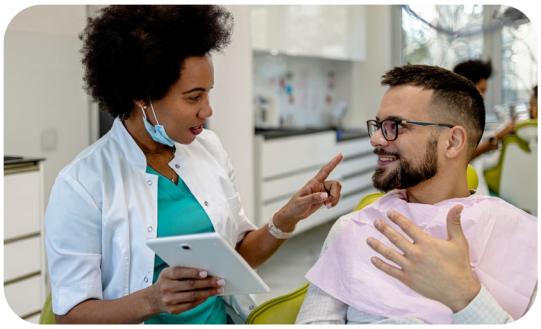
Medicare Clinical Reference Guide



CENTENE™

DENTAL SERVICES

The ***Centene Dental Services Medicare Clinical Reference Guide*** is a supplement to the more comprehensive Provider Manual, Medicare Plan Specs, and clinical policies. It provides a quick and easy source to help dental offices navigate member benefit information, understand prior authorization requirements, and facilitate submission of prior authorizations and claims for review and processing.

The Clinical Reference Guide includes the following sections: Common Links to valuable information; helpful information to facilitate submission of documentation required for certain services identified as requiring prior authorization review; and medical necessity and documentation requirements for the most frequently identified dental procedures requiring prior authorization review.

Common Links to Important Centene Dental Services Benefit Information

The following Internet links will take you to important and valuable Centene Dental Services benefit administration information.

Website	envolvedental.com
Secure Provider Web Portal	envolvedental.com/logon
Online CDT Code Search Tool	envolvedental.com/cdt
Dental Clinical Policies	envolvedental.com/policies
Member ID Card Copies and Phone Numbers	envolvedental.com/mystate
Online Medicare Benefit Summary Tool	envolvedental.com/benefits

Clinical Criteria and Required Documentation

This section lists Medicare clinical policy highlights and documentation requirements for most of the dental procedures targeted for Prior Authorization review. Our policies ultimately determine the disposition of claims and authorizations and can be found using the link above.

When submitting dental services for prior authorization, the submission must include the required documentation to support the requested code(s).

Procedure-Specific Clinical Criteria Requirements

Crowns

- Teeth with completed root canal treatment
  - All canals must be filled completely and to within 2.0 mm of the radiographic apex
  - The tooth must have a minimum of 50% remaining bone support
  - There must be no evidence of periodontal furcation involvement
  - There must be no presence of subcrestal caries
- Teeth without root canal treatment
  - Anterior – there must be a loss of at least 50% incisal edge or 4+ surfaces involved
  - Bicuspid – there must be at least 1 cusp undermined or 3+ surfaces involved
  - Molar – there must be at least 2 cusps undermined or 4+ surfaces involved
  - There must be no evidence of periodontal furcation involvement
  - No evidence of subcrestal caries
- The completion and billable date is date of final cementation

Core Buildups

- There must be insufficient tooth structure (loss of 50% or more of the natural crown due to decay, fracture, or a defective restoration) remaining to provide adequate retention for a full coverage indirect restoration
- Not covered when used as a filler to correct undercuts or other irregularities in the tooth preparation
- No evidence of caries within 2.0 mm of the crestal bone
- The tooth must have at least 50% remaining bone support

Root Canals

- There must be a minimum of 50% remaining bone support
- There must be no evidence of periodontal furcation involvement
- No evidence of subcrestal caries
- There must be no evidence of apical pathology or fistula
- There must be evidence of pain from percussion or temperature tests when no other clinical signs or symptoms are present
- Each tooth root must have a closed apex
- For primary teeth to qualify, there must be no permanent anterior or posterior successor tooth
- The completion and billable date is date of final fill

Scaling and Root Planing

- D4341
  - Four or more teeth must be in the quadrant
  - There must be evidence of both 5+ mm pocketing on 2 or more teeth indicated on the periodontal charting and presence of root surface calculus and/or noticeable loss of bone support on the bitewing radiographs (panoramic radiographs are not diagnostic for periodontitis)
  - No more than two quadrants will be reimbursed on the same date of service unless extraordinary circumstances are documented and submitted
- D4342
  - One to three teeth must be present in the quadrant
  - There must be evidence of both 5+ mm pocketing on 1 or more teeth indicated on the periodontal charting and presence of root surface calculus and/or noticeable loss of bone support on the bitewing radiographs (panoramic radiographs are not diagnostic for periodontitis)
  - No more than two quadrants will be reimbursed on the same date of service unless extraordinary circumstances are documented and submitted

Procedure-Specific Clinical Criteria Requirements

Localized Delivery of Antimicrobial Agents

- There must be at least 28 days of healing for tissue to respond after scaling and root planing
- Re-evaluation after the 28-day healing period must show residual pockets of at least 5 mm AND inflammation must also be present in those pockets
- Requested services not meeting both of the above criteria will be adjudicated as not medically necessary

Full Mouth Debridement to Enable Completion of a Comprehensive Periodontal Evaluation

- There must be no history of prophylaxis or periodontal treatment within the previous 12 months
- There must be extensive coronal calculus on at least 50% of teeth
- There must be an inability to visualize teeth and supporting structures to complete a comprehensive periodontal evaluation

Full Mouth Scaling in the Presence of Generalized Moderate to Severe Gingivitis

- There must be no history of prophylaxis or periodontal treatment within the previous 12 months
- Extensive supra- and sub-gingival coronal calculus must be present on at least 50% of teeth

Complete Dentures

- The existing denture must be greater than 60 months old
- The remaining teeth do not have adequate bone support or are non-restorable
- The standard for all dentures, whether seated immediately after extractions or following alveolar healing, is that the dentures be fully functional
- All adjustments are included in the denture reimbursement for the first 6 months
- The completion and billable date is date of final insertion
- Extractions for immediate dentures must be completed and submitted prior to or on the same date the immediate denture is delivered (completion date)

Partial Dentures

- The existing partial denture must be greater than 60 months old
- Remaining teeth must have greater than 50% bone support and be restorable
- Furcation involvement must not be present
- All adjustments are included in the partial denture reimbursement for the first 6 months
- Completion and billable date is date of final insertion

Implants (Only When Specifically Listed as a Covered Benefit)

- Implants are not covered by every plan. Always verify implants are a covered plan benefit
- Implants must have sufficient bone present to cover the entire implant circumferentially
- A bone graft and guided tissue regeneration membrane are only deemed medically necessary if the implant is being placed as an immediate implant in the site of an extracted tooth
- Bone grafts and membranes not placed in an osteotomy created from an extraction socket created less than six months previously must be documented to demonstrate medical necessity for the procedures

Surgical Removal of an Erupted Tooth (Surgical Extraction)

- The tooth must have greater than 50% remaining bone support
- Presence of periapical pathology or furcation involvement
- Presence of gross carious lesion or large existing restoration
- Presence of curved or dilacerated root
- In addition to any of the above criteria, the extraction must require removal of bone and/or sectioning of tooth (elevation of tissue flap may be necessary)

Impacted Teeth (Asymptomatic Impactions will not be Approved)

- At least one of the following two conditions must be present:

Procedure-Specific Clinical Criteria Requirements

- Documentation describes pain, swelling, etc. around tooth (documentation in the patient record includes tooth number and symptomology)
- The tooth impinges on the root of an adjacent tooth, is distally, mesially, or horizontally impacted, or shows a documented enlarged tooth follicle or potential cystic formation

And;

- Documentation supports procedure for unusual surgical complications (if needed)
- The radiograph(s) match the description of the impaction code reported

Surgical Removal of Residual Tooth Roots

- Requires evidence of failed extraction by another provider or provider group resulting in a retained root(s)
- Residual root removal must be performed by a different provider or provider group when extraction of root was unsuccessful by initial provider
- The residual root removal must involve sectioning of the remaining tooth structure and/or removal of bone
- Evidence demonstrates root removal cannot be accomplished with an elevator or forceps without sectioning the root or removing bone

General Anesthesia / IV Sedation (Dental Office Setting)

- Involves the extraction of impacted teeth or surgical exposure of unerupted cuspids
- Involves 2 or more extractions in 2 or more quadrants
- Involves 4 or more extractions in 1 quadrant
- Involves excision of lesions greater than 1.25 cm
- Involves surgical recovery from the maxillary antrum
- There must be documentation of failed local anesthesia patient record
- There must be documentation of specific patient behavior of severe situational anxiety in patient record
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, or condition that would render patient noncompliant) noted in the patient record

Non-Intravenous Conscious Sedation (Dental Office Setting)

- Involves the extraction of impacted teeth or surgical exposure of unerupted cuspids
- Involves 2 or more extractions in 2 or more quadrants
- Involves 4 or more extractions in 1 quadrant

Procedure-Specific Clinical Criteria Requirements

- Involves excision of lesions greater than 1.25 cm
- Involves surgical recovery from the maxillary antrum
- There must be documentation of failed local anesthesia patient record
- There must be documentation of specific patient behavior of severe situational anxiety in patient record
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, or condition that would render patient noncompliant) noted in the patient record

Hospital Operating Room or Outpatient Facility

- Patients requiring extensive operative procedures (such as multiple restorations, treatment of abscesses, or oral surgical procedures), when in-office treatment (nitrous oxide, GA / IV sedation, or oral sedation) is not appropriate or available and hospitalization is not solely based upon reducing, avoiding, or controlling apprehension; or
- Individuals requiring extensive dental procedures and classified by the American Society of Anesthesiologists (ASA) as Class 3 or Class 4; or
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during dental procedures; or
- Individuals requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate; or
- Individuals requiring extensive dental procedures who have documentation of significant behavioral health conditions or psychiatric disorders that require special treatment (e.g., severe panic disorder); or
- Cognitively disabled individuals requiring extensive procedures whose prior history indicates hospitalization is appropriate; or
- Hospitalized individuals who need extensive restorative or surgical procedures

Diagnostic Radiographs

All teeth or areas involved in the treatment request must be visible on radiographs. Radiographs presented for review must meet the following specific criteria:

- All radiographic images must be clearly readable and free from defect
- The density and clarity must be such that interpretation can be made without difficulty

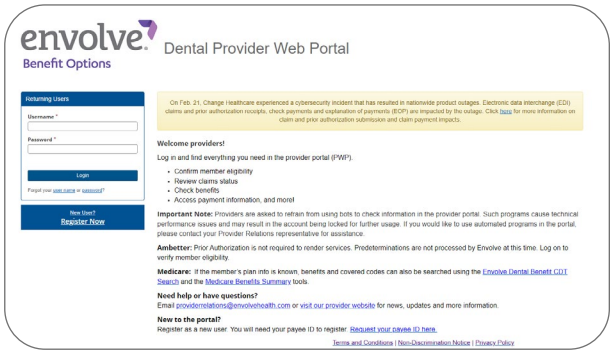
Radiographic images should be labeled with the member's name, ID number and date of the radiograph. When it is necessary to send hard copy image, a prior authorization request should be submitted online, and the radiograph attached to a printed copy of the prior authorization.

- Digital radiographs should be attached to the prior authorization when submitted via any method.
- When using the Envolve Dental Provider Web Portal (**PWP**), attachments can be added after submitting the request. Select *Create Attachment* on Pending Request ID Screen.
- All clinical crowns and root tips must be observable on periapical radiographs. Bitewing radiographs should have reduced overlap. Panoramic radiographs must be free of errors.
- Defective, non-diagnostic or illegible radiographs will not be considered for review and must be remade without additional cost to the Envolve Dental or the member.
- If the total allowed reimbursement for radiographs performed on a member exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a D0210 (Complete Series). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

Prior Authorization Administrative Submission Guidelines

To determine codes that require prior authorization please use the Online CDT Code Tool at envolvedental.com/cdt. When possible, authorization requests should be received at least 14 calendar days in advance of services being rendered. These may be submitted on the Envolve Dental PWP at envolvedental.com/logon or:

- Electronic clearinghouses, using payor ID number 46278
- Alternative pre-arranged HIPAA-compliant electronic files
- Paper request typed on a current (2019 or later preferred) ADA original claim form (copies and handwritten or faxed forms are not accepted)



We use the same electronic and paper formats to process authorization requests as well as claims. Please refer to the Claims and Billing section for more details on using these formats to submit authorization requests, including imaging requirements.

Urgent/Emergent Qualified Situations and Definition

Members who have an urgent or emergent condition should be treated immediately for covered benefits. It is essential that proper records are taken to support the emergency when the claim is submitted demonstrating medical necessity. An urgent or emergent condition is defined as a situation involving oral or facial-related severe acute pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. A member's vacation plans, opportunity to fill an open appointment spot, or other personal considerations do not meet urgent/emergent requirements.

Urgent/Emergent Care Claim Submission Guidelines

For urgent/emergent requests, submit your authorization request and notate “Expedited Request” in the PWP, on your clearinghouse, or with your paper submission. The secure provider portal is the preferred method for submitting authorizations. The provider must be a registered user on the portal. If the provider is not already a registered user on the portal and needs assistance or training on submitting prior authorizations, the provider should contact their Provider Relations representative.

Electronic Claims Submission via PWP or Electronic Clearinghouse

Network providers are encouraged to submit claims and encounters electronically through our PWP or selected electronic clearinghouses. Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims.

Providers who bill electronically must monitor their error reports and explanations of payments (EOPs) to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters within your state or product-specified timeframe.

Electronic Claims Using the Provider Web Portal (PWP)

The PWP (envolvedental.com/logon) is user-friendly and is the fastest way for claims to be processed and paid. Our secure web portal has specific fields to enter all required information. It also contains an upload feature to attach all required documents, x-rays, and other supporting information. To avoid claim denials or delayed payments, refer to the corresponding dental codes to ensure you include all required information before submitting.

Use of Electronic Clearinghouses and Attachments

We work with selected electronic clearinghouses to facilitate dental offices that use one electronic source for all their insurances. Please check with your preferred vendor so that your software is up to date and confirm your first submission using the clearinghouse was successful before sending additional claims. Electronic attachments may be available with your preferred clearinghouse or can otherwise be submitted to us as listed below:

- Use payor ID number 46278 for all clearinghouses.
- We can accept attachments from FastAttach, Change Healthcare or DentalXchange.
- When submitting electronic files, please use the product identifiers found in the plan specifics available on the PWP and on the Medicare tab under Provider Resources at envolvedental.com.

If you use a different electronic clearinghouse and would like us to consider participating, please send your request to Customer Service. Include your practice name, technical contact details and average monthly claim volume.

Alternate HIPAA-Compliant Electronic Submission

Electronic claim submissions must be HIPAA-compliant. We strongly recommend using our custom PWP for all claim submissions because we stay current with HIPAA regulations. If your office uses an alternative electronic claims system that requires direct integration using an 837D file, we consider options to assist. To schedule an appointment with our technical specialists to discuss alternatives, please call or email Customer Service.

Paper Claims

The following information must be included on a current (2019 or later preferred) ADA original claim form for timely claims processing:

- Member name
- Member ID number
- Member date of birth
- Provider name
- Provider location and service setting
- Billing location
- NPI and Tax ID number (TIN)
- Date of service for each service line
- ADA dental codes in the current CDT book for each service line
- Provider signature

Be sure to include all required identifiers (quadrants, tooth numbers, and surfaces). Mail Medicare paper claims with any required supporting documentation to:

Envolve Dental Medicare Claims
PO Box 23768
Tampa, FL 33623-3768

Claims Imaging Requirements

We use an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

DOs

- Do send claims to the P.O. box designated in the applicable Plan Specific
- Do submit all claims in a 9-by-12-inch or larger envelope
- Do type all fields completely and correctly
- Do submit on a current (2019 or later preferred) ADA original claim form

DON'Ts

- Don't submit handwritten claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax

Corrected Claim Submission Guidelines - Medicare

Providers who receive a claim denial due to incorrect or missing information can submit a "corrected claim" (also known as a claim adjustment) on a current ADA original claim form **within the claims timely filing limit of one calendar year from the date of service**. Claims are considered "corrected claims" if at least one code on the original submission was denied due to missing information, such as a missing tooth number or surface identification, an incorrect member ID and/or an incorrect code. If a service was denied for clinical reasons or medical necessity, do not submit a corrected claim; please refer to your plan-specific document for how to appeal clinical and medical necessity denials.

To submit a corrected claim, providers may mail the corrected claim or resubmit the claim through the PWP as follows:

- Complete a current (2019 or later preferred) ADA original claim form with:
  - ALL codes originally submitted, including accurate code(s) and the corrected code(s), even if previously paid.
  - ALL required documentation only for the corrected, unpaid codes.
  - "CORRECTED CLAIM" typed on the top of the form, with the original claim number.
- Corrections must be indicated on a current (2019 or later preferred) ADA original claim form as follows:
  - Make the correction on the service line that was in error (for example, cross through the error and write in correct information).
  - In the "Remarks" section of the form (box 35), write in the details of the correction (for example, add a tooth number, change to accurate service date, code, etc.).
  - Do NOT highlight any items on the form. Doing so prevents our scanners from importing the information.
  - Mail with correct postage to the address listed in the Plan Specifics.

Corrected claim determinations are published on your remittance statement within 30 days of Envolve Dental receiving the corrected claim.

Appeals

An appeal is the mechanism for providers to request a reconsideration of actions by us, such as a claim denial, or if the provider is aggrieved by any rule, policy or decision made by us. Please refer to the Medicare Plan Specifics available under Provider Resources at envolvedental.com for provider appeal details.

Provider Relations Department

Please contact our Provider Relations department at ProviderRelations@envolvehealth.com for questions arising out of this guide or for how to navigate participation with us.