

Beneficiary by entering your 6 digit DentaQuest location number, the Beneficiary's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below.

Directions for using DentaQuest's IVR to verify eligibility:

1. Call DentaQuest Customer Service at 1.888.875.7482.
 2. After the greeting, stay on the line for English or press 1 for Spanish.
 3. When prompted, press or say 2 for Eligibility.
 4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
 5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
 6. Does the Beneficiary's ID have numbers and letters in it? If so, press or say 1. When prompted, enter the Beneficiary ID.
 7. Does the Beneficiary's ID have only numbers in it? If so, press or say 2. When prompted, enter the Beneficiary ID.
 8. Upon system verification of the Beneficiary's eligibility, you will be prompted to repeat the information given, verify the eligibility of another Beneficiary, get benefit information, get limited claim history on this Beneficiary, or get fax confirmation of this call.
 9. If you choose to verify the eligibility of an additional Beneficiary (s), you will be asked to repeat steps 5 through 8 above for each Beneficiary.
- If the system is unable to verify the Beneficiary information you entered, you will be transferred to a Customer Service Representative.

Access to eligibility information via the Internet

DentaQuest's Web site currently allows Enrolled Participating Providers to verify a Beneficiary's eligibility as well as submit claims directly to DentaQuest. You can verify the Beneficiary's eligibility on-line by entering the Beneficiary's date of birth, the expected date of service and the Beneficiary's identification number or last name and first initial. To access the eligibility information via DentaQuest's Web site, simply log on to the DentaQuest Web site. Once you have entered the Web site, click on the "Dentist" icon.

From there choose "Illinois" and press "go". You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. You should have received information from DentaQuest on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 1.888.875.7482. Once logged in, select "Patient" and then "Member Eligibility Search" and then enter the applicable information for each Beneficiary you are checking. You are able to check on an unlimited number of Beneficiaries' and can print a summary of eligibility for your records.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. If you are having difficulty accessing either the IVR or Web sites, please contact the Customer Service Department at 1.888.281.2076 – select option "3". They will be able to assist you in utilizing either system.

= **1.04** – All Kids/HFS Dental Program Copayments
Updated February 2015

All Kids Program eligibility cards authorizing services are issued in the same manner as the HFS medical card. The card indicates the Beneficiary is covered by "All Kids" and is issued annually.

= **14.00** – Clinical Criteria – Children and Adults
Updated February 2015

The criteria outlined in DentaQuest's Dental Office Reference Manual are based around procedure codes as defined in the **American Dental Association's Code Manuals** and are the criteria that DentaQuest will use for making medical necessity determinations for prior authorizations, post payment review and retrospective review. These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and federal requirements as well. In addition, please review the general benefit limitations presented in Exhibit A, Exhibit B, and Exhibit C of this manual for additional information on medical necessity on a per code basis.

Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Prior authorization is required for orthodontic treatment and any procedure requiring in-patient or outpatient treatment in any hospital or surgery center. Some services require pre-payment review, these services are detailed in Exhibits A, B, and C in the "Documentation Required" column.

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

HFS Dental Program providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to Chapter 10 Patient Record for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the HFS Dental Program.

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

DentaQuest hopes that the following criteria will provide a better understanding of the decision-making process for reviews and audits. Please remember the services described may not be covered for all HFS Dental Program members. In addition, there may be additional program specific criteria regarding treatment. Therefore it is essential you review the Benefits Covered Sections, Exhibit A, Exhibit B, and Exhibit C before providing any treatment.

14.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

Appropriate radiographs should be submitted for authorization review, such as bitewings, periapicals or panorex. Treatment rendered under emergency conditions, when authorization is not possible, Requires that appropriate radiographs be submitted with the claim for review for payment. Narrative demonstrating medical necessity may be needed.

Criteria

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.