What is an Action?
An Action, requires the sending of a written Notice of an Action to the enrollee, which occurs when and if the Delta Dental:
- Acts to deny or limit an authorization of a requested Medicaid service, including the type or level of service;
- Acts to reduce, suspend, or terminate a previously authorized service;
- Acts to deny, in whole or in part, payment for a service;
- Fails to arrange for the provision of services in a timely manner; or
- Fails to act within the timeframes established for resolution and notification of a grievance or an appeal

The Notice of Action informs the enrollee of Delta Dental’s decision and of the enrollee’s right to appeal that action.
Section 6 Quality Management

Appeals
The standard timeframe to respond to an appeal is 30 calendar days. However, after providing the enrollee written notification of the reason for the delay Delta Dental may extend the Standard Appeal timeframe by 14 calendar days, if such an extension is required to get additional information and is in the enrollee's best interest. Alternatively, the enrollee, the enrollee's provider or another authorized agent may request a 14 calendar day extension.

Quick Appeal
A request by the enrollee, the enrollee's provider or another authorized agent of the enrollee for Delta Dental to review or reconsider an Action and render an expedited decision because the timeframe for a Standard Appeal could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function. Any request for an Expedited Appeal must be submitted within 30 calendar days from the date on the Notice of Action. The timeframe for an Expedited Appeal is as soon as possible, but no later than 3 business days of receipt. However, after providing the enrollee written notification of the reason for the delay, the Delta Dental may extend the Expedited Appeal timeframe by 14 calendar days, if such an extension is required to get additional information and is in the enrollee's best interest. Alternatively, the enrollee, the enrollee’s provider or another authorized agent may request a 14 calendar day extension. If the Delta denies the request for a Quick Appeal the enrollee will be notified and the request will be processed as a standard Appeal. We will not take any negative action against a provider who requests a Quick Appeal. The enrollee has the right to file a Grievance about the denial of your Quick Appeal request.

Provider's Right to Request a Hearing
A provider may appeal any corrective or adverse action taken by Delta Dental, including restriction in a provider’s authorized scope of services or termination for cause of the Contracting Provider Agreement and any other action that results in a report to the state Board of Dental Examiners and/or the National Practitioner Data Bank.

If the provider does not request a hearing in writing by the effective date of the proposed action, the right to appeal is lost and Delta Dental shall impose or initiate the corrective or disciplinary action and furnish appropriate reports to state and federal agencies.

Filing for an Appeal
An enrollee or the enrollee’s agent must file a request for a Standard Appeal within 30 calendar days from the date on the Notice of Action. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date). If an enrollee or the enrollee’s agent calls and files an oral Standard Appeal, a written Appeal request must be submitted within 5 business days of the oral request. If the oral request is not followed up by a written letter within 5 business days Delta has no further obligation to take action on the appeal.
Section 6 Quality Management

The standard timeframe for Delta Dental to respond to an appeal is 30 calendar days. However, after providing the enrollee written notification of the reason for the delay, the Standard Appeal timeframe may be extended by 14 calendar days, if such an extension is required to get additional information and is in the enrollee’s best interest. Alternatively, the enrollee, or one of the other parties listed above, may request a 14 calendar day extension.

Enrollee, or authorized agent may file by:

- Calling Member Services at 1-866-467-4219 and ask to file an Appeal
- Sending an Appeal letter to the Delta Dental Insurance Company, Quality Management Department, P.O. Box 1860, Alpharetta, GA 30023

We have translators and help for those with hearing problems.

Member Advocate

Enrollees who are minors or have legal guardians may have a parent or guardian act on their behalf to file a grievance or appeal. Similarly, with the express written permission of the enrollee, and with a signed release to allow the disclosure of confidential information, Delta will not prohibit a provider or enrollee representative on acting on an enrollee’s behalf during the grievance process. Enrollee has the right to have a provider file a grievance or an appeal on behalf of the enrollee, as the enrollee’s authorized representative. Member must designate the provider in writing on their behalf.

If the enrollee requires assistance to accomplish any of the procedural steps required to file a grievance or appeal, the Plan will provide all reasonable assistance, including, but not limited to, assistance filling out forms, providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Grievance, action, and appeal informational and instructional materials are available in the prevalent non-English language. Information and instruction materials will also be made available to enrollees who are visually limited or have limited reading proficiency.

Appeal Decision

The grievance and appeal system is the responsibility of the Quality Management department, the Manager of the QM department and Dental Director. The Quality Management department is responsible to investigate, review, and resolve all enrollee grievances and appeals.

If the appeal is about an Action to decrease or end a service, a request can be made to have that service continued while a decision is being made. But, if an Appeal is not found in enrollee’s favor they may have to pay for that service.

State Fair Hearing Process

A state hearing before an administrative law judge appointed by the Utah State Department of Health Division of Medicaid and Health Financing (DMHF) in response to a written request to the DMHF by a provider or a recipient who has been adversely affected by any action or inaction of the:

- DMHF;
- Department of Human Services (DHS);
- Department of Workforce Services (DWS); or
- A managed health care plan.
Section 6 Quality Management

The DMHF will follow prescribed standards when an enrollee requests an expedited fair hearing. A request for a fair hearing must be made within 30 days from the date of the Plan’s notice of an appeal resolution. The requested may be made by the:
- Enrollee
- Enrollee’s provider or other authorized agent acting on his or her behalf with the enrollee’s consent; or
- Estate of a deceased enrollee.

When granted by the DMHF, a Medical Fair Hearing is conducted in a manner consistent with Title XIX of the Social Security Act, the Code of Federal Regulations, and Utah rules including Rule R410-14, Administrative Hearing Procedures. QM provides enrollees or their authorized agent with information concerning State fair hearings and affords them reasonable assistance in submitting a hearing request to the DMHF. Appeal acknowledgment letters and notices of an appeal decision provide key State fair hearing time frames, DMHF contact information, and other relevant information. A copy of the required DMHF hearing request form is enclosed with all adverse notices of an appeal decision. These notices also include information regarding their opportunity to:
- Examine, prior to the hearing, the content of their case file and all documents and records to be used by Plan in the hearing;
- Bring witnesses;
- Establish all pertinent facts and circumstances;
- Present an argument without undue interference;
- Question or refute any testimony or evidence, including confronting and cross-examining adverse witnesses; and
- Request the continuance of dispute service.

If the enrollee requests continuation of disputed services during the State Fair Hearing, the request must be submitted within 10 days after Delta mails the Notice of Appeal resolution. The enrollee has a right to request continuation of disputed services that are related to the termination, suspension or reduction of previously authorized services. If the State Fair Hearing decision is adverse to the enrollee, the enrollee may be liable for the cost of any continued disputed services.

The DMHF will reach its standard fair hearing decision within 90 calendar days from the date the enrollee filed a Standard Appeal with the Plan, not including the days the enrollee takes to file the request. The DMHF will conduct an expedited fair hearing if the Plan fails to resolve an Expedited Appeal within the required timeframe or makes a wholly or partially adverse resolution of an Expedited Appeal.

An expedited fair hearing decision is made within 3 business days from the date the DMHF receives all needed information from the Plan, including information from the enrollee’s dental record.
Section 6 Quality Management

To Ask for a Fair Hearing;
By Mail:
- Download and complete the Fair Hearing Form (deltadentalins.com/ut-medicaid/Forms/Forms/HearingRequest2010.pdf)
- Return the form to Medicaid By Mail: Director's Office/Formal Hearings
  Division of Medicaid and Health Financing
  PO Box 143105
  Salt Lake City, UT 84114-3105
By Fax: (801) 536-0143
Call (801) 538 6576 if you have any question

Hearing Process
If the provider requests a hearing, a written notice containing the following information will be mailed by the dental director to the provider no more than 60 days from the receipt of the request from the provider:
- Place, time, and date of the hearing
- Reason for the proposed action, including the acts or omissions with which the provider is charged
- Copies of any non-privileged documents relevant to the proposed action that Delta Dental has in its possession or under its control
- A request to inspect all relevant non-privileged documents that the provider has in his/her possession or control within 15 days after receipt of the notice of hearing
- Names, credentials, and backgrounds of at least three participating Utah Medicaid providers who will serve as members on the hearing panel and the name, credentials, and background of a licensed attorney who will serve as the hearing officer

The hearing shall be conducted without the necessity of complying with formal rules of evidence or the presence of attorneys. Delta Dental will arrange to have a record made of the hearing. Delta Dental will have the initial duty to present evidence supporting its Utah Medicaid Provider Manual proposed action. Each party shall have the right to call, examine, and cross-examine witnesses, the right to present and rebut relevant evidence, and the right to submit a written statement at the conclusion of the hearing. Delta Dental shall have the burden of proof by a preponderance of the evidence that the corrective or disciplinary action is reasonable or warranted. The matter shall be decided by a majority vote of the hearing panel. The panel shall provide a written decision, including findings of fact and a conclusion based on the evidence produced.

Delta Dental will mail a copy of the written decision to the provider. There is no administrative appeal of the decision of the hearing panel. A provider who is dissatisfied with the hearing panel's decision may seek a judicial remedy within one year after receiving notice of the decision.

Hearings for Providers and Peer Review
When a Medicaid member, provider, or other interested party is dissatisfied with an action taken by Utah Medicaid, a hearing may be requested by filing a hearing request with the Office of Formal Hearings to appeal the action. For more information or to contact the Office of Formal Hearings, click here.
Section 6 Quality Management

- Procedures for Provider Hearing and the Utah Medicaid Hearing Form can be found in Section 1, Chapter 5-4, of the Utah Medicaid Provider Manual.
- Procedures for Peer Review: SECTION 1, Chapter -4-8, of the Utah Medicaid Provider Manual

Quality Assessment and Performance Improvement (QAPI) Program

As part of Delta Dental’s Quality Assessment and Performance Improvement (QAPI) program, we may require selected providers to obtain prior authorization for some or all dental services. Providers may be required to submit additional x-rays and/or documentation to substantiate the need for the treatment requested or to demonstrate that the quality of the treatment performed is consistent with generally accepted standards of care.

Providers may be randomly selected to obtain prior authorization or for special claims review as a result of utilization review or after consideration of other reasonable circumstances. Written notification will be sent to all selected providers at least 30 days in advance of prior authorization or special claims review requirements.

Utilization Management

Delta Dental’s Utilization Management department serves as the primary repository for all data related to the quality of services provided by Utah Medicaid providers. A utilization analyst generates quarterly utilization reports from our automated system to assist in the identification of trends — specifically, underutilization and overutilization of services. These reports include, but are not limited to, provider profiles, provider-trended analyses, frequency of procedures performed and claims analyses.

Following analysis of all reports and data to identify providers with indicators of over- or underutilization of services and/or practice patterns inconsistent with normative data, a report summarizing the results is prepared for presentation to Delta Dental’s UM Committee. The UM Committee evaluates the case report and determines whether aberrant practice patterns are a result of case mix (as with pediatric providers) or other explainable conditions for a network provider and whether member activity was unusual but appropriate for the particular situation. Results that do not appear to have a justifiable basis for deviation from norms are recommended for further review and may result in a process of care audit.

Provider profiling activities include developing provider-specific reports that include a multi-dimensional assessment of a provider’s performance using clinical, administrative and member satisfaction indicators of care that are accurate, measurable and relevant to the enrolled population. Activities also include establishing provider, group, statewide or regional benchmarks for areas profiled, where applicable, and providing feedback to individual providers regarding the results of their performance and the overall performance of the provider network.

Utilization analysts generate statistical reports each month to detect providers whose service patterns deviate from expected norms. Provider profiles compare each provider to all network providers and also by type of service (e.g., diagnostic, preventive, operative, endodontics, oral surgery, periodontics, and prosthetics). Ratio reports identifying providers who exceed norms in terms of services per member are generated from Delta Dental’s system database. Based on the result of the ratio report analysis, additional detailed reports are generated for providers who warrant further investigation to identify the basis for the aberrant statistical results.
Section 6 Quality Management

Quality assessment and utilization management staff also identify quality issues and trends through input from other departments during regularly scheduled staff meetings and review of member and provider grievances/appeals, satisfaction survey results and other feedback mechanisms.

**Member Grievance and Appeals**
Delta Dental’s grievance system reviews, investigates and resolves enrollee grievances in a timely, equitable manner compliant with applicable state and federal regulations. It is sensitive to the member’s individual needs, including cultural, linguistic and disability-related issues. Please see “Member Grievance and Appeal” form in Section 10, Forms.
Section 7 Covered Services and Guidelines

Providers are responsible for providing covered dental services which are within their expected scope of practice. General Dentists and Pediatric Dentists are responsible for helping facilitate referrals to a specialist (see Section 8: Specialty Referral Guidelines for detailed guidelines). Prior authorization is required for some services provided by a specialist.

Covered services must be medically necessary and/or consistent with the member’s dental condition and generally accepted professional standards. There is no cost to an eligible member and providers may not collect any copayment. If a procedure is not listed in this section, it is not covered by the Program.

Medicaid Program does NOT cover the following procedures:

- Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex
- Fixed bridges or pontics
- Dental implants, including but not limited to endosteal implants, eposteal implants, transosteal implants, subperiosteal implants
- Tooth transplantation
- Ridge augmentation
- Osteotomies
- Vestibuloplasty
- Treatment of temporomandibular joint syndrome (TMJ), its prevention, sequela, subluxation, therapy, arthrostomy, meniscectomy or condylectomy
- House calls
- Processing claim forms
- Charges for laboratory tests or pathology reports (the laboratory or pathologist must bill the charges directly to Medicaid)
- Except in emergencies, services which require a prior authorization and are provided before the prior authorization is given.
- Limited orthodontic treatment, including removable appliance therapies
- Habit control appliances
- Incomplete root canal
- When pulpal debridement (D3221) is completed by the same facility as the root canal therapy (RCT), it is considered part of and included in the RCT.
  - If the provider has the required agreement with the member, but did not collect a fee for D3221 at the time of service, then the provider may bill a member who fails to return to have the RCT completed.
  - If a member had a pulp chamber accessed during an out-of-area emergency, completion of the RCT remains a covered benefit. If RCT was started prior to the member’s eligibility with the plan, completion of RCT may be subject to a work-in-progress limitation.
### Section 7 Covered Services and Guidelines

#### DIAGNOSTIC SERVICES D0100-D0999

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Diagnostic Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation – established patient</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Four D0120 or/ D0140 per calendar year, per provider. One evaluation/exam (D0120, D0140 or D0150) per patient per day, even if more than one provider is involved from the same office or clinic. D0150 is covered only once per provider and is considered one of the covered evaluation/exams allowed per calendar year. Pregnant adults are allowed 2 per calendar year, or one comprehensive and one periodic oral evaluation per calendar year.</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation – problem focused</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation – new or established patient</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Medicaid considers it standard practice to bill for a full mouth series if more than 12 periapicals are taken during a single visit. Any periapical x-rays billed additionally with D0210 will be considered part of the full mouth series. X-rays submitted in conjunction with a root canal will be considered part of and included in the fee for a root canal. A panoramic x-ray may be billed with bitewings. A panoramic x-ray with bitewings (2 or 4 films), plus 2 periapicals will be considered to be D0210. Panoramic x-rays and full series x-rays shall not be taken more often than once every two years unless there is specific dental diagnostic need documented in the member’s records.</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral – complete series of radiographic images</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional radiographic image</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing – single radiographic image</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two radiographic images</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four radiographic images</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic Casts</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
</tbody>
</table>
### Section 7 Covered Services and Guidelines

**PREVENTIVE SERVICES D1000-D1999**

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Preventive Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis – adult</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Two per calendar year, with or without fluoride. D1110 limited to age range 16-20.</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis - child</td>
<td>No Cost</td>
<td></td>
<td>Four per calendar year, with or without fluoride.</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
<td>No Cost</td>
<td></td>
<td>Four per calendar year, age range 0-18.</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant - per tooth</td>
<td>No Cost</td>
<td></td>
<td>1st and 2nd permanent molars or premolars (bicuspids). One every two years per tooth.</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer - fixed - unilateral</td>
<td>No Cost</td>
<td></td>
<td>Space maintainers are covered for EPSDT children 0-20 years of age. D1510 and 1520 allowed one every three years, per quadrant.</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer - fixed - bilateral</td>
<td>No Cost</td>
<td></td>
<td>D1515 and D1525 allowed one every three years, per arch.</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer - removable - unilateral</td>
<td>No Cost</td>
<td></td>
<td>1550 allowed one every six months per quadrant.</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer - removable - bilateral</td>
<td>No Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1550</td>
<td>Re-cementation or re-bond of space maintainer</td>
<td>No Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section 7 Covered Services and Guidelines

#### RESTORATIVE SERVICES D2000-D2999

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Restorative Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Routine amalgam fillings on posterior teeth are covered. Composite resin restorations on posterior teeth are downgraded to amalgam. Composite resin restorations on anterior teeth are covered. Allowed one every two years, per tooth, per surface.</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three surfaces, primary or permanent</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - three surfaces, primary or permanent</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D2330</td>
<td>Amalgam - three surfaces, primary or permanent</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two surfaces, anterior</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Limited to primary, permanent anterior teeth. Allowed one every two years, per tooth, per surface.</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three surfaces, anterior</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - four or more surfaces or involving incisal angle (anterior)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are <strong>REQUIRED</strong>: ✓ Prior authorization ✓ Periapical x-rays Covered on permanent anterior teeth one time every five years.</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominantly base metal</td>
<td>No Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown - primary tooth</td>
<td>No Cost</td>
<td>No Cost</td>
<td>It is not allowable to submit a primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth on the same date of service. A provider must submit for one or the other but not both procedures. D2930 may not be submitted with a core and buildup with pins (D2950). Allowed one every two years.</td>
</tr>
</tbody>
</table>
## Section 7 Covered Services and Guidelines

### RESTORATIVE SERVICES D2000-D2999

<table>
<thead>
<tr>
<th>CDT Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown - permanent tooth</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Benefit when a missing cusp, entire incisal corner or edge has fractured off a natural tooth; or crown is failing which requires replacement and meets the plan-specific benefit, limitations and exclusions. A permanent stainless steel crown and alloy/composite filling for the same tooth, same date of service, is not a covered benefit. It is allowable to bill for a core and buildup with pins, D2950, and a stainless steel crown – permanent teeth (numbers 2-15 and 18-31).</td>
</tr>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins when required</td>
<td>No Cost</td>
<td>No Cost</td>
<td>When the majority of a clinical crown is missing and an extensive buildup is required, the buildup is covered as a separate benefit. Covered for posterior teeth (tooth numbers 2-15 and 18-31). It is not allowable to submit a primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth on the same date of service. A provider must submit for one or the other but not both procedures. D2930 may not be submitted with a core and buildup with pins (D2950). Benefit when a missing cusp or entire incisal corner/edge has fractured off a natural tooth; or the member has a failing crown which requires replacement and meets the plan-specific benefit, limitations and exclusions. A permanent stainless steel crown and alloy or composite filling for the same tooth, same date of service, is not a covered benefit. It is allowable to bill for a core and buildup with pins, D2950, and a stainless steel crown – permanent for teeth numbers 2-15 and 18-31.</td>
</tr>
<tr>
<td>D2951</td>
<td>Resin-based composite - three surfaces, anterior</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D2980</td>
<td>Crown repair necessitated by restorative material failure</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
</tbody>
</table>
Section 7 Covered Services and Guidelines

**ENDODONTIC SERVICES D3000-D3999**

Recommending endodontic procedures should take into account prognosis, maintainability and restorability of the tooth (teeth), including crown lengthening. Any x-rays listed on a claim with an endodontic procedure will be considered included in that procedure.

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Endodontic Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Primary teeth only.</td>
</tr>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth (excluding final restoration)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Limited to permanent teeth only.</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, bicuspid tooth (excluding final restoration)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar (excluding final restoration)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Root canal therapy is a covered benefit excluding third molars. X-rays are considered part of and included in a root canal procedure. Root canal therapy is only complete after all the canals have been completely obturated with the final filling.</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy - anterior</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy - bicuspid (first root)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy - molar (first root)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Excludes permanent third molars.</td>
</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy (each additional molars)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling - per root</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
</tbody>
</table>
Section 7 Covered Services and Guidelines

PERIODONTIC SERVICES D4000-D4999

Members should be screened for periodontal disease during comprehensive and periodic examinations. If screening evidences periodontal disease, full mouth pocket charting is indicated with sufficient x-rays to diagnose and/or monitor the member’s condition. It is the responsibility of the treating provider to explain why the member may initially need scaling and root planing instead of a prophylaxis.

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Endodontic Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>No Cost</td>
<td>No Cost</td>
<td>For drug-induced gingival hyperplasia only (such as Dilantin and Cyclosporin).</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing - four or more teeth per quadrant</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are REQUIRED: ✅ Prior authorization ✅ Periapical x-rays and or bitewings ✅ Periodontal pocket charting Must have pocket depth of 4 mm or greater. Covered once a year per quadrant. Scaling and root planing is a covered benefit for all periodontal case types. However, members who have Refractory Chronic/Aggressive Periodontitis may be referred to a specialist for scaling and root planing as well as possible periodontal surgery. D4341 does not eliminate the need or benefit for an adult prophylaxis at a later date.</td>
</tr>
<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive evaluation and diagnosis</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are REQUIRED: ✅ Prior authorization for ages 0-17 Must have subgingival calculus present. Oral debridement may be done once per year and may be done in conjunction with a prophylaxis in cases requiring subgingival scaling. For oral debridement to be covered, heavy subgingival calculus must be removed in order to do periodontal probing and a comprehensive evaluation and diagnosis.</td>
</tr>
</tbody>
</table>
Section 7 Covered Services and Guidelines

PROSTHODONTIC SERVICES D5000-D5999

Replacement of an existing partial or complete denture is not a benefit when the existing denture has been neglected or abused or can be relined for proper fit. Dentures less than five years old shall be repaired or relined. Medicaid does not cover temporary stayplate partials or temporary dentures.

While an interim partial denture (stayplate) is not a covered benefit, the delivery of one does not affect the subsequent benefit for other covered prosthetic appliances. A resin-based partial denture is indicated when periodontal conditions prohibit use of a metal framework.

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Prosthodontic Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
</table>
| D5110    | Complete denture - maxillary           | No Cost        | No Cost        | The following are REQUIRED:  
  ✓ Prior authorization must be obtained before fabricating a complete denture.  
  ✓ Narrative  
  Complete dentures include routine post-delivery care and adjustments for six months. The fabrication of a complete denture includes establishing vertical dimension. |
| D5120    | Complete denture - mandibular          | No Cost        | No Cost        |                                                                                                               |
| D5130    | Immediate denture - maxillary          | No Cost        | No Cost        | The following are REQUIRED:  
  ✓ Prior authorization must be obtained before removing teeth in preparation for the immediate denture.  
  ✓ Mounted full series or panoramic x-ray.  
  An immediate denture is covered when all remaining natural teeth are extracted at the time of denture delivery.  
  An immediate denture includes routine post-delivery care and adjustments and soft liners for six months. |
| D5140    | Immediate denture - maxillary          | No Cost        | No Cost        |                                                                                                               |
## PROSTHODONTIC SERVICES D5000-D5999

<table>
<thead>
<tr>
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</thead>
</table>
| D5211    | Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | No Cost        | No Cost        | The following are **REQUIRED**:  
  ✓ Prior authorization must be obtained before fabricating a partial denture.  
  ✓ Mounted full series or panoramic x-ray.  
  ✓ List of teeth to be removed.  
  **NON-EMERGENCY partial dentures guidelines:**  
  Anterior tooth must be missing or the partial denture must restore mastication ability.  
  If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he/she has two maxillary and two mandibular posterior teeth on the same side in occlusion. Minimum of one posterior tooth or canine present with adequate bone support on each side of the arch is required. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch.  
  **EMERGENCY D5212 guidelines:**  
  In addition to the non-emergency criteria listed above, EMERGENCY D5212 may be covered if anterior permanent teeth (tooth numbers 6-11) are fractured, avulsed, or abscessed, requiring immediate removal of tooth. Note: The provider may call the Delta Dental Provider Customer Service department at 866-616-1475 and ask for telephone authorization of an emergency D5212, but must submit a narrative, which identifies the tooth or teeth replaced, as well as mounted periapical or panoramic x-rays. |
| D5212    | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | No Cost        | No Cost        |                                                  |
| D5213    | Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | No Cost        | No Cost        |                                                  |
| D5214    | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | No Cost        | No Cost        |                                                  |
# Section 7 Covered Services and Guidelines

**PROSTHODONTIC SERVICES D5000-D5999**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>D5410</td>
<td>Adjust complete denture - maxillary</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Payable to provider who did not originally provide the denture. May be payable to originating provider six months post-delivery.</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture - mandibular</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture - maxillary</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture - mandibular</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture (each tooth)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Only covered if a clasped tooth has been extracted.</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Medicaid covers only hard relines completed by a laboratory. It is difficult to establish a time for a reline following an immediate denture, but typically, hard relines must be delayed until bone resorption has stabilized following the extractions, which would be 6 to 12 months following the extractions. Medicaid will not cover more than two relines per year per arch.</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline maxillary partial denture (laboratory)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5760</td>
<td>Reline mandibular partial denture (laboratory)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>CDT Code</td>
<td>Prosthodontic Services</td>
<td>EPSDT Under 21</td>
<td>Pregnant Adult</td>
<td>Processing guidelines, Limitations and Exclusions</td>
</tr>
<tr>
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<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D5931</td>
<td>Obturator prosthesis, surgical</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The Utah Department of Health Fee-for Service program is solely responsible for any of the following: Facility charges for hospital and ambulatory surgical centers. Medical and surgical services of a provider, including general anesthesia performed at a hospital or ambulatory surgical center. Emergency services provided in an emergency department. Services performed at the state hospital or state developmental center.</td>
</tr>
</tbody>
</table>
| D5932    | Obturator prosthesis, definitive          | No Cost        | No Cost        | The following are **REQUIRED**:  
  ü Prior authorization  
  ü Mounted full series or panoramic x-ray  
  ü Narrative                                                          |
| D5954    | Palatal Augmentation Prosthesis           | No Cost        | No Cost        |                                                                                                                  |
| D5955    | Palatal Lift Prosthesis                   | No Cost        | No Cost        |                                                                                                                  |
Section 7 Covered Services and Guidelines

**ORAL SURGERY SERVICES D7000-D7999**

Benefits for extraction should be based on a clearly recorded diagnosis. Provider agrees to perform all extractions within the scope of general dentistry. The contracted facility is responsible for providing all oral surgery services to members except those services that qualify for specialty care referral (refer to Section 8, “Specialty Referral Guidelines).

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Oral Surgery Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - deciduous tooth</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony, with unusual surgical complications</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7260</td>
<td>Oral antral fistula closure</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
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<td>Oral Surgery Services</td>
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</tr>
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</tr>
<tr>
<td>D7280</td>
<td>Surgical access of an unerupted tooth</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Excludes primary teeth and third molars.</td>
</tr>
<tr>
<td>D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are REQUIRED: Prior authorization, Periapical(s) Members currently receiving orthodontic services under an approved prior authorization from Delta Dental will be approved for a prior authorization for D7283.</td>
</tr>
<tr>
<td>D7285</td>
<td>Biopsy of oral tissue - hard (bone, tooth)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7286</td>
<td>Biopsy of oral tissue - soft</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7410</td>
<td>Excision of benign lesion up to 1.25 cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7411</td>
<td>Excision of benign lesion greater than 1.25 cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7412</td>
<td>Excision of benign lesion, complicated</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7413</td>
<td>Excision of malignant lesion up to 1.25 cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7414</td>
<td>Excision of malignant lesion greater than 1.25 cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7450</td>
<td>Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7451</td>
<td>Removable odontogenic cyst/tumor – lesion &gt; 1.25 cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7460</td>
<td>Removable nonodontogenic cyst/tumor – lesion to 1.26 cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
</tbody>
</table>
### Section 7 Covered Services and Guidelines

#### ORAL SURGERY SERVICES D7000-D7999

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Oral Surgery Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7461</td>
<td>Removable nonodontogenic cyst/tumor - lesion &gt; 1.25 cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7465</td>
<td>Destruct lesion(s) phys/chemical method by report</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are REQUIRED:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓ Prior authorization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓ Periapical(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓ Narrative</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>This service is covered only in conjunction with</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>a new denture or partial denture fabrication.</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis (maxilla or mandible)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7520</td>
<td>Incision and drainage of abscess - extra oral soft</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7530</td>
<td>Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7540</td>
<td>Removal of reaction producing foreign bodies musculoskeletal system</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7550</td>
<td>Partial ostectomy/sequestrectomy for removal of non-vital bone</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7560</td>
<td>Maxillary sinusotomy for removal of tooth fragment or foreign body</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7610</td>
<td>Maxilla – open reduction (teeth immobilized, if present)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7620</td>
<td>Maxilla – closed reduction (teeth immobilized, if present)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7630</td>
<td>Mandible – open reduction (teeth immobilized, if present)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7640</td>
<td>Mandible – closed reduction (teeth immobilized, if present 2)</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
</tbody>
</table>
## Section 7 Covered Services and Guidelines

### ORAL SURGERY SERVICES D7000-D7999

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Oral Surgery Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7670</td>
<td>Alveolus closed reduction may include stabilization of teeth</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Medicaid considers this procedure to be open to services provided by an in network provider for EPSDT only. However, the Utah Department of Health Fee-for Service program is solely responsible for any of the following: Facility charges for hospital and ambulatory surgical centers. Medical and surgical services of a provider, including general anesthesia performed at a hospital or ambulatory surgical center. Emergency services provided in an emergency department. Services performed at the state hospital or state developmental center.</td>
</tr>
<tr>
<td>D7710</td>
<td>Maxilla – open reduction</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7720</td>
<td>Maxilla – closed reduction</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7730</td>
<td>Mandible – open reduction</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7740</td>
<td>Mandible – closed reduction</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7911</td>
<td>Complicated suture – up to 5cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7912</td>
<td>Complicated suture &gt; 5cm</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7920</td>
<td>Skin graft (identify defect covered, location and type of graft)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7950</td>
<td>Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
</tbody>
</table>
## Section 7 Covered Services and Guidelines

### ORAL SURGERY SERVICES D7000-D7999

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Oral Surgery Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7955</td>
<td>Repair of maxillofacial soft and/or hard tissue defect</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7960</td>
<td>Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7980</td>
<td>Sialolithotomy</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D7981</td>
<td>Excision of salivary gland, by report</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7982</td>
<td>Sialodochoplasty</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7983</td>
<td>Closure of salivary fistula</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D7999</td>
<td>Unspecified oral surgery procedure, by report</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are REQUIRED:</td>
</tr>
</tbody>
</table>

- Prior authorization
- Periapical(s)
- Narrative
Section 7 Covered Services and Guidelines

ORTHODONTIC SERVICES D8000-D8999

Medicaid provides orthodontic services for children who have a handicapping malocclusion due to birth defects, accidents or abnormal growth patterns of such severity that it renders them unable to masticate, digest or benefit from their diet.

Medicaid provides orthodontic services for pregnant women who have a handicapping malocclusion as a result of a recent accident or disease of such severity that they are unable to masticate, digest or benefit from their diet.

A tooth must be rotated 30 degrees or more to be scored on the Salzmann Index per Medicaid policy. Orthodontic treatment is limited to one per lifetime.

The following are not covered benefits under Medicaid Program:
- Limited orthodontic and removable appliance therapies,
- Removable orthodontic appliances in conjunction with fixed banded treatment,
- Habit control appliances
- Cosmetic or esthetic services

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Oral Surgery Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8080</td>
<td>Comprehensive orthodontic treatment of the adolescent dentition (includes banding and adjustments)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are REQUIRED: Prior authorization, Mounted full series or panoramic, Salzmann Index/Study Models/Waxbite</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic retention (removal of appliances, construction and placement of retainer(s))</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are REQUIRED: Prior authorization, Narrative At the completion of treatment, the orthodontic provider should preauthorize D8680 for orthodontic retention (removal of appliance, construction and placement of retainer(s).</td>
</tr>
<tr>
<td>D8690</td>
<td>Orthodontic treatment (alternative billing to a contract fee)</td>
<td>No Cost</td>
<td>No Cost</td>
<td>The following are REQUIRED: Prior authorization, Mounted full series or panoramic, Salzmann Index/Study Models/Waxbite</td>
</tr>
</tbody>
</table>
### ORTHODONTIC SERVICES D8000-D8999

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Oral Surgery Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
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<tbody>
<tr>
<td>D8692</td>
<td>Replacement of lost or broken retainer</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Limited to one D8692 per lifetime for those who are receiving orthodontic treatment paid by Utah Medicaid. This code is not to be used for the initial retainer.</td>
</tr>
</tbody>
</table>
| D8999    | Unspecified orthodontic procedure, by report                | No Cost        | No Cost        | The following are **REQUIRED**:  
  ✓ Prior authorization  
  ✓ X-rays, as appropriate  
  ✓ Narrative                                                        |
Section 7 Covered Services and Guidelines

ADJUNCTIVE GENERAL SERVICES D9000-D9999

Except when medically necessary, the Medicaid Program does not cover general anesthesia for removal of erupted teeth. General anesthesia performed at an ambulatory surgical center, hospital or other medical facility may be covered under Utah’s “Medicaid Fee-for-Service” Program. Delta Dental and contracted network dentists do not administer any services under that plan. Medicaid does not cover nitrous oxide (D9230), other drugs including oral sedation (D9630) and/or behavior management (D9920). Oral sedation medications may be covered under the members Medicaid pharmacy program by prescription only.

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Adjunctive General Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain - minor procedure</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Responsibility for palliative treatment, even for teeth that may meet specialty care referral guidelines, is that of the PCP. Palliative services are applicable per visit, not per tooth, and include all treatment provided during the visit other than necessary radiographic images. A description of emergency and palliative treatment should be documented. Delta Dental benefits include D9110 and other listed covered services performed in a dental office to treat a dental emergency when an unforeseen, sudden and acute onset of symptoms or injuries requires immediate treatment and where delay in treatment would jeopardize or cause permanent damage to a person’s dental or medical health. Through its Medicaid Fee-for-Service program, the Utah Department of Health is solely responsible for:  ✓ Facility charges for hospital and ambulatory surgical centers.  ✓ Medical and surgical services of a provider, including general anesthesia performed at a hospital or ambulatory surgical center.  ✓ Emergency services provided in an emergency department.  ✓ Services performed at an Indian Health Services (IHS) or tribal facility, an Urban Indian Facility (UIF), the state hospital or state developmental center.</td>
</tr>
</tbody>
</table>
## Section 7 Covered Services and Guidelines

### ADJUNCTIVE GENERAL SERVICES D9000-D9999

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Adjunctive General Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No Cost</td>
<td>No Cost</td>
<td>General anesthesia is a covered service for patients that meet age and/or other criteria:</td>
</tr>
<tr>
<td>D9223</td>
<td>Deep sedation/general anesthesia - each 15 minute increment</td>
<td>No Cost</td>
<td>No Cost</td>
<td>a) For patient 4 years of age or younger, prior authorization is not required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>b) Patient is at least 5 years of age with a physical or mental disability. Document the physical or mental disability that justifies the use of general anesthesia.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>c) Patient is 5 - 8 years of age and without physical or mental disability; the patient must have a documented condition such as a failure and inability to treat when using a premedication which justifies the use of general anesthesia.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>d) Patient is at least 9 years of age and without physical or mental disability; the patient must have a documented condition such as a failure and inability to treat when using a pre-medication that justifies the use of general anesthesia, OR in conjunction with the extraction of a partial or full boney impacted third molar.</td>
</tr>
<tr>
<td>D9243</td>
<td>Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Member’s record MUST include detailed documentation about the physical or mental disability or other condition that necessitates use of I.V. sedation. Anxiety does not qualify as a medical condition. Prior authorization is not required when service is performed by a dentist with state licensure to perform I.V. sedation.</td>
</tr>
</tbody>
</table>
### Section 7 Covered Services and Guidelines

#### ADJUNCTIVE GENERAL SERVICES D9000-D9999

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Adjunctive General Services</th>
<th>EPSDT Under 21</th>
<th>Pregnant Adult</th>
<th>Processing guidelines, Limitations and Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9248</td>
<td>Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D9310</td>
<td>Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D9420</td>
<td>Hospital or ambulatory surgical center call</td>
<td>No Cost</td>
<td>No Cost</td>
<td></td>
</tr>
<tr>
<td>D9440</td>
<td>Office visit - after regularly scheduled hours</td>
<td>No Cost</td>
<td>No Cost</td>
<td>D9440 is only to be submitted for an office visit that occurred after the regular business day, which is considered to be from 8 a.m. to 5 p.m. and typically involves a dental emergency. Only used for instances when provider is called away from home to return to the office in the evening, night or early morning, or on a non-business day when staff is not present, to treat an emergency condition which cannot be scheduled.</td>
</tr>
<tr>
<td>D9930</td>
<td>Treatment of complications (postsurgical) - unusual circumstances, by report</td>
<td>No Cost</td>
<td>No Cost</td>
<td>Covered only when provided by an oral surgeon.</td>
</tr>
<tr>
<td>D9951</td>
<td>Occlusal adjustment - limited</td>
<td>No Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| D9999    | Unspecified adjunctive procedure, by report                                                  | No Cost        | No Cost        | The following are **REQUIRED**:  
  ✓ Prior authorization  
  ✓ X-rays, as appropriate  
  ✓ Narrative  |
Section 8  Specialty Referral Guidelines

These guidelines set forth the required steps by procedure code and type of provider making the referral (e.g. general dentist, pediatric provider, endodontist, periodontist, oral surgeon and orthodontist).

Failure to follow any of these guidelines may result in financial penalties. All referred procedure codes listed in this section are subject to a member’s specific plan benefits, limitations and exclusions. Please refer to Section 7 for detail information about the Utah Medicaid Covered Dental Services and Limitations. Reimbursement of specialty services is contingent upon the member’s eligibility at the time of service.

Questions concerning emergency treatment, member eligibility, a referral, prior authorization or claim should be directed to Delta Dental’s Provider Customer Service at 866-616-1475.

Submit prior authorization and claims to:
   Claims payer #DDCA2
Or mail to: Delta Dental Insurance Company
   Re: Utah Medicaid Dental Services
   P.O.Box 1810
   Alpharetta, GA 30023

Failure to use the proper forms or submission option listed above may cause delays in processing and/or payment.

X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality, including paper copies of digitized images, are acceptable.
Section 8 Specialty Referral Guidelines

ENDODONTICS REFERRAL GUIDELINES D3000-D3999

Referral Guidelines:
- Confirm the need for a referral.
- Refer members to a contracted Delta Dental network endodontist. Select an endodontist from the Utah Medicaid provider directory, available at deltadentalins.com/ut-medicaid.
  - Please contact Provider Customer Service at 866-616-1475 for assistance in selecting a network endodontist if needed.
- Either provide the member with a copy of the pre-operative x-ray(s) or forward these directly to the endodontist.
- Inform the patient that:
  - Referrals are subject to a member’s program-specific benefits, limitations and exclusions.
  - The patient will be financially responsible for non-covered services provided by the endodontist.
  - Payment is subject to eligibility at the time services are rendered.

Note: Delta Dental will review the documentation when the endodontist submits a prior authorization request and/or claim. All verbal/emergency authorization is subject to consultant review.

Guidelines for the Endodontist:
- Prior to services being rendered, endodontists must:
  - Check member’s eligibility to ensure he/she is eligible on the date of service.
- For non-covered services, endodontist are required to collect any payment from the member directly.

X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality, including paper copies of digitized images, are acceptable.
PERIODODONTICS REFERRAL GUIDELINES D4000-D4999

Referral Guidelines:

- Confirm the need for a referral and that the referral criteria listed on the following table are met.
- Provider/facility must refer members to a contracted Delta Dental network periodontist. Select a periodontist from the Utah Medicaid provider directory, available at deltadentalins.com/ut-medicaid.
- Please contact Provider Customer Service at 866-616-1475 for assistance in selecting a network periodontist if needed.
- Either provide the member with a copy of the pre-operative x-ray(s), complete periodontal charting showing six-point probing of each natural tooth and any furcation involvements, abnormal mobility or areas of recession, or forward these directly to the periodontist.
- Inform the patient that:
  - The patient will be financially responsible for non-covered services provided by the periodontist.
  - Payment is subject to eligibility at the time services are rendered.

Note: Delta Dental will review the documentation when the periodontist submits a Prior authorization request and/or claim. All verbal/emergency authorization is subject to consultant review.

Guidelines for the Periodontist:

- Obtain the full mouth x-rays and/or pre-operative periapical x-rays and periodontal charting from the facility or member.
- Prior to services being rendered, periodontist must:
  - Check member’s eligibility to ensure he/she is eligible on the date of service.
- For emergency periodontics services, please contact Provider Customer Service at 866-616-1475 for an emergency authorization number if a pre-authoriziation is required. Periodontists must submit a written prior authorization request when required for all other proposed non-emergency treatment.
- After completion of treatment, submit your claim for payment with prior authorization number in the comment section of the claim form. If emergency care was completed, include the emergency authorization number on the claim form and attach pre-operative x-ray(s).
- For non-covered services, periodontists are required to collect any payment from the member directly.

X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality, including paper copies of digitized images, are acceptable.
### PERIODONTICS REFERRAL GUIDELINES D4000-D4999

**AMERICAN DENTAL ASSOCIATION and AMERICAN ACADEMY OF PERIODONTOLOGY CASE TYPES AND COVERAGE**

<table>
<thead>
<tr>
<th>AMERICAN DENTAL ASSOCIATION and AMERICAN ACADEMY OF PERIODONTOLOGY CASE TYPES AND REFERRAL COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gingivitis associated with dental plaque</strong></td>
</tr>
<tr>
<td><strong>Slight chronic or aggressive periodontitis (Localized or generalized)</strong></td>
</tr>
<tr>
<td><strong>Moderate chronic or aggressive periodontitis, (Localized or generalized)</strong></td>
</tr>
<tr>
<td><strong>Severe chronic or aggressive periodontitis (Localized or generalized)</strong></td>
</tr>
<tr>
<td><strong>Severe chronic or aggressive periodontitis is eligible for specialty referral.</strong></td>
</tr>
</tbody>
</table>

Severe chronic or aggressive periodontitis is eligible for specialty referral.

Defined as a periodontitis case that treatment fails to arrest the progression of periodontitis – whatever the thoroughness or frequency – as well as recurrent disease at single or multiple sites.
Section 8 Specialty Referral Guidelines

ORAL SURGERY REFERRAL GUIDELINES D7000-D7999

Referral Guidelines:
► Confirm the need for a referral.
► Facility must refer members to a contracted Delta Dental network oral surgeon. Select an oral surgeon from the Utah Medicaid provider directory, available at deltadentalins.com/ut-medicaid.
  ◆ Please contact Provider Customer Service at 866-616-1475 for assistance in selecting a network oral surgeon if needed.
  ◆ Either provide the member with a copy of the panoramic or periapical x-rays or forward these directly to the oral surgeon.
► Inform the patient that:
  ◆ The patient will be financially responsible for non-covered services provided by the oral surgeon.
  ◆ Payment is subject to eligibility at the time services are rendered.

Note: Delta Dental will review the documentation when the oral surgeon submits a Prior authorization request and/or claim. All verbal/emergency authorization is subject to consultant review.

Guidelines for the Oral Surgeon:
► Obtain the pre-operative periapical or panoramic x-rays from the facility or member.
► Prior to services being rendered, oral surgeon must:
  ◆ Submit a prior authorization request when required to Delta Dental with a copy of pre-operative periapical x-rays or panoramic x-ray.
  ◆ Check member’s eligibility to ensure he/she is eligible on the date of service.
► For emergency endodontic services, please contact Provider Customer Service at 866-616-1475 for an emergency authorization number. The oral surgeon must submit a written prior authorization request, when required for all other proposed non-emergency treatment.
► After completion of treatment, submit your claim for payment with prior authorization number in the comment section of the claim form. If emergency care was completed, include the emergency authorization number on the claim form and attach a pre-operative and post-operative x-rays. For a biopsy, also attach a copy of the laboratory’s report.
► For non-covered services, the oral surgeon is required to collect any payment from member directly.

X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality, including paper copies of digitized images, are acceptable.
ORTHODONTIC REFERRAL GUIDELINES D8000-D8999

Medicaid only covers comprehensive treatment. Patients must score 30 or more using the Salzmann Index. The Salzmann Index means the “Handicapping Malocclusion Assessment Record” by J. A. Salzmann, used for assessment of handicapping malocclusion, as adopted by the board of directors of the American Association of Orthodontists and the Council on Dental Health of the American Dental Association.

Medicaid provides orthodontic services for children who have a handicapping malocclusion due to birth defects, accidents, or abnormal growth patterns of such severity that it renders them unable to masticate, digest or benefit from their diet.

Referral Guidelines:
A score of 30 points or more must be achieved to be eligible for comprehensive orthodontic treatment under the Utah Medicaid dental Program. Complete and submit a Delta Dental specialty referral or claim form and inform the member that:

- The dentist/orthodontist will be required to submit a request for prior authorization and receive authorization prior to initiating orthodontic treatment. This prior authorization request should be mailed to: Delta Dental Insurance Company, Re: Utah Medicaid, PO Box 1810, Alpharetta, GA 30023.
- The member will be financially responsible for non-covered services provided by the orthodontist.
- Payment by the Plan is subject to eligibility at the time services are rendered.

Guidelines for the Dentist/Orthodontist:
- Once you have obtained models and necessary diagnostic imaging, complete a Salzmann’s Handicapping Malocclusion Assessment record.
- Submit a request for prior authorization; include a copy of the Salzmann’s Assessment record, orthodontic models, wax bite and diagnostic imaging.
- A Delta Dental orthodontic consultant will evaluate the case and score the case using the Handicapping Malocclusion Assessment Record. A score of 30 or above is necessary in order for the case to qualify for orthodontic treatment. If the case score is 30 or above, the orthodontic office will receive an authorization from Delta Dental.
- You may initiate treatment only after you have received authorization to perform orthodontic treatment. After the member is banded, submit your claim to the Plan for payment.
Section 8  Specialty Referral Guidelines

ORTHODONTIC REFERRAL GUIDELINES D8000-D8999

A. INTRA-Arch Deviations
The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the “Handicapping Malocclusion Assessment Record.” The scoring can be entered later.

1. Anterior Segment
A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated.

A tooth scored as crowded is not scored also as rotated. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced. A tooth must be rotated 30 degrees or more to be scored on the Salzmann Index per Medicaid policy.

Spacing:
Open spacing refers to tooth separation that exposes to view the interdental papillae on the alveolar crest. Score the number of papillae visible (not teeth).

Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior Segment
A value of 1 point is scored of each tooth affected.

Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced. A tooth must be rotated 30 degrees or more to be scored on the Salzmann Index per Medicaid policy.

Spacing:
Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).

Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.
Section 8  Specialty Referral Guidelines

B. INTER-Arch Deviations
When casts are assessed for inter-arch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior Segment
A value of 2 points is scored for each affected maxillary tooth only.

Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.

Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.

Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.

Open-bite refers to vertical inter-arch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.

Spacing:
Open spacing refers to tooth separation that exposes to view the interdental papillae on the alveolar crest. Score the number of papillae visible (not teeth).

Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior Segment
A value of 1 point is scored for each affected tooth.

Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.

Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.

Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.
Section 9 Member Rights and Protections

MEMBER RIGHTS AND PROTECTIONS

Members Rights:

1. Members have the right to get correct information that is easy to understand.
2. Members have the right to get information on the Prepaid Ambulatory Health Plans.
3. Members have the right to get information on all the treatment choices available to them.
4. Members have the right to receive services that are:
   a. Covered by dental plan.
   b. Plan’s standards for access to care.
   c. Meet plan’s standards for quality of care.
5. Members have the right to know their dentists are paid. They have a right to know about what those payments are and how they work.
6. Members have the right to know:
   a. How Delta Dental decides if a service is covered.
   b. How Delta Dental decides of a service is medically necessary.
   c. Who at Delta Dental makes those decisions
7. Members have the right to know the names of your PDP and other Delta Dental providers.
8. Members have the right to pick from a list of providers that is large enough so that you can get the right kind of care when you need it.
9. Members have the right to take part in all the choices and decisions about your dental care. This includes your right to refuse treatment.
10. Members have the right to speak for themselves or their child in all treatment choices.
11. Members have the right to get a second opinion from another provider about what kind of treatment they or their child need.
12. Members have the right to ask for and receive a copy of their medical records. They also have the right to ask that they be amended or corrected.
13. Members have the right to be treated fairly by Delta Dental dentists and other providers. If a member thinks they have been treated unfairly, call the U.S. Department of Health and Human Services at 1-800-368-3019.
14. Members have the right to be treated with respect and with due consideration for their dignity and privacy.
15. Members have the right to:
   a. Talk to their dentists and other providers in private
   b. To have dental records kept private
   c. To look over and copy their dental records
   d. To ask for changes to those records.
16. Members have a right to know that providers who treat them can advise about:
   a. Health status
   b. Dental care
   c. Treatment
Section 9 Member Rights and Protections

Providers include:

- Dentists
- Hospitals
- Other providers

Delta Dental will not prevent a provider from providing information, even if the care or treatment is not a covered service.

17. Members have a right to know they are not responsible for paying for covered services. Providers cannot require a member to pay any other amounts for covered services.

18. Member have the right to get medical care no matter what race, color, nationality, disability, sex, religion or age.

If a member has any questions about that right, call the:
Nondiscrimination coordinator at 1-866-467-4219 or the
- U.S. Department of Health and Human Services (HHS) at 1-800-368-3019.
- Members have the right to file a Grievance if they think any of their member rights have been violated.

1. Members have the right to be free to exercise all member rights without being treated in a negative way by:
- The Utah Department of Health
- Delta Dental
- Any plan provider

2. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

For more information about member’s rights, go to the HHS Office of Civil Rights website at www.hhs.gov/ocr.

Member Protections:

1. Follow healthy habits.
2. Be involved in the dentist’s decisions.
3. Work with provider to pick treatments that you have all agreed are the best ones for you or your child.
4. If Member has a disagreement with Delta Dental, they must try first to resolve it using Delta Dental’s Grievance process.
5. Member’s responsibility to learn about what Delta Dental Medicaid does and does not cover.
6. Member’s are required to try to get to the dentist’s office on time. If they cannot keep the appointment, be sure to call and cancel it.
7. Member’s must report waste, abuse and fraud.

You can view additional information at HHS Office of Civil Rights online at www.hhs.gov/ocr.
Section 10  Forms

- Delta Dental Prior Authorization Request/Claim Form
- Salzmann Index
- Member Grievance and Appeal Form

Forms are also available online: deltadentalins.com/dentists/ref/ut-medicaid.html
Utah Medicaid Dental Services

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<th>Relation to Subscriber</th>
<th>If Full Time Student</th>
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<th>City</th>
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<th>DENTIST’S PRE-TREATMENT ESTIMATE OF CHARGES</th>
<th>DENTIST’S STATEMENT OF ACTUAL CHARGES</th>
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<th>X-RAYS OR MODELS ENCLOSED. HOW MANY?</th>
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</tbody>
</table>

**FACIAL**

Teeth or Letter | Surface or Crown | DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis, Materials Used, etc.) | Date Service Performed | Procedure Number | Fee | Allowance |

I hereby accept the foregoing treatment plan and authorize release of information relating hereto. I certify the truth of all personal information above. I authorize payment directly to the named dentist and agree to be responsible for payment for services rendered during an insurable period.

Subscriber’s Signature | - | The Treatment listed is necessary in my professional judgment | - | - | - | - | - | - | - | - | - |

Dentist’s Signature | Date | - | - | - | - | - | - | - | - | - | - |

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose if misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. 18 Pa.C.S. § 4117(A)(1)
A score of 30 points or more must be achieved to be eligible for comprehensive orthodontic treatment under the Utah Medicaid dental program.
Delta Dental Salzmann Index - Handicapping Malocclusion Assessment Record (Page 2)

Delta Dental
UTAH MEDICAID DENTAL PROGRAM

<table>
<thead>
<tr>
<th>PLEASE COMPLETE THE FOLLOWING IN DETAIL:</th>
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<tr>
<td>DESCRIPTION OF PATIENT'S CONDITION AND DIAGNOSIS</td>
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Instructions for Completing the Salzmann Index Evaluation

Introduction
This assessment record is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment.

A. Intra-Arch Deviations
The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the “Handicapping Malocclusion Assessment Record.” The scoring can be entered later.

1. Anterior segment: A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.
   - Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
   - Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
   - Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.
   - Spacing:
     - Open spacing refers to tooth separation that exposes to view the interdental papillae on the alveolar crest. Score the number of papillae visible (not teeth).
     - Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior segment: A value of 1 point is scored of each tooth affected.
   - Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
   - Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
   - Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.
- **Spacing:**
  - Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).
  - Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

**B. Inter-Arch Deviations**

When casts are assessed for inter-arch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. **Anterior segment:** A value of 2 points is scored for each affected maxillary tooth only.
   - **Overjet** refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.
   - **Overbite** refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.
   - **Cross-bite** refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.
   - **Open-bite** refers to vertical inter-arch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.

2. **Posterior segment:** A value of 1 point is scored for each affected tooth.
   - **Cross-bite** refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.
   - **Open-bite** refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.
   - **Anteroposterior deviation** refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.
Please return your completed Grievance/Appeal form to Delta Dental Insurance Company, Quality Management Department, P.O. Box 1860, Alpharetta, GA 30023. If you need help filling out this form, please call us. We have translators and help for those with hearing problems. For Medicaid Providers only, the toll-free number is 1-866-616-1475. Medicaid Members can call 1-866-467-4219 toll-free. The Hearing Impaired can call TTY 7-1-1 (Relay Utah).

### About this Issue (Please check the boxes below to answer.)

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<tr>
<th>Who is filing this Grievance or Appeal?</th>
<th>□ Member</th>
<th>□ Provider (requires the member’s written permission)</th>
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<td></td>
<td>□ Other authorized representative on the member’s behalf.</td>
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<tr>
<td>How is this complaint being filed?</td>
<td>□ With this form</td>
<td>□ A call was already made to the Contact Center to file it.</td>
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<td>Is this about an Action to end or</td>
<td>□ No</td>
<td>□ Yes</td>
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<td>decrease any dental services?</td>
<td></td>
<td>□ I want the service(s) during the Appeal.</td>
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<td>Is a Quick Decision needed?</td>
<td>□ No</td>
<td>□ Yes, the member’s life or health is in real danger.</td>
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### Member Information:

- **Member Name:**
- **Member ID Number:**
- **Telephone Number:**
- **Address:**
  - **City:**
  - **State:**
  - **ZIP:**

### Provider Information:

If submitted by the Member, complete the DDIC Facility Name and Number, if known, as well any other information.

- **Provider Name:**
- **License:**
- **NPI:**
- **DDIC Facility Name:**
- **DDIC Facility Number:**
- **Telephone Number:**
- **Address:**
  - **City:**
  - **State:**
  - **ZIP:**

### What is your Grievance or Appeal about?

If needed, you can attach a page and tell us more about your complaint. If this complaint is about a Grievance decision we have made or a Delta Dental Action, please attach a copy of the letter or Notice of Action sent to the member.

### Release of Medical Records

This signed release allows us to get dental records and other information needed to review your Grievance or Appeal. To be accepted, this form must be signed and dated below by member or the member’s authorized representative.

- **Signature:**
- **Print Name:**
- **Date:**

If signed by the member’s authorized representative, what is your relationship to the member?