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Section I–Purpose of Qualis Health Care Management Program

The purpose of the Care Management program is to ensure that appropriate medical services are provided in accordance with state and federal regulations, statutes and policies to recipients of the District of Columbia (DC) Department of Health Care Finance (DHCF) state Medicaid Plan (fee for service).

History of Peer Review
The Federal government has expended significant dollars in developing and supporting review of care in facilities. In fact, this type of review was required by law in 1972 for Medicaid and Medicare programs. Qualis Health has been in existence since 1974, providing utilization management, care coordination, case management, quality assurance services and special studies for Medicare, Medicaid and private sector entities.

Corporate Background and Experience
Qualis Health is one of the nation’s leading healthcare consulting and care management organizations, helping to transform care and improve care delivery and patient outcomes. We work with clients throughout the public and private sectors to advance the quality, efficiency and value of healthcare for millions of Americans every day.

Programs offered include traditional utilization management services, such as pre-service, concurrent, retrospective review, coding validation, and medical consultation. Services designed for the managed care arena include the early identification of high-risk patients, specialty referral management services, consumer advocacy services and audits of access to care.

Mission and Vision
Mission: To generate, apply and disseminate knowledge to improve the quality of healthcare delivery and health outcomes.

Vision: To be recognized for leadership, innovation and excellence in improving the health of individuals and populations.

Core Values: Integrity and Professionalism; Collaboration; Stewardship

Utilization Management and Medical Necessity
Utilization Management
Utilization management is the evaluation of medical necessity, appropriateness and efficiency of the use of healthcare procedures and facilities under the auspices of the applicable health benefit plan. Sometimes utilization management is referred to as utilization review or UR.
Section 2–Communications with Qualis Health

Introduction

Qualis Health’s review process is flexible and is set up to handle review requests received via the internet (preferred), fax, and mail. Qualis Health offers secure web-based review capability using the internet to create a two-way link, via the Qualis Health Provider Portal, that can be used to exchange care management data and get your questions answered, thus facilitating real-time, online approvals. Qualis Health also maintains toll-free, dedicated phone and fax numbers for Medicaid providers to use to request and review services.

Qualis Health’s regular business hours are 8:00 am to 5:00 pm Eastern Time, Monday through Friday; excluding scheduled holidays (Please refer to Appendix A, Contact Information). Qualis Health staff members are available to handle review requests received from 8:00 am to 5:00 pm on regular business days.

Contacting Qualis Health by Phone

To reach Qualis Health’s customer service for questions about reviews you may also call (800) 251-8890. In the event your call is after business hours, or an attendant is not available, your call will be directed to Qualis Health’s 24-hour voice mail system.

During regular business hours, Qualis Health monitors the voice mail system checking messages and ensuring callbacks are handled in a timely manner. Messages left after 5:00 pm, or on weekends, or holidays are retrieved on the next business day and calls are returned by 12:00 pm Eastern Time.

Contacting Qualis Health via the Internet (the preferred method of submitting a review)

Providers submitting web-based review requests will need to obtain a User ID and password to log in and access the Qualis Health Provider Portal. Registered, trained providers can log in and directly enter information and attach documents required for the admission (i.e. prior-authorization, pre-admission, emergency admission, continued stay, retrospective, level of care review request).

For more information on how to submit web-based review submissions, please visit: http://www.qualishealth.org/healthcare-professionals/dc-medicaid/provider-resources (scroll down to ‘Qualis Health Provider Portal’ for links, Quick Start Guides, FAQs, and training videos) or contact Qualis Health at (800) 251-8890.
Contacting Qualis Health by Mail

Requests for prior authorization certification for admissions and concurrent (continued stay) treatment services, and requests for retrospective reviews may be submitted on the web via the web-based review system (preferred method) or via fax (for infrequent submissions), or mail. Requests submitted by mail to Qualis Health’s Washington, DC office should be sent to:

Qualis Health District of Columbia
Attn: Utilization Review Department
PO Box 34800
Washington, DC 20043

Contacting Qualis Health by Fax

Providers who submit infrequent requests may fax review requests to Qualis Health at the numbers specified below (the preferred method of submitting a review is electronically via the Qualis Health Provider Portal and reviews submitted in the Portal are prioritized). Faxed submissions (only one patient per fax) must be legible and include all required demographic, clinical information, and forms required. Completed medical necessity reviews may be faxed as indicated below. Please do not send the entire medical record via fax; only the required clinical documentation to complete a review.

<table>
<thead>
<tr>
<th>Review Submission</th>
<th>Toll-Free Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All review types (For Providers who submit reviews infrequently)</td>
<td>1 (800) 731-2314</td>
</tr>
</tbody>
</table>

A fax cover sheet with a confidentiality disclaimer is recommended. The following are suggestions in submitting your fax:

- No bold font
- No italics
- No underlining
- No all caps
- If possible no special characters, i.e., * or = (quotes are OK)
- Sans serif fonts
- Normal spacing (i.e., looks like a normal document not written in a column that takes up a horizontal third of the page)
- Typed is preferred over handwritten

Please complete the 719A, 1728 and other District of Columbia Department of Health Care Finance forms completely as required by the review type. Forms not completely filled out will be returned to the provider and if not completed, a technical denial will be issued.
Qualis Health’s Communication of Review Determinations

Our secure Qualis Health Provider Portal offers immediate feedback from Qualis Health concerning the request for review—pended awaiting review, approved, pended for further review, or additional information required. For requests submitted through the preferred web-based review system, an internet-based notification of the final determination is posted for the provider. Providers using the web-based system for their request submissions will not need to wait for the transmission of a fax or mailed document to learn of the final determination.

Requests that are not submitted through the web-based review system, Qualis Health will communicate the determination and the Prior Authorization number (i.e., the certification number) to the provider via fax. Qualis Health will send letter notifications for all adverse determinations and appeal reviews within five business days after the determination is given. These notifications will be sent to the recipient, (or if a minor, to the parent or guardian), and the requesting provider.
Section 3–Compliance with URAC’s Utilization Review Standards

Frequently Asked Questions about Utilization Review Decisions

Qualis Health complies with URAC health utilization management (UM) standards when performing utilization reviews (UR). These standards provide a process for conducting a utilization review that is clinically sound and respects recipients’ and providers’ rights. URAC standards ensure that only appropriately trained, qualified clinical personnel conduct and oversee the utilization review process; that a reasonable and timely appeals process is in place; and that medical decisions are based on valid clinical criteria. Some frequently asked questions about the process of making utilization review decisions are answered in the following section.

1. Who makes the utilization review decision?

   URAC (formerly known as Utilization Review Accreditation Committee) Health Utilization Management Accreditation requires Qualis Health to use a three-step process to determine if a proposed medical treatment or service is medically necessary:

   • Initial Clinical Review - A licensed clinical reviewer conducts this first step of the review process using InterQual or the District of Columbia’s Department of Health Care Finance (DHCF) Criteria and review protocols. If the clinical information provided does not meet medical necessity criteria and review protocols for approved services, or if, in the clinical reviewer’s judgment, a physician should review the case, it is referred for peer clinical review.

   • Peer Clinical Review - A licensed physician qualified to render a clinical opinion about the proposed treatment or service performs a peer clinical review by reviewing all available information and then making a decision about certifying care or services. When a non-certification decision is made by the physician reviewer a Qualis Health reconsideration process is available.

   • Qualis Health Reconsideration (appeal) Process - A provider or recipient may initiate a written request for reconsideration within 21 business days from the date of the denial notice for all review types except for Nursing Home Medical Eligibility Reviews. A written request for reconsideration for Nursing Home Medical Eligibility Reviews must be made within 30 business days of the date of the denial notice. Requests may also be made via telephone, followed by a written request. The process may be expedited, if requested (Please refer to Section 15)
2. **What recourse is there when we disagree with a Qualis Health determination?**

Qualis Health’s written notice of non-certification decision contains instructions of initiating a reconsideration request to Qualis Health or an appeal of the non-certification determination to the District for the recipient. Please refer to Section 15 of this manual for details on the reconsideration and appeal process. If, after reconsideration review, the recipient still disagrees with the Qualis Health determination, their reconsideration letter will outline the steps that must be taken to request a Fair Hearing with the District of Columbia Medicaid.

3. **What is considered an urgent review?**

An urgent review is performed when a case involves urgent care and the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function, or (b) in the opinion of a physician with knowledge of the recipient’s medical condition would subject the recipient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

4. **How are review timelines determined?**

The number of days allotted for each type of review for the District of Columbia’s Fee for Service Medicaid program is based on the District’s Fee for Service Medicaid Program review protocols. Review timelines differ by review type and by urgent reviews and non-urgent reviews. If the review requires additional information, additional time is allotted. Tables of review timeliness are shown in following pages under questions 5 and 8 of this section.

When additional information is required to complete the review, the timeline is adjusted accordingly. When this occurs, it is the provider’s responsibility to provide Qualis Health with the additional information requested to complete the review. If the information is not received within two business days (for non-dental and Medical Eligibility reviews), and 3 business days for Dental and Medical Eligibility reviews, the review will be completed with the information already received or a technical denial will be issued, putting the case at risk of a potential non-certification. If the District’s required forms are not completely filled out, a technical denial will be issued.

5. **Time Frames for Qualis Health Utilization Management Review Decisions per District Requirements**

When all necessary clinical information has been received and no referral for clinical physician review is needed, the timeframes for completion of reviews are as follows:
### Review Type

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Timeframes for Completion from Date All Information Required/Submitted to Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization Review</td>
<td>5 business days</td>
</tr>
<tr>
<td>Pre-Admission Review</td>
<td>5 business days</td>
</tr>
<tr>
<td>Emergency Admission Reviews</td>
<td>24 hours/1 business day</td>
</tr>
<tr>
<td>Continued Stay Reviews</td>
<td>24 hours/1 business day</td>
</tr>
<tr>
<td>Retrospective Reviews</td>
<td>14 business days</td>
</tr>
<tr>
<td>Level of Care Review</td>
<td>3 business days</td>
</tr>
<tr>
<td>Medical Eligibility Nursing Home</td>
<td>Within 30 days of admission to a nursing facility</td>
</tr>
<tr>
<td>Medical Eligibility Reviews</td>
<td>Within 18 days, prior to expiration of the bed hold</td>
</tr>
<tr>
<td>Readmission to Nursing Home</td>
<td></td>
</tr>
<tr>
<td>Nursing Home Continued Stay Reviews</td>
<td>Within 6 months from admission to a nursing facility and then annually</td>
</tr>
<tr>
<td>EPD Waiver Level of Care</td>
<td>3 business days</td>
</tr>
<tr>
<td>EPD Waiver Program Medical Review</td>
<td>5 business days</td>
</tr>
</tbody>
</table>

#### 6. What if Qualis Health requests additional information?

When additional information is required to complete the review, the timeline is adjusted accordingly. When this occurs, Qualis Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the additional information required to complete the review.

Should additional information be required to complete the review, **Qualis Health will notify the requesting provider and pend the review for two business days awaiting additional information**. If the information requested is not received within two business days, the review will be processed with the information already provided or a technical denial will be issued.

For instances in which required forms are not completed or there is late notification, a technical denial will be issued per District requirements. Technical denials are not eligible for reconsideration/appeals, however a new review may be requested with required, completed forms and clinical information, if required District review submission timelines have not expired.
Section 4–HIPAA

Business Associate Standing
Qualis Health provides care management services on behalf of its clients and is considered a “Business Associate” of these clients under the Health Insurance Portability and Accountability Act (HIPAA) “Administrative Simplification” regulations governing patient health information. These regulations include the Standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”) and the Security Standard (“Security Rule”) and in accordance with the requirements of the District of Columbia.

Section 5–Provider Billing Concerns

Claim Discrepancies
Providers are encouraged to thoroughly examine discrepancies in claims for accuracy prior to contacting Qualis Health. Xerox Business Services, LLC, the fiscal agent for the District of Columbia, Department of Health Care Finance has a provider inquiry telephone line for this purpose. Providers may contact the fiscal agent at (202) 906-8319 (inside DC metro area) or (866) 752-9231 (outside DC metro area).

Providers may call Qualis Health to investigate a discrepancy that has caused or has the potential to cause a claim to fail. A discrepancy may occur when adjustments are made after an authorization has been completed by Qualis Health and different information is submitted during the billing process. The Provider is responsible for ensuring that submitted information is consistent from authorization through the billing process. Examples of such discrepancies are as follows:

- The date(s) on the Qualis Health review does not match the certified admission or discharge date on the claim. Admitting or principal diagnosis codes and/or modifiers on the Qualis Health review do not match the code(s) on the claim.
- Incorrect recipient Medicaid Identification number indicated on the Qualis Health review.
- The Prior Authorization number (11 numeric characters) used for billing does not match.
- The Provider number (nine numeric characters) used for billing does not match.

Contingency for Payment
Qualis Health certification indicates only that the admission is medically necessary. This certification (approval) does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in the District of Columbia.
Section 6–Eligibility

Overview

The District’s Medicaid utilization review program has been established to provide a way to authorize medically necessary services. The Federal and State Medicaid program was established and is regulated by Federal and District Codes.

There are times when DC Medicaid recipients could be covered under another insurance or program, and the requirements for review may vary. If another insurer is the primary, a review with Qualis Health will not be required.

Provider Responsibility for Eligibility Verification

Providers are responsible to verify recipient eligibility prior to submitting a review request to Qualis Health for prior authorization of admission, continued stay, or retrospective review. The following information is available to assist the provider in the eligibility verification process.

Prior to submitting a review request to Qualis Health remember to verify eligibility first.

Verify recipient eligibility for Medicaid benefits and services at the beginning of each month or at each visit/care encounter. Recipients may be enrolled in programs with restricted services. Certain services require prior approval for reimbursement. Please refer to the fee schedule to confirm if a PA is required. This information may be obtained from the Interactive Voice Response (IVR) system by calling (202) 906-8319 (in District) or (866) 752-9231(outside DC metro area).

The IVR will prompt you to enter your provider number. This is the nine-digit number assigned to you through the Medicaid program. The system will then prompt you to enter the recipient number. This nine-digit code is listed on the patient’s Medical Assistance Card.
Section 7–Utilization Review Methods of Submission

Submission Methods

Qualis Health will accept review requests submitted by providers:
- Over the internet (internet is the preferred method of review)
- via Fax (only for providers who submit infrequently or for out of state providers)
- or Mail (If you do not have internet access, fax is the preferred method of review submission).

Include demographics in your submission, any forms required by the District entirely completed, and a clinical review to substantiate the reason the service is being requested.

### Submission Mode

<table>
<thead>
<tr>
<th>Submission Mode</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internet</strong> (preferred)</td>
<td>The Qualis Health Provider Portal is the preferred method of review submission. Providers log in to web-based review system and directly enter information for prior authorization for admission, concurrent (continued stay), or retrospective review request instead of sending records for shorter stays. For information on how to submit web-based review submissions, please visit: <a href="http://www.qualishealth.org/healthcare-professionals/dc-medicaid/provider-resources">http://www.qualishealth.org/healthcare-professionals/dc-medicaid/provider-resources</a> (scroll down to ‘Qualis Health Provider Portal’ for links, Quick Start Guides, FAQs, and training videos) or contact Qualis Health at (800) 251-8890.</td>
</tr>
<tr>
<td><strong>Fax</strong></td>
<td>Providers may request prior authorization for admission, concurrent (continued stay), or retrospective reviews by faxing the request to Qualis Health’s toll free fax number:</td>
</tr>
<tr>
<td><strong>Review Type</strong></td>
<td><strong>Toll-Free Fax Number</strong></td>
</tr>
<tr>
<td>Hospital Emergency and Continued Stay</td>
<td>1 (800) 731-2314</td>
</tr>
</tbody>
</table>

(Please send one request per fax; faxes containing more than one request will be returned.)

Include a cover sheet regarding confidentiality, and your admission information from the medical record. Longer lengths of stay require mailing of password protected CDs or charts.

| **Mail** | Requests can be mailed to Qualis Health’s District of Columbia office: Qualis Health District of Columbia Attn: Utilization Review Department PO Box 34800 Washington, DC 20043 |

Section 8–Process for Utilization Review Submissions

Purpose
Qualis Health has adopted a browser-based product that uses the internet to create a two-way link between healthcare providers and Qualis Health Utilization Management Review to facilitate the prior authorization review process. The web-based review system allows providers to submit utilization review requests to Qualis Health using a secure internet connection and is available to the provider 24 hours a day, seven days a week. Reviews submitted during non-office hours will be processed as received on the next business day (Please refer to Appendix A).

Responsibility
Providers are responsible for verifying eligibility prior to submitting all review requests as required by the District’s Medicaid Program utilization review policies and regulations. Providers are responsible to submit all reviews to Qualis Health in a timely manner as required by District of Columbia, Department of Health Care Finance. Providers are also responsible for submitting reviews to Qualis Health for recipients who are covered by other Third Party Liability (TPL) resources for admission and continued stay if utilizing DC Medicaid Fee for Service as a form of primary reimbursement.

Requirements
Use of the Qualis Health Provider Portal, web-based review system requires internet access and establishment of provider logon information for each user. Training is conducted by Qualis Health via WebEx sessions. If you are interested in receiving training, please see Qualis Health’s website at: http://www.qualishealth.org/healthcare-professionals/dc-medicaid/provider-resources (scroll down to ‘Qualis Health Provider Portal’ for links, Quick Start Guides, FAQs, and training videos) or contact Qualis Health at (800) 251-8890.

Process and Procedures
Submission
If you have already received Qualis Health Provider Portal web-based review submission training from Qualis Health, submit your review requests via the internet at the following web address: https://qualishealthpp.zeomega.com/

For assistance with use of the web-based review submission once registration and training have occurred, please contact the Qualis Health DC Office at (800) 251-8890 or email your inquiry to dcmedicaid@qualishealth.org. If you do not have internet access the preferred method of review submission is via fax.

Operational hours for Qualis Health District of Columbia Medicaid utilization reviews are: 8:00 am to 5:00 pm Eastern Time Monday through Friday except for designated holidays (Please refer to Appendix A).
The provider may submit the prior authorization review request to Qualis Health via web-based review system (preferred method), or fax for providers who submit infrequently or are out of state providers. (Please refer to Section 7).

### How to Reach Qualis Health

| Qualis Health Provider Portal       | [https://qualishealthpp.zeomega.com/](https://qualishealthpp.zeomega.com/) |
|------------------------------------|------------------------------------------------|---|
| Phone                              |  (800) 251-8890                                 |---|
| Fax                                | Review Type  | Toll-Free Fax Number |
|                                    | All providers who submit reviews infrequently        |1 (800) 731-2314 |

### Required Review Documentation

The provider will submit all required, completed Department of Health Care Finance forms, depending on review type, in addition to any clinical review information required to substantiate the service requested.

Additional requirements for clinical documentation and/or other necessary information to complete the review process is available within this manual. The requirements of the DC DHCF Policies and Transmittals are available on the DHCF website at [http://dhcf.dc.gov/page/dhcf-our-providers](http://dhcf.dc.gov/page/dhcf-our-providers).

### Medical Necessity Screening

Once the information for the specific review period has been received, Qualis Health’s clinical reviewer will assess the medical information to determine whether the condition of the recipient meets medical necessity for the services and level of care requested. If the Criteria and Federal and District regulations are met, the Qualis Health clinical reviewer will issue a Prior Authorization number and the review will be certified. (Please refer to [http://www.mckesson.com](http://www.mckesson.com) for information about InterQual criteria, Appendix D for DHCF’s Dental Criteria Guidelines, and Appendix E for the DHCF’s Level of Care Assessment form).

### Second-Level Peer Review

Cases that clinical reviewers have determined do not meet criteria are referred to a Qualis Health physician reviewer (medical director or physician consultant). The physician reviewer will review the clinical information and either certify the admission or issue a potential non-certification. In the event of a potential non-certification, the attending physician will be given an opportunity to discuss the review with the Qualis Health physician reviewer. Following the discussion, Qualis Health will either certify or non-certify the medical review.
Adverse Determinations

If the Qualis Health physician reviewer non-certifies the medical review, a Qualis Health representative will notify the appropriate facility by web-based review system or by fax. Qualis Health will send the non-certification letter within five business day to the following parties: the recipient, guardian or parents of recipient (if minor) and the requesting provider.

The adverse determination (denial) letters will contain justification for the non-certification and an explanation of the right to request a reconsideration review to Qualis Health’s initial adverse determination as well as recipient appeal rights with the District of Columbia Office of Administrative Hearing (OAH).

Qualis Health will not send letter notifications on certified reviews. Certified reviews and prior authorization numbers can be found on the Qualis Health Provider Portal for reviews submitted via the web. Providers who faxed their reviews will receive notification of their certified reviews and prior authorization numbers via fax.

Qualis Health will send letter notifications for all non-certified reviews and Qualis Health reconsideration reviews. These notifications will be sent to the recipient and the requesting provider or facility.

The District of Columbia Department of Health Care Finance will not reimburse providers for services that have not been approved by Qualis Health, with the exception of adverse determinations that are reversed as a result of a reconsideration review performed by Qualis Health or a recipient Fair Hearing by the District.
Procedures for Admissions or Continued Stay (Concurrent) Review - Due on Weekends and Holidays

In those instances where the concurrent review date falls on a weekend or holiday, the following procedure is to be followed:

If the concurrent review is due on Saturday, Sunday or a holiday, the concurrent review will take place on the preceding Qualis Health business day. Adverse determinations can be retrospective to the first day the recipient was not meeting the level of care criteria or protocols.

Late Submission Review Requests

Late review requests will result in a technical denial and authorization for services moving forward only, if the review was not submitted timely.

Reviews for continuing services are due on or before the last day of service authorized. Review requests submitted after the date of service renewal are

The required timeframe for submitting all review documentation to Qualis Health for Emergency Admission is within **two (2) business days** of the actual admission. Submission deadlines are dependent on the day the patient was admitted; for example:

- The following Monday for a Thursday admission
- The following Tuesday for Saturday and Sunday admissions
- The following Wednesday for a Monday admission
- The following Thursday for a Tuesday admission
- The following Friday for a Wednesday admission

In the event of an emergency transfer, it is the responsibility of the receiving hospital to obtain authorization for the emergency admission within the timeframes outlined above.

Chart Requests

At the direction of the District of Columbia, Department of Health Care Finance, Qualis Health may request the chart of a recipient to verify quality of care or accuracy of the information provided. The chart request may be made telephonically, through the web-based review system, or in writing.
Section 9–Prior Authorization

Purpose
The most effective form of utilization review is prior-authorization which takes place before the recipient receives a service. The biggest advantage is that inappropriate health care services can be avoided rather than contested after an expense is incurred.

The District of Columbia’s Medicaid utilization review program has been established to provide a way to prior authorize before services are rendered. The Federal and State Medicaid program was established as a prior authorization system and is regulated by Federal and State codes. Providers are required to submit clinical reviews in a timely manner with complete documentation to substantiate the service request for the recipient.

Responsibility
Providers are responsible for obtaining the prior authorization review from Qualis Health in advance of delivering the services to the recipient.

Prior to submitting a review request to Qualis Health remember to verify eligibility first.

Receiving providers are to submit review information to Qualis Health. The applicable portions of the 719A form pertaining to the service being requested will be completed (the provider is to retain the original copy of the 719A form). Only the relevant clinical information to satisfy the District’s Fee for Service Medicaid Program utilization review protocols and InterQual criteria is required to complete the review process.

Providers will be notified of incomplete 719A forms or incomplete clinical information and be given up to 2 business days to submit additional information to complete the review. Notification of an incomplete review submission will occur via the web portal for web submission (preferred), via fax for fax submission. If the 719A form remains incomplete after 2 business days a technical denial will be issued. If clinical information remains incomplete after two or three business days as appropriate, a non-certification may result when referred to the physician reviewer.

Qualis Health has 5 days to complete the review, once all the information has been received to complete the review process. Please refer to the process and procedures outlined in Sections 5 and 8 of this manual.
Requirements

All of the services listed below, must be prior-authorized by Qualis Health in order to be reimbursed by the District of Columbia:

- Acute Care Hospitals
- Acute Care Hospitals Bordering Counties
- Gastric Bypass Surgery
- Outpatient Medical and Surgical Procedures (if a PA requirement is noted on the fee schedule)
- Hearing Aids
- Home Health Services
- Hospice (Outpatient) Services
- Eyewear and Contact Lenses
- Dental and Orthodontic Services
- Specific Durable Medical Equipment, Prosthetics, Orthotics, Medical Supplies (DME/POS)
- Out of State Nursing Home Placement
- Intellectual and Developmental Disabilities Waiver
- EPD Waiver Program Services

Authorization for services will remain valid for 6 months

Information Needed for the Review

Qualis Health representatives require all information below for clinical reviews. Please refer to Appendix C for the 719A form.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address, phone number and fax number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or surgery/service date
- Justification for the hospitalization or service request, and pertinent history
- Anticipated discharge date
• Documentation to justify the medical necessity of the service at the requested level of care; including pertinent test results, labs, medications and treatment
• Discharge planning details to include placement (provider)
• Completed section 14 (for Dental use only) on the 719A form

Hearing Aids
Hearing Aid Requests may be submitted via the Qualis Health Provider Portal. Please include the clinical justification, documentation, and the 719A form (the provider is to retain the original copy of the 719A form).

Eyewear and Contact Lenses
Eyewear and contact lens requests may be submitted via the Qualis Health Provider Portal attaching the required prescription documentation and the 719A form (the provider is to retain the original copy of the 719A form).

Dental and Orthodontic Services
Dental and Orthodontic Service requests may be submitted via the Qualis Health Provider Portal. Please include all the required documentation with your submission:
• Submit only services requiring prior-authorization (Please refer to Appendix D)
• Completed 719A form, fields 1-6, 7, 8, 9, 10, 11, 13, 14, 15a and 15b (the provider is to retain the original copy of the 719A form)
• Attach electronic radiographs as required
• Please refer to Appendix D for the DHCF approved Dental Criteria Guidelines

Specific Durable Medical Equipment (DME)
Specific DME requests may be submitted via the Qualis Health Provider Portal submitting the complete, required documentation:
• Submit requests only for services requiring prior-authorization:
  o prosthetic devices not included in the fee schedule
  o medical supplies and equipment in excess of specific limitations; cost, rental or lease equipment, specific procedure codes
  o DME costing more than $500.00 and
  o repair of purchased equipment that exceeds 75% of the purchase price of the equipment
• Completed 719A form (Please refer to Appendix C).
• The provider is to retain the original copy of the 719A form
• For DME and items not included in the fee schedule
  o Beneficiaries enrolled in IDD waiver will have Qualis Health notify the provider and refer the request with documentation to DHCF for review within 2 days of the completed 719A
  o Beneficiaries enrolled in Fee for Service Medicaid will have Qualis Health notify the provider and refer the request with documentation to DHCF for
review within 5 days of the completed 719A

- Notification of authorization will be provided via the Qualis Health Provider Portal or fax depending on the method of submission.

**Out of State Nursing Home Placement**

May be appropriate when there is no appropriate nursing home bed available in the District of Columbia and requires that the following additional information be submitted for an initial admission review. All forms must be fully completed:

- Cover Page for Request for Out-of-State Nursing Facility Placement
- Request for Out-of-State Placement
- **Proof of Contact In-State Nursing Facilities is the responsibility of the requesting facility/provider** (a minimum of 2 DC facilities must be contacted and deny placement within 48 hours of submission to Qualis Health)
- Copy of the Level of Care (LOC) approval letter (must be within 30 days of the request)
- Copy of the Request for Medicaid Nursing Facility Level of Care, DHCF Form 1728
- Copy of the Pre-admission Screening and Annual Resident Review (PASRR)
- Beneficiary Agreement
- Copy of the beneficiary history and physical as well as the discharge summary, if completed, and
- If the beneficiary requires specialized care (such as tracheostomy, dialysis, etc.), submit a copy of the most recent physician orders and or notes (DHCF transmittal #15-23)

**Timeframes for submission of Prior Authorization Reviews**

- Requests for Prior-Authorization require a minimum of 5 days advanced notice prior to the anticipated date of the service delivery. If additional information is required, the review timeline may take longer than 5 days due to awaiting additional information from the provider.

**Timeframes for Pended Reviews**

When a review has been submitted and is pended awaiting clinical/required information, Qualis Health will notify the provider via web-based review system fax or phone. The provider has no more than **two business days to submit the requested information** before Qualis Health will proceed to review with the information already submitted. This may result in an adverse determination due to lack of documentation to support the certification of the review.
Medical Necessity Review Process
During the prior authorization review, Qualis Health’s clinical reviewer will review the medical record and evaluate the medical necessity for admission at the requested level of care. Medical Necessity Criteria and review protocols are met, the Qualis Health Clinical Reviewer will issue a Prior Authorization number and the review will be authorized. Please refer to Sections 7 and 8 of this manual for the process and procedures, and Section 8 for adverse determinations.

Transfer (Admission) Reviews
Transfers between hospitals require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes inter-facility transfers, such as discharge from acute inpatient to acute rehabilitation, for example, as well as discharges to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following special considerations apply:

- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.
- All transfer requests must be submitted by the receiving facility via the Qualis Health Provider Portal or fax submission for providers who submit infrequently.
Section 10–Pre-Admission Reviews

Purpose
The District of Columbia Medicaid utilization review program pre-admission reviews allow for review in advance of services being provided. Providers are required to submit clinical reviews in a timely manner with complete documentation to substantiate the service request for the recipient.

Responsibility
Providers are responsible for obtaining the Pre-Admission review from Qualis Health in advance of delivering the services to the recipient. Receiving providers are to submit review information to Qualis Health. The applicable portions of the 719A form pertaining to the service being requested will be completed. Only the relevant clinical information to satisfy the District’s Medicaid Program utilization review protocols and InterQual criteria is required to complete the review process.

Prior to submitting a review request to Qualis Health remember to verify eligibility first.

Providers will be notified of incomplete 719A forms or incomplete clinical information and be given up to two or three business days as appropriate to submit additional information to complete the review. Notification of an incomplete review submission will occur via the web portal for web submission (preferred), and via fax for fax submission. If the 719A form remains incomplete after 2 business days a technical denial will be issued. If clinical information remains incomplete after 2 days, a non-certification or technical denial may result when referred to the physician reviewer.

Qualis Health has 5 days to complete the review, once all the information has been received to complete the review process.

Requirements
All inpatient services at the following hospitals listed below must complete pre-admission review and be approved by Qualis Health in order to be reimbursed by the District of Columbia.

• BridgePoint Hospital (Capitol Hill and National Harbor)
• National Rehabilitation Hospital (or other rehabilitation hospital)
• Hospital for Sick children (or other specialty hospital)
• Psychiatric Institute of Washington (or other psychiatric inpatient facility)

Authorization for services will remain valid for 6 months
Information Needed for the Review
Qualis Health representatives require all information below for clinical reviews.
Please refer to Appendix C for the 719A form.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address, phone number and fax number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or surgery/service date
- Justification for the hospitalization and pertinent history
- Anticipated discharge date
- Documentation to justify the medical necessity of the service at the requested level of care; including pertinent test results, labs, medications and treatment
- Discharge planning details to include placement (provider)

Timeframes for submission of Pre-Admission Reviews
Requests for Pre-Admission require a minimum of 5 days advanced notice prior to the anticipated date of the service delivery. If additional information is required, the review timeline may take longer than 5 days when Qualis Health is awaiting additional information from the provider.

Medical Necessity Review Process
During the Pre-Admission review, Qualis Health’s clinical reviewer will review the medical information submitted and evaluate the medical necessity for admission at the requested level of care. Medical Necessity Criteria and review protocols are met, the Qualis Health clinical reviewer will issue a Prior Authorization number and the review will be authorized. Please refer to the process and procedures outlined in Sections 7 and 8 of this manual, and Section 8 regarding adverse determinations.
Transfer (Admission) Reviews

Transfers between hospitals require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes inter-facility transfers, such as discharge from one level of care to another as well as discharges to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following considerations apply:

- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.
- All transfers require the receiving facility to submit a request for authorization prior to the transfer.
Section 11–Emergency Reviews

Purpose
The District of Columbia’s Medicaid utilization review program Emergency reviews allows for review of services being provided within District of Columbia acute care hospitals and those in bordering counties. Providers are required to submit clinical reviews in a timely manner with complete documentation to substantiate the service provided for the recipient.

Responsibility
Providers are responsible for obtaining the Emergency Review from Qualis Health within two business days of the onset of service delivery to the recipient. Late review submission or submission without clinical information will result in a technical denial.

Prior to submitting a review request to Qualis Health remember to verify eligibility first.

Providers will be notified of incomplete 719A forms or incomplete clinical information and be given up to 2 business days to submit additional information to complete the review. Notification of an incomplete review submission will occur via the web portal for web submission (preferred) or via fax for fax submission. If the 719A form remains incomplete after 2 business days a technical denial will be issued. If clinical information remains incomplete after 2 days, an adverse determination may result when referred to the physician reviewer.

Qualis Health has 24 hours/1 business day to complete the review, once all the information has been received to complete the review process.

Requirements
All unscheduled admissions for inpatient services within the District and in bordering counties must be authorized by Qualis Health in order to be reimbursed by the District of Columbia.

- Receiving providers are to submit review information to Qualis Health for all reviews within two business days of admission.
- The applicable portions of the 719A form pertaining to the service being requested will be completed.
- Only the relevant clinical information to satisfy the District’s Medicaid Program utilization review protocols and InterQual criteria is required to complete the review process.
Information Needed for the Review
Qualis Health representatives require all information below for clinical reviews. Please refer to Appendix C for the 719A form.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address, phone number and fax number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or surgery/service date
- Justification for the hospitalization and pertinent history
- Anticipated discharge date
- Documentation to justify the medical necessity of the service at the requested level of care; including pertinent test results, labs, medications and treatment
- Discharge planning details to include placement (provider)

Timeframes for submission of Emergency Reviews
The required timeframe for submitting all review documentation to Qualis Health for Emergency Admission is within two (2) business days of the actual admission. Submission deadlines depending on the day the patient was admitted; for example:

- The following Monday for a Thursday admission
- The following Tuesday for Saturday and Sunday admissions
- The following Wednesday for a Monday admission
- The following Thursday for a Tuesday admission
- The following Friday for a Wednesday admission

In the event of an emergency transfer, it is the responsibility of the receiving hospital to obtain authorization for the emergency admission within the timeframes outlined above.

Late review submission or submission without clinical information will result in a technical denial.
Medical Necessity Review Process
During the Emergency Review process, the Qualis Health’s Clinical Reviewer will review the clinical information submitted and evaluate the medical necessity for admission at the requested level of care. Medical Necessity Criteria and review protocols are met, the Qualis Health Clinical Reviewer will authorize the review and a prior-authorization number will be issued. Please refer to the process and procedures outlined in Section 9 of this manual, and Section 8 regarding non-certifications.

Transfer (Admission) Reviews
Transfers between hospitals require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes inter-facility transfers, such as discharge from one level of care to another as well as discharges to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following special considerations apply:

- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.
- All transfers require the receiving facility to submit a request for authorization prior to the transfer.
Section 12–Continued Stay (Concurrent) Utilization Reviews

Purpose
The purpose of the continued stay review process is to evaluate whether the patient requires an extension of inpatient services and meets medical necessity. During the continued stay review, the Qualis Health Clinical Reviewer evaluates what services have already been provided to the patient and the plan for continuing in-patient treatment. Providers should submit reviews in a timely manner, on or preceding the last review date authorized.

A continued stay (concurrent) review takes place during the time in which a recipient is receiving inpatient treatment at the acute care or residential care facility. If the first review was submitted before the recipient discharged from the facility, the subsequent reviews will be considered continued stay reviews through the patient’s discharge date.

Responsibility
Providers are responsible for checking Medicaid eligibility prior to seeking authorization of services from Qualis Health. Once eligibility has been established, submission via the Qualis Health web portal is the preferred method for submitting a review request. Providers are responsible for obtaining certification for continued stays from Qualis Health. The clinical reviewer will receive all of the appropriate detailed clinical information for the requested review period to satisfy InterQual Criteria or DHCF’s criteria before the continued stay review will be certified. The provider is responsible to assure that the information submitted in the review is accurate for the time frame of the review and documented in medical record of chart.

Requirements
The continued stay request is to be received in advance of the next review date provided during the previous certified review.

- Specialty Hospital of Washington (Capitol Hill and Hadley)
- National Rehabilitation Hospital (or other rehabilitation hospital)
- Hospital for Sick children (or other specialty hospital)
- Non-DRG Acute Care Hospitals
- Psychiatric Institute of Washington (or other inpatient psychiatric facility)

Process and Procedures
The provider will submit the continued stay review request to Qualis Health via web-based system (preferred method) or by fax. Please refer to Section 7 of this manual for methods of and processes for submission.
Procedures for Continued Stay Review - Due on Weekends and Holidays

In those instances where the concurrent review date falls on a weekend or holiday, the following procedure is to be followed:

If the concurrent review is due on Saturday, Sunday or a holiday, the concurrent review will take place prior to the next review date. Adverse determinations can be retrospective to the first day the recipient was not meeting the level of care criteria or protocols.

Information Needed for the Review

- Clinical information provided must specifically substantiate the medical necessity of the continued stay request and the continued length of stay requested.
- Information should also be provided to indicate progress with discharge planning and goals to meet discharge readiness.

Continued Stay Review Process

Once the information for the review has been received, the Qualis Health clinical reviewer will assess the documentation submitted using InterQual Criteria or DHCF Criteria to determine whether the condition of the recipient meets criteria for the level of care and the type of services requested.

During the prior authorization review, the next review date is set for continued stay review. Qualis Health will establish the date when a concurrent review will be due if the recipient has not been discharged before this date. Providers are responsible for submitting current information for continued stay review if the client has not discharged. Providers are to contact Qualis Health and submit the next continued stay review within the following timeframes:

**Timeframes for Continued Stay Review Submissions**

Qualis Health has 24 hours, or 1 business day to complete the continued stay review if all required information is submitted to complete the review.

**Timeframes for Pended Reviews**

When a review has been submitted and is pended awaiting clinical/required information, Qualis Health will notify the provider via the Qualis Health Provider Portal, fax or phone, depending on the mode of submission. The provider has no more than **two calendar days to submit the requested information** before Qualis Health will proceed with the information already submitted. This may result in an adverse determination due to lack of documentation to support the certification of the review. Please refer to Section 8 regarding non-certifications.
Section 13—Retrospective Reviews

Definition and Purpose
A retrospective review for medical necessity is indicated after services have been rendered, the client has been discharged and subsequent eligibility has been established.

Prior to submitting a review request to Qualis Health remember to first verify active eligibility dates were present during the time the services were provided.

Providers are required to submit the request for a retrospective review within the allotted timeframe of 12 months after discharge and/or that billing was initiated within the 12 months after discharge. Provider is responsible to assure that the information submitted in the review is accurate for the time frame of the review and documented in medical record of chart.

Process and Procedures
The provider will submit the Subsequent Eligibility Admission review request to Qualis Health via the web-based system. Please refer to Section 7 and 8 of this manual for methods of and processes for submission.

Submitting Retrospective Reviews Via Web-based Review System
- Subsequent Eligibility Admissions will be initiated by the provider. Providers should include sufficient information for the clinical reviewer to complete the review. Please do not send the entire medical chart for review. The entire review may be submitted into the web-based system in seven day (one week) increments with attached:
  - Admission Summary
  - Physician orders and notes
  - Discharge Summary
  - Review summary of progress toward meeting discharge goals for days of stay and for longer lengths of stay each week, until last week of discharge, then daily clinical information submitted
Information Needed for the Review

Qualis Health representatives require all information below for clinical reviews. Please refer to Appendix C for the 719A form.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address and phone number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or surgery/service date
- Justification for the hospitalization and pertinent history
- Anticipated discharge date
- Documentation to justify the medical necessity of the service at the requested level of care; including pertinent test results, labs, medications and treatment
- Discharge planning details to include placement (provider)

Medical Necessity Screening

The Qualis Health clinical reviewer will review the information provided for the retrospective review and will apply the appropriate InterQual Criteria. If the criteria and Federal and District regulations are met, Qualis Health will issue a retrospective authorization number. Qualis Health certification indicates that the admission was medically necessary. Please refer to Section 8 regarding non-certifications.

Timeframes for Retrospective Review Submissions

Qualis Health has 14 business days to complete the continued stay review if all required information is submitted to complete the review.
Section 14–Long Term Care Reviews

Purpose
The Long Term Care Reviews determine that the services and environment for delivery of those services are medically appropriate to allow the consumer to live with a permanent or chronic condition.

Responsibility
The Qualis Health clinical reviewer will receive all of the appropriate detailed level of care assessment form (Please refer to Appendix E) information for the requested services before services are delivered. The provider is responsible to assure that the information submitted in the review is accurate for the time frame of the review and is present in the documented medical record.

Prior to submitting a review request to Qualis Health remember to verify eligibility first.

Requirements
Providers are responsible for submitting the long-term care review service requests and required documents as indicated by District of Columbia policy:

- EPD Level of care (LOC) determinations (require CaseNet entry)
- EPD Waiver program medical reviews (require CaseNet entry)
  - Approved LOC for the certification/recertification period of request
  - Completed Case Management Conflict Free Personalized Care Plan
- Level of care (LOC) determinations
  - Pre-admission Screening and Resident Review (PASRR) must be included with LOC requests for Nursing Home Placement and Nursing Home Reviews.
- Medical Eligibility Reviews (Nursing Home)
  - Pre-admission Screening and Resident Review (PASRR)
  - 1728 DHCF LOC Request
  - 1728 DHCF LOC Approval Letter from Qualis
  - Current or Up to Date Completed Minimum Data Set (MDS)
  - Physician Certification/Recertification every 60 days
  - Supporting Clinical Documents
- Medical Eligibility continued stay reviews (Nursing Home)
  - Pre-admission Screening and Resident Review (PASRR)
  - 1728 DHCF LOC Request
  - 1728 DHCF LOC Approval Letter from Qualis Health
  - Current or Up to Date Completed Minimum Data Set (MDS)
  - Physician Certification/Recertification every 60 days
  - Supporting Clinical Documents
Information Needed for the Review
Qualis Health representatives require all information below for clinical reviews. Please refer to Appendix E for Form 1728, which must be attached to the Qualis Health Provider portal (preferred mode of submission) during the review process or faxed to Qualis Health at 800-731-2314. Incomplete forms will be returned to the provider and two business days will be given to complete the form. Forms that are incomplete will result in a technical denial.

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (all five digits) and modifiers, if required
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address and phone number
- Facility Medicaid provider number
- Type of review requested
- Primary and secondary reason for treatment
- Admit or service date
- Justification for the services and pertinent history
- Anticipated discharge date
- Discharge planning details to include placement (provider)

Submitting Level of Care Reviews via the Qualis Health Provider Portal
- Level of Care Reviews (LOC) may be submitted via the Qualis Health Provider Portal and the 1728 form may be attached to your review request in the web based system. The provider is to retain the original copy of the form.

- If you do not have internet access, you may fax your review request to 800-731-2314, including the 1728 form.

- Qualis Health will review the LOC request within 3 business days of receipt and issue a determination.

- Approval notifications will be visible via the Qualis Health Provider Portal or faxed for those review requests received via fax.

- If the Qualis Health physician reviewer non-certifies the LOC requested, the determination status will immediately be posted in the web-based review system and a adverse determination letter will be mailed out within 5 business day to the
following parties; the recipient and the requesting provider/facility. The letters will contain justification for the adverse determination with an explanation of the right to request reconsideration to Qualis Health. And a description of the recipient appeal procedure to the District. Please refer to Reconsideration and Appeals, Section 15.

- The District of Columbia, Department of Health Care Finance will not reimburse providers for services that have been non-certified by Qualis Health, with the exception of non-certifications that are reversed as a result of an appeal review by Qualis Health or a provider appeal or recipient Fair Hearing by the State.

EPD WAIVER Program Medical Reviews

- Level of Care Reviews (LOC) must be submitted in CaseNet. A completed paper 1728 and an electronic 1728 must be included in your review form from the provider agency or Aging and Disability Resource Center (ADRC) in CaseNet. The provider is to retain the original copy of the form.
- Once the LOC is approved Qualis Health sends the information to DHCF’s Long Term Care Division and Case-management agency via CaseNet. DHCF’s LTCD will then send a transmittal to the Economic Security Association to determine financial eligibility. (for the initial LOC approval).
  - This process within ESA can take up to 45 days
- Once Qualis Health is tasked from DHCF’s Long Term Care Division or Provider agency, Qualis Health will conduct a review of the Personalized Care Plan within five business days according to DHCF’s Policy and Procedures to make a determination of services requested.
- Recertification for the LOC review; a task request is submitted from the provider agency via Casenet to Qualis Health. The provider is to retain the original copy of the 1728 form.

Nursing Home Reviews

- Medical Eligibility Reviews will be performed at the Nursing Home facility by a Qualis Health Clinical Review Specialist.
  - A minimum of one week’s advanced notice will be provided prior to visiting the facility to perform reviews.
  - Reviews will be conducted within 30 days of admission to a nursing facility
  - The recipient records subject to review will be faxed, or sent via secure email, in advance to the Nursing Home facility with the review date notice.
  - For readmissions to the nursing home, review will be conducted within 18 days, prior to expiration of the bed hold.
  - Documentation to justify the level of care as well as the presence of a completed Pre-admission Screening and Resident Review (PASRR), if required.
The Nursing Home facility will have all individual medical records (electronically or hard copy) available for review when the Qualis Health Clinical Review Specialist arrives at the facility.

- **Continued Stay Reviews** will be performed at the Nursing Home facility by a Qualis Health Clinical Review Specialist.
  - A minimum of one week’s advanced notice will be provided prior to visiting the facility to perform reviews.
  - Reviews will be conducted 30 days from the nursing home admission date, 6 months from the initial nursing home review and then annually.
  - The recipient records subject to review will be faxed, or sent via secure email, in advance to the Nursing Home facility with the review date notice.
  - Documentation to justify the level of care as well as the presence of a completed Pre-admission Screening and Resident Review (PASRR), if required.
  - The Nursing Home facility will have all individual medical records (electronically or hard copy) available for review when the Qualis Health Clinical Review Specialist arrives at the facility.

- **Approval Determinations**
  - Qualis Health will send letter notifications for approved review requests.
  - Notification of the approval determination will be provided via fax or via secure email within 5 business days of the approval determination being made for Nursing Home facility onsite reviews.

**Second-Level Peer Review**
- Cases that clinical reviewers have determined do not meet criteria are referred to a Qualis Health Medical Reviewer.
- The physician reviewer will review the clinical information and either certify the admission or issue a non-certification.

**Adverse Determinations**
- If the Qualis Health physician reviewer non-certifies the medical review, a Qualis Health representative will notify the appropriate facility by fax or secure email. Qualis Health will send the adverse determination letter within five business day to the following parties: the recipient, guardian or parents of recipient (if minor) and the requesting provider.
- The adverse determination letters will contain justification for the non-certification and an explanation of the right to request reconsideration review to Qualis Health’s initial non-certification determination as well as recipient appeal rights with the District.
• Qualis Health will send letter notifications for all non-certified reviews and Qualis Health reconsideration reviews. These notifications will be sent to the recipient and the requesting provider or facility within 5 business days of the determination being made.
• If the beneficiary and or the facility wishes to request a reconsideration, the reconsideration request must be made within 30 business days from the date the non-certified notification was sent.

The District of Columbia Department of Health Care Finance will not reimburse providers for services that have been non-certified by Qualis Health, with the exception of adverse determinations that are reversed as a result of a reconsideration review performed by Qualis Health or a recipient Fair Hearing by the District of Columbia Office of Administrative Hearing (OAH)
Section 15–Utilization Review Reconsiderations and Appeals

Overview

Qualis Health offers process in all cases involving an adverse determination. When a reconsideration review determination is to non-certify a review request, Qualis Health will generate written notification of the adverse decision within one business day of the date the decision is made. Qualis Health’s non-certification notification will include rights for an appeal review. Qualis Health’s reconsideration process features a second opinion by a physician who specializes in the services under review.

URAC requires that appeal reviews be conducted by individuals who:

- Are clinical peers
- Hold an active, unrestricted license to practice medicine or a health profession
- Are board-certified
- Are in the same profession and in a similar specialty as typically manages the condition
- Are neither the individual who made the original non-certification nor the subordinate of such an individual
- Have no conflicts of interest with the patient, attending physician, or facility being reviewed.

There are two types of reconsiderations potentially available—expedited or standard. Instructions on how to initiate each type of appeal are included in the adverse determination letter Qualis Health sends.

Expedited Reconsideration

Definition

An expedited reconsideration is an appeal of an adverse determination in a case involving urgent care.

Process and Procedures

A request for an expedited reconsideration may be made by telephone, fax or mail, within two business days of the date that appears at the top of the Non-Certification Letter if the recipient has not yet been discharged. If an expedited appeal request is filed after two business days, Qualis Health will respond to that request through the standard appeal process.
Requests for expedited appeals should be directed as follows:

How to Request an Expedited Appeal from the Qualis Health District of Columbia Office

<table>
<thead>
<tr>
<th>Call</th>
<th>(800) 251-8890</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax</td>
<td>(800) 731-2314</td>
</tr>
<tr>
<td>Write</td>
<td>Qualis Health Reconsideration Review PO Box 34800 Washington, DC 20043</td>
</tr>
</tbody>
</table>

Upon receipt of the request for an expedited appeal, the following will occur:

- Qualis Health will notify all appropriate parties of the request.
- Qualis Health will, if needed, request that any additional medical information necessary for the appeal review be submitted to us within two hours.
- The case will be referred to a Qualis Health physician reviewer who is licensed and/or accredited in the appropriate specialty or subspecialty who is not the same individual who initially reviewed and non-certified the review.
- The physician reviewer will review the medical information.
- If the physician reviewer reverses the non-certification decision, the Qualis Health representative will issue a certification number and length of stay (if applicable) and will notify all appropriate parties telephonically and in writing.
- If the physician reviewer modifies the decision or upholds the adverse determination, the requesting physician or facility will be notified telephonically and in writing.
- The District of Columbia MMIS will be updated electronically accordingly if decision is either reversed or modified.
- Notification with the review outcome, including clinical rationale will be sent to the recipient, attending physician as appropriate, and facility.

If the recipient, attending physician, or facility disagrees with the expedited outcome, a standard appeal may be filed.
Standard Reconsideration

Definition
A standard reconsideration is an appeal of an adverse determination. It is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals.

Process and Procedures
A request for a standard reconsideration must be made telephone, fax or mail within 21 days (for all review types with the exception of Medical Eligibility Nursing Home Reviews and Dental Reviews) of the date shown on the Non-certification Letter. A request for a standard reconsideration for Medical Eligibility Nursing Home Reviews and Dental Reviews must be made within 30 business days of the date shown on the Non-certification letter. Requests may also be made via telephone, followed by a written request.

Requests for standard appeals should be directed as follows:

<table>
<thead>
<tr>
<th>How to Request a Standard Appeal from the Qualis Health District of Columbia Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call</td>
</tr>
<tr>
<td>Fax</td>
</tr>
<tr>
<td>Write</td>
</tr>
</tbody>
</table>

Any request for reconsideration of an adverse determination will be reviewed by a Qualis Health physician/practitioner consultant licensed and/or accredited in the appropriate specialty or subspecialty as the attending physician, but will not be the same individual(s) who initially non-certified the review or the expedited appeal, if applicable.

Qualis Health will issue the reconsideration decision within 14 days of receipt of the request for a standard appeal. All appropriate parties will be notified in writing of Qualis Health’s determination to uphold, reverse, or modify the initial non-certification decision.

Qualis Health’s reconsideration decision will take precedence over the initial adverse determination or the expedited appeal decision, if applicable. For example, if the appeal review certifies more facility days than the original review, then more facility days will be recommended for certification.
District of Columbia, Department of Health Care Finance Fair Hearing Rights for Recipients

The District of Columbia, Department of Health Care Finance Fair Hearing procedure is the process by which recipients can contest the Qualis Health non-certification decision. Recipients may request a fair hearing by phone or in writing to the Fair Hearing representative at DC Office of Administrative Hearings within 90 days of the date on Qualis Health’s adverse determination or reconsideration determination letter non-certifying the service.

For Nursing Home denials, if a recipient requests a fair hearing within thirty (30) calendar days of the postmark date on the date of notice, the District of Columbia Medicaid program will continue to pay for the nursing facility costs while your appeal is pending.

Recipients may still request a hearing after thirty (30) calendar days of the postmark date on this notice, but the request must be filed no later than ninety (90) calendar days of the postmark date of the notice letter. If the request is filed after the thirty (30) calendar day period, the District of Columbia Medicaid program will not pay for the nursing facility costs during the appeal.

The request must state the rationale for requesting a Fair Hearing. The address and phone number to request a fair hearing:

Office of Administrative Hearings
One Judiciary Square
441 4th Street, NW
Suite 450 North
Washington, DC 20001
Telephone: (202) 442-9094
Fax: (202) 442-4789

You may also call, write or visit the Office of the Health Care Ombudsman at:
441 4th Street, NW 9th Floor
South Washington, DC 20001
Telephone: (202) 724-7491 or 1-877-685-6391
Fax: (202) 535-1216
Section 16–Potential Quality of Care Reviews

Overview

Qualis Health is committed to promoting optimum quality of care for all recipients and therefore will use the Centers for Medicare & Medicaid (CMS) Physician Reviewer Assessment Form (PRAF) “C” Category of Concern codes to assess quality of care in various settings while performing reviews. (Please refer to Appendix F.)

The facility and attending physician are responsible for delivering the utmost quality of care for their patients. The Qualis Health clinical reviewer is responsible for identifying potential quality of care concerns regarding District of Columbia Medicaid recipients. Potential quality of care concerns may be identified during all types of reviews, including retrospective chart reviews.

Process

If the Qualis Health clinical reviewer identifies a potential quality of care concern, when performing a review, the situation will be handled in one of two ways:

- If the clinical reviewer determines that the recipient’s quality of care is currently being compromised, a Qualis Health physician (medical director or P/PC) will be consulted. If the Qualis Health physician concurs that there is a potential quality of care concern, Qualis Health will refer the case to DHCS for further action.

- If the clinical reviewer determines that there is a potential quality of care concern, but the recipient’s care is not currently being compromised, a Qualis Health physician (medical director or P/PC( physician reviewer) will be consulted. If the Qualis Health physician concurs that there is a potential quality of care concern, Qualis Health will refer the case to the Division of Health Care Services for further action, and obtain the records if requested.
Section 17 – Miscellaneous Reviews

Overview

Miscellaneous reviews are received directly from the Department of Health Care Finance by Qualis Health. These ad hoc reviews require a specialized clinician (networks of clinicians) to render expert opinion.

Process

Qualis Health will review and provide an expert opinion on individual cases subject to review by another entity, but referred to us by the Contract Administrator for the purpose of determining whether the service under review was reasonable, medically necessary, and appropriate. Individual reviews will be performed by a Medical Reviewer (RN or Physician) with the components of the review to be determined by the individual case. Qualis Health will prepare an individual letter with outcomes documented for each individual review. This letter, which is the written report of findings, will also serve as the Special Cases Report that is submitted to the DHCF Contract Administrator within 48 hours of review of special cases.
Appendices

District of Columbia
Department of Health Care Finance
Utilization Review Quality Improvement Organization
Provider Manual
Appendix A – Contact Information and Business Hours

Qualis Health District of Columbia Office
PO Box 34800
Washington, DC 20043
Phone: (800) 251-8890

Fax Number (2017):

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Toll-Free Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All review types for providers who submit reviews infrequently</td>
<td>1 (800) 731-2314</td>
</tr>
</tbody>
</table>

Business Hours:
Monday through Friday,
8:00 am to 5:00 pm Eastern Time

Holiday Schedule:

Qualis Health District of Columbia Office Leadership
Janet Blackwood, RN, BSN, MA/MPA
Director, Qualis Health District of Columbia
Phone: (202) 847-2986
janetb@qualishealth.org

Cara Robinson, RN, BSN, CCM
Vice President Care Management, Qualis Health
Phone: (800) 949-7536 ext 2343
carar@qualishealth.org

District of Columbia, Department of Health Care Finance
Cavella Bishop
Program Manager, District of Columbia, Department of Health Care Finance
Phone: (202) 724-8936
cavella.bishop@dc.gov
Appendix B – DC DHCF Transmittal No. 14-09: New Quality Improvement Organization for the District of Columbia
GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Department of Health Care Finance  

Office of the Senior Deputy Director  

Transmittal No. 14-09  

TO: District of Columbia Medicaid Providers  

FROM: Linda Elam, Ph.D., M.P.H.  
Senior Deputy Director & State Medicaid Director  

DATE: DEC 12 2013  

SUBJECT: New Quality Improvement Organization for the District of Columbia  

The District of Columbia Department of Health Care Finance (DHCF) has contracted with Qualis Health (Qualis) to serve as the Quality Improvement Organization (QIO) responsible for conducting utilization reviews and quality improvement activities for the District’s fee-for-service (FFS) Medicaid program. As the QIO, Qualis will assist DHCF in improving safeguards against unnecessary and/or inappropriate care through prospective, concurrent, and retrospective reviews of medical services provided to District of Columbia Medicaid FFS recipients. This contract also provides for the review of hospital and nursing facility services provided to DC Medicaid recipients in the District and surrounding areas.  

A. Utilization Review Overview  

Qualis will conduct the following review activities:  

1. Prior-Authorization Reviews  
   a. Acute Care Hospitals  
   b. Gastric Bypass Surgery  
   c. Outpatient Medical and Surgical Procedures  
   d. Personal Care Aide (PCA) (re-certifications only)  
   e. Hearing Aids  
   f. Eyewear and Contact Lenses  
   g. Dental and Orthodontia Service  
   h. Durable Medical Equipment
i. Out-of-State Nursing Home Placement

j. Intellectual and Developmental Disabilities Waiver

k. Hospice Services

2. Pre-Admission Reviews

a. Specialty Hospital of Washington (Capitol Hill & Hadley)

b. National Rehabilitation Hospital (or other rehabilitation hospital)

c. Hospital for Sick Children (or other specialty hospital)

d. Psychiatric Institute of Washington

3. Emergency Admission Reviews

a. Acute Care Hospitals

b. Acute Care Hospitals Bordering Counties

4. Continued Stay Reviews

a. Specialty Hospital of Washington (Capitol Hill & Hadley)

b. National Rehabilitation Hospital (or other rehabilitation hospital)

c. Hospital for Sick Children (or other specialty hospital for special needs)

d. Non-DRG Acute Care Hospitals

e. Psychiatric Hospital of Washington

5. Retrospective Reviews

a. Subsequent Eligibility Admissions

6. Long Term Reviews

a. Level of Care Determinations (All)

b. Nursing Home Continued Stay Reviews

c. Elderly and Persons with Physical Disabilities (EPD) Waiver Level of Care

B. Medical Review Screening Criteria
1. Qualis will use nationally accepted utilization review criteria (Interqual) to conduct initial screening to determine medical necessity and to assess whether reasonable services were provided at the appropriate level of care for the following providers:

   a. Acute Care Hospitals,
   b. Specialty Hospitals,
   c. Rehabilitation Hospitals, and
   d. Acute Psychiatric Inpatient Hospitals

2. Qualis will utilize the DHCF developed criteria for Level of Care determinations, and admission and continued stay of Medicaid recipients in Long Term Care facilities.

C. Educational and Communication Activities

Over the next two months, Qualis will communicate with all providers on the transition process. Qualis will identify the review process and procedures for all review activities, and define the provider’s duties and responsibilities. Qualis will develop a provider website to house all documents related to the review process, including a Provider Manual, Policies and Procedures, and QIO contact information.

Qualis will schedule multiple orientation meetings with the various provider groups to provide more detailed information regarding communication, review procedures, medical review criteria, and the QIO’s web-based review process. Providers will also have an opportunity to ask questions and discuss any concerns.

Qualis will be fully functional to perform all review types on February 1, 2014.

If you have any questions regarding this information, please contact Cavella Bishop, Office of Clinicians, Pharmacy, and Acute Provider Service at (202)724-8936 or cavella.bishop@dc.gov.
Appendix C – DC DHCF 719A Form
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

TO: District of Columbia Home Care and other Fee-for-Service Medicaid Providers
FROM: Claudia Schlosberg, J.D.
       Senior Deputy Director and State Medicaid Director
DATE: February 24, 2017
SUBJECT: REVISED: 719A Form

The Department of Health Care Finance (DHCF’s) 719A form is used to request an authorization for medical/surgical service(s), for the Fee-for-Service (FFS) Medicaid beneficiaries. The 719A has been revised, and will be in effect starting March 1, 2017. The new 719A form incorporates the CMS requirement that a physician or nurse practitioner certify a face-to-face encounter, when ordering home care services and Durable Medical Equipment (DME). Moving forward, all sections of the 719A form must be completed in its entirety, hence the removal of specific numbered sections as specified in preceding transmittals.

The revisions are as follows:

- Addition of the Face-to-Face certification section for Home Care and DME
- Addition of Pharmacy and Hospice to the Requested Services section
- Corrections to the dental section
- Alignment of the prescribing and servicing provider sections
- Addition of the NPI section (both the DC provider ID and the NPI are required)
- Addition of the discharge date, if the beneficiary is in a treating facility at the time of the prior authorization request

If you have questions about these changes, please contact Cavella Bishop, Program Manager for the Division of Clinicians, Pharmacy, and Acute Provider Services via e-mail at cavella.bishop@dc.gov.

cc: Medical Society of the District of Columbia
    DC Hospital Association
    DC Health Care Association
    DC Primary Care Association
    DC Home Care Association
    DC Behavioral Health Association
    DC Coalition of Disability Service Providers
719A Prior Authorization Request

<table>
<thead>
<tr>
<th>Patient</th>
<th>Prescribing Provider</th>
<th>Servicing Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary DCID Number</td>
<td>Provider Number</td>
<td>NPI</td>
</tr>
<tr>
<td>Address City, State, Zip</td>
<td>Address City, State, Zip</td>
<td>Andrews City, State, Zip</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>DOB</td>
<td>SEX</td>
</tr>
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<thead>
<tr>
<th>Other Health Insurance Coverage</th>
<th>Requested Service</th>
<th>Beneficiary Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>DME</td>
<td>Home</td>
</tr>
<tr>
<td>Medical</td>
<td>Pharmacy</td>
<td>ICF/MR</td>
</tr>
<tr>
<td>Dental</td>
<td>Eyewear</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>Hospice</td>
<td>Other</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Requested Service Data</th>
<th></th>
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<tbody>
<tr>
<td>Diagnostic Code</td>
<td>Procedure Code</td>
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</table>

Justification

For Dental Use Only

<table>
<thead>
<tr>
<th>PRIMARY TEETH</th>
<th>FACIAL</th>
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<tbody>
<tr>
<td>Q1</td>
<td>01 02 03 04 05 06 07 08</td>
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<td>R</td>
<td>A B C D E F G H I J</td>
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<td>G</td>
<td>T S R Q P O N M L K</td>
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<td>H</td>
<td>32 31 30</td>
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<tr>
<td>T</td>
<td>29 28 27 26 25</td>
</tr>
<tr>
<td>Q4</td>
<td>24 23 22 21 20</td>
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</table>

A SIGNATURE OF THE REQUESTING PROVIDER: I CERTIFY THAT THE SERVICES REQUESTED ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

DATE

For DME and Home Care Use Only

I CERTIFY THAT THIS PATIENT IS UNDER MY CARE AND THAT I HAD A FACE-TO-FACE ENCOUNTER THAT MEETS PHYSICIAN FACE-TO-FACE ENCOUNTER REQUIREMENTS.

DATE

Durable Medical Equipment Face to Face Regulations

1. Any HCPCS code for the following types of DME: + Transcutaneous Electrical Nerve Stimulation (TENS) unit +Rollator Chair +Traction-cervical +Oxygen and Respiratory equipment +Hospital beds and accessories

2. Any item of DME that appears on the DMEHCPCS Fee Schedule with a price ceiling at or greater than $1,000.

3. Any other item of DME that CMS adds to the list of Specified Covered Items.
Appendix D – Dental Utilization Review Criteria Guidelines
Introduction

The following criteria will help to standardize the provider’s and consultant’s exercise of professional judgment. If the clinical condition of the patient reflects the criteria required by and such information is fully documented by the provider, the consultant may grant approval if in his/her professional judgment the service request is reasonable and consistent with the dental needs of the patient and conforms to the intent of the program.

Without sufficient acceptable diagnostic information, the consultant has no option but to deny approval or defer a decision. The necessity for the consultant to obtain adequate information and, thereby, to make a judgment on dental necessity is an integral part of the prior authorization and payment process.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Criteria and Benefits</th>
<th>Required Documentation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0160</td>
<td>DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT</td>
<td>A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dento-facial anomalies, complicated perio-prosthetic conditions, complex temporo-mandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc. A benefit once per patient per provider. The following procedures are not a benefit when provided on the same date of service with D0160: a. periodic oral evaluation (D0120), b. limited oral evaluation-problem focused (D0140), c. comprehensive oral evaluation- new or established patient (D0150), d. re-evaluation-limited, problem focused (established patient; not post-operative visit) (D0170), e. office visit for observation (during regularly scheduled hours-no other services performed (D9430). f. Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician (Dental Consultation) 1. Written documentation for payment-shall include documentation of findings that supports the existence of one of the following: a. dento-facial anomalies, b. complicated perio-prosthetic conditions, c. complex temporo-mandibular dysfunction, d. facial pain of unknown origin, e. severe systemic diseases requiring multi-disciplinary consultation.</td>
<td>Plans generally include an age restriction: extensive oral evaluation cannot be adequately completed on a patient under the age of 3. D0145 is used for reimbursement purposes. A comprehensive oral evaluation- new or established patient (D0150), detailed and extensive oral evaluation (D0160), or comprehensive periodontal evaluation (D0180) is allowed for the same patient and by the same dentist at a subsequent date, after the patient reaches three years of age. DHCF agrees with the age limit and dental provider may bill twice per year per same provider.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Criteria and Benefits</td>
<td>Required Documentation</td>
<td>Comments</td>
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| D0364 | CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW- LESS THAN ONE WHOLE JAW | Cone Beam CT is covered for the following indications:  
1. Evaluation prior to one of the following oral surgery indications:  
   A. Removal of maxillo-facial tumor, cyst, neoplasm or other pathologic entities that, due to their size and/or anatomic location, appear to encroach, impinge or are invested in/on critical anatomic structures (i.e., inferior alveolar nerve, maxillary sinus);  
   B. Arthroplasty of Temporomandibular (TM) fossae or condyle, TM joint replacement;  
   C. Developmental mid-face syndromes such as cleft palate, Treacher-Collins syndromes, etc.;  
   D. Surgical reconstruction of severe oral-facial trauma (such as those resulting from motor vehicle accidents, gunshot wounds, boating accidents or other disfiguring trauma).  
   In addition, when Cone Beam CT is requested prior to an oral surgery (a-d above), one of the following criteria must also be satisfied:  
   E. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach;  
   -OR-  
   F. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure.  
   In addition, when Cone Beam CT is requested prior to an oral surgery (a-d above), one of the following criteria must also be satisfied:  
   E. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach;  
   -OR-  
   F. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure.  
   Written documentation for prior authorization which includes rationale for request and  
   A. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach;  
   -OR-  
   B. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure.  
   Cone Beam CT refers to a tomographic imaging beam that is concentrated to a narrow field of the body, as in the case of dental views. Multi-dimensional images of the hard tissue of the jaw are created to assist the dentist in diagnosis and treatment planning for the patient. Cone beam CT provides an image of hard tissue that has no distortion and is anatomically correct. Views may include cross-sectional axial, coronal, sagittal, cephalometric, or panoramic.  
   Indications that are not covered (list may not be all inclusive)  
   1. Cone beam CT is not covered when used in conjunction with non-covered dental procedures.  
   2. Cone beam CT is not covered for other medically-related dental indications not listed as covered. |                                                                                                                                  |                                                                                                                  |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Criteria and Benefits</th>
<th>Required Documentation</th>
<th>Comments</th>
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<tbody>
<tr>
<td>D0365</td>
<td>CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MANDIBLE</td>
<td>2. Evaluation prior to orthognathic surgery when coverage criteria under the orthognathic surgery coverage policy are met AND information obtained by a CB/CT Scan is considered critical in determining surgical plan for the avoidance of disruption, invasion or fracture of a surrounding critical oral-facial structure.</td>
<td>• Written documentation for prior authorization which includes rationale for request</td>
<td>See D0364</td>
</tr>
<tr>
<td>D0366</td>
<td>CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW ONE FULL DENTAL ARCH – MAXILLA, WITH OR WITHOUT CRANIUM</td>
<td></td>
<td>• Written documentation for prior authorization which includes rationale for request</td>
<td>See D0364</td>
</tr>
<tr>
<td>D0367</td>
<td>CONE BEAM CT CAPTURE WITH INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM</td>
<td></td>
<td>• Written documentation for prior authorization which includes rationale for request</td>
<td>See D0364</td>
</tr>
<tr>
<td>D0470</td>
<td>STUDY MODELS/ DIAGNOSTIC CASTS</td>
<td>Also known as diagnostic models or study models. Benefits are available for diagnostic casts when taken as an initial diagnostic aid in determining a patient’s total treatment plan. Diagnostic casts are for the evaluation of orthodontic benefits only. A benefit: a. once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment). b. for patients under the age of 21.</td>
<td>1. Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned. 2. Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. 3. Photographs submission via the Qualis Health Provider Portal is preferred.</td>
<td>There are other situations for which study models/diagnostic cases are needed: D8080 (adolescent orthodontia) D8090 (adult orthodontia) and D8999 (unspecified orthodontic procedure by report) may require study models. Root canal therapy (D3310-D3348) guidelines state: “2. Periapical preoperative diagnostic radiographs of the involved tooth (teeth), additionally sufficient radiographs or other diagnostic material to establish the integrity of the remaining teeth and arches are</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Criteria and Benefits</td>
<td>Required Documentation</td>
<td>Comments</td>
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<tr>
<td>c.</td>
<td>for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).</td>
<td></td>
<td></td>
<td>required for prior authorization of permanent root canal therapy or retreatment of a previous root canal.” Oral Surgery (D7140-D7960) guidelines state: “For Procedure D7320 (alveoloplasty on an edentulous quadrant.) If radiographs are not sufficient to justify a need, (i.e., for soft tissue procedures) additional diagnostic material (photographs or models) and/or a statement of justification must be presented.” Bridges are a non-covered benefit without prior authorization from DHCF.</td>
</tr>
<tr>
<td>D2970</td>
<td>TEMPORARY CROWN (FRACTURED TOOTH)</td>
<td>Usually a preformed artificial crown, which is fitted over a damaged tooth as an immediate protective device. This is not to be used as temporization during crown fabrication. A provisional crown billed as a therapeutic measure for a fractured tooth may be allowed, subject to individual consideration. A benefit: a. once per tooth, per provider. b. for permanent teeth only. Not a benefit on the same date of service as: a. palliative (emergency) treatment of dental pain- minor procedure (D9110). b. office visit for observation (during regularly scheduled hours) - no other services performed (D9430). This procedure is limited to the palliative treatment of traumatic injury only and shall meet the criteria for a laboratory processed crown (D2710-D2792).</td>
<td>1. Tooth number, pre-operative periapical x-ray and narrative 2. Radiographs for payment - submit a pre-operative periapical radiograph. 3. Written documentation for payment - shall include a description of the circumstances leading to the traumatic injury. 4. Requires a tooth number.</td>
<td>Comment on D9110: If a tooth has been fractured to involve and/or expose the pulpal tissue (by carious lesion and/or extent of fracture, a pulpectomy (sometimes referred to as “open and broach” which is typically billed out as D9110) is indicated and a provisional or temporary restoration must be placed. In some cases, depending on the extent of the destruction of clinical crown, the only possible restoration is a temporary crown.</td>
</tr>
</tbody>
</table>
### Code Description | Criteria and Benefits | Required Documentation | Comments
--- | --- | --- | ---

**Rationale:**
Temporary crowns are used after a tooth is prepped and while awaiting the placement of the permanent crown. They are considered part of the procedure for the permanent crown and the charge is included in the fee for the permanent crown. A separate charge for a temporary crown is not allowed.

### ENDODONTICS (PROCEDURES D3110-D3450)

**General Policies, Procedures D3110-D3450:**

1. Includes those procedures which provide complete root canal filling on permanent teeth and pulpotomies (pulpectomies) on both deciduous and permanent teeth. Root canal therapy is covered if dentally necessary. It is dentally necessary when pathology is present, when the tooth is nonvital or the pulp has been compromised by caries, trauma, or accident which may lead to the death of the pulp, and the criteria set forth in this manual.

2. The prognosis of the affected tooth, other remaining teeth, and the type of final restoration allowable will be evaluated in considering root canal therapy.

3. Authorization and payment for root canal treatment includes, but is not limited to, any of all of the following procedures:
   a. Any incision and drainage or open and medicating procedure necessary in relation to the root canal therapy.
   b. Vitality test.
   c. Radiographs required during treatment including final treatment radiographs.
   d. Culture.
   e. Medicated treatment.
   f. Final filling of canal(s).
   g. Final treatment radiographs(s).

4. The initial opening into the canal, sealing of the access opening, all treatment visits and routine post-operative visits are included in the fee for the completed endodontic treatment.

5. Necessary postoperative care within a ninety (90)-day period is included in the reimbursement fee.

6. Necessary retreatment within a two (2)-year period is included in the fee for completed endodontic treatment. The time limitation does not apply when the re-treatment procedure is performed by a different provider/office.

7. Root canal therapy is not a benefit when extraction is appropriate for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.

8. Root canal treatment must be completed prior to payment.

9. The date of service on the payment request should reflect the final treatment date.

10. Cement bases, and insulating liners are considered part of restorations and are included in the fee for the completed restoration(s).

11. Permanent restoration for an endodontically treated tooth is a benefit when the coverage criteria specified in this manual for the particular restoration are met.

12. A non-resorbable filling material and a resorbable paste or cement should be used (silver points are not acceptable).

13. Films taken as part of the root canal therapy are part of and included in the fee for the completed endodontic therapy.
ROOT CANAL THERAPY (D3310-D3348)

General Policies, Procedures D3310-D3348:
1. Root canal treatment procedures D3310 (anterior), D3320 (bicusp)id), and D3330 (molar), or retreatment procedures D3346 (anterior), D3347 (bicusp)id), and D3348 (molar), are benefits with prior authorization for any permanent tooth and subject to criteria for coverage set forth in this manual.
2. Periapical preoperative diagnostic radiographs of the involved tooth (teeth), additionally sufficient radiographs or other diagnostic material to establish the integrity of the remaining teeth and arches are required for prior authorization of permanent root canal therapy or retreatment of a previous root canal.
3. Root canal therapy is a benefit for permanent teeth when dentally necessary and the final post-treatment restoration of the treated tooth will afford acceptable retention longevity; and:
   a. Missing teeth do not jeopardize the integrity or masticatory function of the dental arches; and
   b. The tooth is necessary to maintain adequate masticatory function; and
   c. Periodontal condition of the tooth and the remaining teeth must be no more involved than Periodontal Case Types II and III, as defined in General Policies - Periodontics procedures D4210 (Gingivectomy or Gingivoplasty) and D4920 (unscheduled dressing change).
4. Root canal therapy may be performed as an emergency service, without prior authorization, under the following conditions, which must be justified by documentation:
   a. Fracture of a coronal portion of a permanent tooth, exposing the vital pulpal tissue.
   b. When a tooth has been accidentally evulsed, the root canal may be performed prior to replacement of the tooth in the socket. These two (2) emergency situations must meet the arch integrity, tooth longevity, and all other criteria listed must be met.
   c. Payment of a root canal performed on an emergency basis is subject to review of documentation describing the emergency and pre-operative x-rays.
5. All endodontic treatment procedures include the removal of posts, silver point and previous root canal filling material, and any procedures necessary to prepare the canals for placement of the canal filling.
6. Films taken as part of the root canal therapy are part of and included in the reimbursement for the root canal therapy.

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### ENDODONTIC RETREATMENT

This procedure may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. A request for endodontic re-treatment must meet **at least one** of the following criteria:

- Apical pathology or a draining fistula.
- Lingering pain from percussion or temperature.
- Teeth must exhibit a minimum of 50% bone support.

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| D3346  | RETREATMENT OF PREVIOUS ROOT CANAL - ANTERIOR        | An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated. Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant. | 1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.  
2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.  
3. Requires a tooth number. |          |
| D3347  | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID |                                                                                        | 1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.  
2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.  
3. Requires a tooth number. |          |
| D3348  | RETREATMENT OF PREVIOUS ROOT CANAL - MOLAR           |                                                                                        | 1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.  
2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.  
3. Requires a tooth number. |          |
# APEXIFICATION/ RECALCIFICATION PROCEDURES (D3351-D3353)

## General Policies, Procedures D3351-D3353:

1. Apexification/Apexogenesis is defined as a technique for encouraging continued root formation and apical closure in teeth with incomplete apical development when the pulp is affected by trauma or caries.

2. Final obliteration of the root canal(s) may be accomplished when a radiograph indicates sufficient apical formation. The criteria for authorizing root canal treatment also apply to apexification and must be present prior to the initial pulpotomy treatment.

3. Not payable when procedure D3351 (apexification/recalcification, pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.), D3352 (apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.), or D3353 (apexification/recalcification, final visit), and a completed root canal treatment are performed on the same tooth on the same day.

<table>
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<tr>
<td>D3351</td>
<td>APEXIFICATION/RECALCIFICATION/PULPAL REGENERATION - INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)</td>
<td>Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy). A benefit: a. once per permanent tooth. b. for patients under the age of 21. Not a benefit: a. for primary teeth. b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. c. on the same date of service as any other endodontic procedures for the same tooth. This procedure includes initial opening of the tooth, performing a pulpectomy, preparation of canal spaces, lacement of medications and all treatment and post treatment radiographs.</td>
<td>1. Radiographs for prior authorization – submit periapical radiographs. 2. Requires a tooth number. 3. If an interim medication replacement is necessary, use apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) (D3352). 4. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post-treatment radiograph to demonstrate sufficient apical formation.</td>
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### APICOECTOMY/PERIRADICULAR SERVICES (D3410-D3432)

**General Policies, Procedures D3410-D3430:**
1. Apicoectomy/Periradicular Services, procedures D3410, D3421, and D3425, and D3427-D3432 require prior authorization.
2. Apicoectomy/Periradicular surgery, procedures D3410, D3421, and D3425, are defined as the excision of the apical portion of the root of a previously endodontically treated tooth to remove the diseased tissue.
3. These procedures may be indicated when an abnormality or blockage of the root end prevents the cleaning and sealing of the apical portion of a root canal through a coronal approach and the tooth remains symptomatic. They may also be indicated if the tooth is asymptomatic as clinically indicated. This occurs most commonly when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, or when a canal wall has been perforated or "shelved" during canal enlargement.
4. Procedure D3426 (apicoectomy/each additional root) is payable to a maximum of three (3) roots per tooth.
5. Not a benefit in conjunction with root canal therapy.

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<tr>
<td>D3410</td>
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<td>Typically used for procedures D3410, D3421, and D3425, and D3427-D3432.</td>
<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.</td>
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<td>D3421</td>
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<td>Typically used for procedures D3410, D3421, and D3425, and D3427-D3432.</td>
<td>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.</td>
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<tr>
<td>D3425</td>
<td></td>
<td>Typically used for procedures D3410, D3421, and D3425, and D3427-D3432.</td>
<td>3. Requires a tooth number.</td>
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<tr>
<td>D3426</td>
<td><strong>APICOECTOMY/(EACH ADDITIONAL ROOT)</strong></td>
<td>Typically used for procedures D3410, D3421, and D3425, and D3427-D3432.</td>
<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.</td>
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<td>A benefit for permanent teeth only.</td>
<td>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.</td>
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<td>Not a benefit:</td>
<td>3. Requires a tooth number.</td>
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<td>a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.</td>
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<td>b. to the original provider within 24 months of a prior apicoectomy/periradicular surgery, same root.</td>
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<td>c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.</td>
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<td>Only payable the same date of service as procedures D3421 or D3425.</td>
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<td>The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.</td>
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<tr>
<td>D3427</td>
<td>PERIRADICULAR SURGERY WITHOUT APICOECTOMY</td>
<td>Typically used for bicuspid and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement. A benefit for permanent teeth only. Not a benefit: a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented. b. to the original provider within 24 months of a prior Apicoectomy/Periradicular surgery, same root. c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. Only payable the same date of service as procedures D3421 or D3425. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.</td>
<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment. 3. Requires a tooth number.</td>
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<tr>
<td>D3428</td>
<td>BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY- PER TOOTH, SINGLE SITE</td>
<td></td>
<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment. 3. Requires a tooth number.</td>
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<td>D3429</td>
<td>BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY-EACH ADDITIONAL CONTIGUOUS TOOTH IN THE SAME SURGICAL SITE</td>
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<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.</td>
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<td>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.</td>
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<td>3. Requires a tooth number.</td>
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<tr>
<td>D3432</td>
<td>GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE, IN CONJUNCTION WITH PERIRADICULAR SURGERY</td>
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<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.</td>
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<td>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.</td>
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<td>3. Requires a tooth number.</td>
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### PERIODONTICS D4000-D4999: General Policies and Procedures

Radiographs must be **less than one (1) year old** and of diagnostic quality, showing the entire treatment site.

**Required Periodontal Charting:**
- Must be dated within 1 year of request and include the patient's full name.
- Current periodontal charting taken (no more than 12 months old) w/4-6 probing depths per tooth

General policy for all periodontal surgical procedures - Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three months, as well as any surgical reentry, except soft tissue grafts, for 24-36 months depending on the procedure. When a surgical procedure is billed within three months of the initial surgical procedure by the same dentist/dental office, the fee for the surgery is DISALLOWED. In the absence of documentation of extraordinary circumstances, the fee for additional surgery by the same dentist/dental office for 24 months is DISALLOWED.

Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented.

Current periapical radiographs of the involved areas and arch radiographs are required for periodontal scaling and root planing (D4341 and D4342) and osseous surgery (D4260 and D4261) for prior authorizations. A panoramic film alone is non-diagnostic for periodontal procedures.

Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) are a benefit once per quadrant in a 36 month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit a minimum of one 5mm+ pocket and radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.

Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by-case basis.

Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing. **NOTE: D4342 does not require Prior Authorization.**

Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.

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</table>
| D4210  | GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | It is performed to eliminate supra-bony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4260). Do not count tooth bounded spaces for D4210, D4341; count only "diseased teeth/periodontium." A tooth bounded space is the edentulous area bounded by two qualifying teeth. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. A benefit:  
  a. for patients age 13 or older except in unusual circumstances  
  b. once per quadrant every 36 months. | 1. Quadrant or tooth numbers, current periodontal charting (no more than 12 months old) w/4-6 probing depths per tooth or narrative describing condition of the tissue  
  2. Photographs for prior authorization-submit photographs of the involved areas.  
  3. Written documentation for prior authorization – shall include a definitive periodontal diagnosis.  
  4. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudo-pockets as a result of gingival hyperplasia, which is demonstrated on a photograph.  
  5. Requires a quadrant code. |
This procedure cannot be prior authorized within 30 days following periodontal scaling and root planning (D4341 and D4342) for the same quadrant.

6. If three or fewer diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4211).

**GINGIVECTOMY OR GINGIVOPLASTY (D4210-D4211)**

**General Policies, Procedures D4210-D4211:**
1. Gingivectomy or gingivoplasty procedures D4210 and D4211, are benefits in the treatment of moderate to deep gingival pockets (4-5 mm), moderate to severe bone loss, and include the removal of the soft tissue side of the pocket, eliminating the pocket, and creating a new gingival contour.

2. The quadrant shall be indicated on the request for payment.

3. Procedures D4210/D4211 (gingivectomy or gingivoplasty) may be allowable when an isolated pocket(s) has not responded to conservative treatment.
   a. Any combinations of gingivectomy or gingivoplasty (procedures D4210 or D4211), gingival flap procedures including root planing (procedures D4240/D4241) or osseous surgery (procedure D4260/D4261) are benefits once in thirty-six (36) months in the same quadrant.
   b. This procedure requires periodontal charting of the patient’s entire dentition.

4. Procedures D4210/D4211 (gingivectomy or gingivoplasty) may be allowable where a drug-induced hyperplasia is exacerbated in isolated areas.

5. These surgical procedures are directed at correction of the soft tissue around the tooth. Gingivectomy is the excision of the soft tissue wall of the periodontal pocket when the pocket is uncomplicated by extension into the underlying bone. Gingivoplasty is the procedure by which gingival deformities (particularly enlargements) are reshaped and reduced to create normal and functional form.

6. When muco-gingival procedures and osseous surgery are performed in the same quadrant and in the same treatment episode, the procedure code for the most inclusive procedure is appropriate for the quadrant.

**PERIODONTICS (PROCEDURES D4210-D4920)**

**General Policies, Periodontal Procedures D4210-4920:**
1. Periodontal Definitions.
   a. Type I-Gingivitis; inflammation of the gingiva, characterized clinically by gingival hyperplasia, edema, retractability, gingival pocket formation, pocket depth less than 4mm and no bone loss.
   b. Type II-Early periodontitis; progression of gingival inflammation into the alveolar bone crest and early bone loss resulting in moderate pocket formation (4-6mm).
   c. Type III- Moderate periodontitis; a more advanced state with increased destruction of periodontal structures associated with moderate-to-deep pockets (5-8mm), moderate-to-severe bone loss and tooth mobility.
   d. Type IV-Advanced periodontitis; further progression of periodontitis with severe destruction of the periodontal structures with increased pocket depth, usually greater than 7-8mm with increased tooth mobility.
   e. Type V-Refractory periodontitis; continues demonstration of numerous sites of periodontitis where loss of attachment is progressing, even after traditional therapy has been completed and good home care is evident.

2. Periodontal care shall be limited to those patients:
   a. Who exhibit generalized periodontal pocket depths in excess of 4-5 mm.
   b. Who have a minimum of one isolated pocket 5 mm or greater in depth per quadrant, and
   c. Where the isolated pockets of 5 mm or greater in depth have failed to respond to conservative treatment, including emergency treatment of periodontal abscesses.

3. Subgingival curettage, in the generally accepted sense, is a surgical service involving removal of the epithelial lining, granulation tissue, and other pocket contents, and includes the planing of the root surface to remove deposits and smoothing of the root surfaces. It is performed for patients with generalized pocket depths within the range of more than 4-5 mm and a minimum of one isolated pocket over 5 mm in depth per quadrant. This procedure is usually performed with local anesthesia.

4. Periodontal services shall be approved on an ordered schedule initially encompassing only the direct, least invasive measures.

5. In order to make a fair evaluation of prior authorization requests for periodontal procedures the following information shall be included with the request:
   a. Diagnostic radiographs dated within 1 year of the request.
b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition to charting missing and tooth treatment planned for extraction. Additional documentation of recession is also a consideration, as it points to one aspect of the preexisting condition of the hard and soft tissue.

   a. Case Type I is essentially gingivitis, little or no bone loss. Prophylaxis shall be adequate to control these cases. Authorization for sub-gingival curettage, mucogingival or osseous surgery for these cases shall not be granted.
   b. Case Types II and III (Early to moderate periodontitis, deep pockets (4-6 mm+), moderate to severe bone loss. The major emphasis of periodontal care covered under the DDSGP shall be the treatment of Case Types II and III, provided in an ordered schedule of services. Generally, initial treatment shall be limited to nonsurgical services such as sub-gingival curettage, followed by an evaluation period of a minimum of four (4) weeks.
   c. Case Type IV (deep pockets, severe bone loss, advanced mobility patterns) and Case Type V treatment plans shall not be authorized or rendered.

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<tr>
<td>D4211</td>
<td>GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH, OR TOOTH BOUNDED SPACES PER QUADRANT</td>
<td>It is performed to eliminate supra-bony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Crown lengthening involving soft tissue only is appropriately coded as D4211. A benefit: a. for patients age 13 or older. b. once per quadrant every 36 months. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planning (D4341 and D4342) for the same quadrant.</td>
<td>1. Quadrant or tooth numbers, current periodontal charting (no more than 12 months old) w/4-6 probing depths per tooth or narrative describing condition of the tissue 2. Photographs for prior authorization—submit photographs of the involved areas. 3. Written documentation for prior authorization – shall include a definitive periodontal diagnosis. 4. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudo-pockets as a result of gingival hyperplasia, which is demonstrated on a photograph. 5. Requires a quadrant code. 6. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).</td>
<td>Consider granting benefit exceptions for individuals &lt;age 13 in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care.</td>
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### Code | Description | Criteria and Benefits | Required Documentation | Comments
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**OSSEOUS AND MUCOGINGIVAL SURGERY PER QUADRANT (D4260-D4261)**

**General Policies, Procedures D4260-D4261:**

1. Osseous Surgery procedures D4260 and D4261, require prior authorization, the following information shall be included with the Prior Authorization Request:
   - a. Diagnostic radiographs.
   - b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition charting of missing teeth and teeth treatment planned for extraction.

2. A benefit for the surgical eradication of intrabony pockets and sufficient bone contouring to achieve adequate gingival architecture.

3. The quadrant shall be indicated on the Prior Authorization Request.

4. Scaling and root planing procedures D4341/D4342 performed in the same quadrant as osseous surgery must precede the surgery by at least four (4) weeks. When the interval between the procedures is less than four (4) weeks, the scaling and root planing is considered to be included in the fee for the surgery.

5. This procedure requires periodontal charting of the patient’s entire dentition following a minimum evaluation period of four (4) to eight (8) weeks post-operative to scaling and root planing procedures D4341/D4342. **NOTE: D4342 does not require prior Authorization.**

6. Any combinations of gingivectomy or gingivoplasty (procedures D4210 or D4211), gingival flap procedures including root planing (procedures D4240/D4241) or osseous surgery (procedure D4260/D4261) are benefits once in thirty-six (36) months in the same quadrant.

7. The fee for osseous surgery is considered to include osseous contouring; distal or proximal wedge surgery, frenectomy, scaling and root planing, soft tissue grafts, gingivectomy, and flap procedures. If there is a combination of procedures in one (1) quadrant then the most inclusive procedure applies.

**D4263** | BONE REPLACEMENT GRAFT FIRST SITE IN QUADRANT
--- | --- | --- | ---
This procedure involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes.

- a. Diagnostic radiographs.
- b. Quadrant or tooth numbers, current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.

**D4264** | BONE REPLACEMENT GRAFT EACH ADDITIONAL SITE IN QUADRANT
--- | --- | --- | ---
This procedure involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved.

- a. Diagnostic radiographs.
- b. Quadrant or tooth numbers, current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.
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<tr>
<td>D4341</td>
<td>PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT</td>
<td>This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. A benefit: a. for patients age 13 or older. b. when there is a minimum of one 4mm+ pocket on each diseased tooth. c. once per quadrant every 12 months. Exception for special needs population may require procedure more than once a year. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant. Prophylaxis (D1110 and D1120) are not payable on the same date of service.</td>
<td>1. Full mouth periodontal charting including 4 to 6 probing depths per tooth; indication of furcation involvement, mobility, or bleeding upon probing. Consideration should also be given to include recession if documented. 2. Radiographs for prior authorization – submit periapical radiographs of the involved areas and arch radiographs. 3. Written documentation for prior authorization – shall include a definitive periodontal diagnosis. 4. A current and complete periodontal evaluation chart is required for prior authorization. 5. Requires a quadrant code. 6. If three or fewer diseased teeth are present in the quadrant, use periodontal scaling and root planning (D4342).</td>
<td>NOTE: D4342 does not require prior approval.</td>
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<td>Consider granting benefit exceptions for individuals &lt;age 13 in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care.</td>
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<td>General Policies, Procedures D4341-D4342: Please refer to Transmittal 10-26 for exception for the special needs population. 1. Periodontal scaling and root planing procedures D4341 and D4342, require prior authorization and shall be authorized by quadrant, the following information shall be included with the Prior Authorization Request: a. Diagnostic radiographs. b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition charting of missing teeth and teeth treatment planned for extraction. 2. Each quadrant requested must have a minimum of one (1) 5 mm or greater pocket. 3. When justified, a maximum of five (5) quadrant treatments may be authorized in a twelve (12)-month period. 4. Procedures D1110-D1120, prophylaxis, adult &amp; child, are not payable on the same date of service as scaling and root planing procedures D4341/D4342. NOTE: D4342 does not require prior Authorization 5. Periodontal scaling and root planing procedures D4341/D4342 are not payable same date of service as any surgical periodontal procedure. 6. Generally, periodontal scaling and root planing procedures D4341/D4342 is performed prior to the provision of either procedures D4210/D4211, gingivectomy or gingivoplasty, or procedures D4260/D4261 osseous and muco-gingival surgery.</td>
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</table>
Dental implants are an accepted method for tooth replacement. The therapeutic goal of dental implants is to support restorations that replace a missing tooth or teeth so as to provide the member comfort and function and to assist in the ongoing maintenance of the remaining intraoral and perioral structures. The first dental implant was a titanium implant in a human volunteer in Sweden by Dr. Per-Ingvar Branemark, a Swedish Orthopedic Surgeon in 1965.

There are three types of dental implants, the endosseous, subperiosteal and transosteal. Dental Implants can be performed as delayed procedures (over months or years) or immediate (at the time of tooth extraction).

An abutment is a connection to a dental implant that is a manufactured component usually made of machined high noble metal, titanium, titanium alloy or ceramic. A custom abutment is fabricated for a specific member using a casting process and usually is made of noble or high noble metal.

Surgical stents are highly recommended for more accurate placement of dental implants.

Factors influencing the selection of patients for dental implants include age, general and dental health and individuals with special needs.

Candidates for dental implants must be age 18 or older and not pregnant.

When a tooth or teeth adjacent to the site of the requested dental implants requires restoration, the tooth or teeth should be treated prior to requesting the dental implant. If the tooth or teeth demonstrate significant disease treat the diseased tooth or teeth prior to submitting for the dental implant request. If there is injury to the tooth or teeth, and/or multiple missing teeth, more conservative treatment shall be considered as an alternative to dental implants to treat the condition and replace all missing teeth.

I. Single dental implants are medically appropriate when a functional deficit exists.

II. Dental implant bodies are medically appropriate to anchor a removable denture, not a fixed prosthesis, if the traditional removable dentures cannot be worn or are painful.

   Coverage is limited to four upper dental implant bodies in the maxilla or two lower dental implant bodies in the mandible for the edentulous patient.

III. Dental implants are not medically appropriate in the following situations:

   • Presence of local or systemic conditions that may interfere with the normal healing process and subsequent tissue homeostasis.
   • Inadequate quality or quantity of alveolar bone and soft tissues.
   • The patient currently has active periodontal disease and poor hygiene.
   • Replacement of a second molar if used to extend the functional first molar occlusion, unless the patient has an Orthodontic problem.
   • Replacement of wisdom teeth (1, 16, 17 and 32).
   • When maintenance of the tooth/teeth is/are not considered. By this, it is meant that placement of dental implants in an area which is not truly of functional benefit to the patient or in an arch which should actually be edentulated altogether should not be covered. In this case, it will be up to the Qualis dental reviewer to determine if the patient can reasonably and successfully (or at least adequately) function with non-implant-borne dentures.
   • When the teeth are not in occlusion (meeting of the upper and lower teeth when the jaw is closed and the tooth/teeth surfaces come in contact). There is the possibility that the dental implant would be placed in a site unopposed (i.e. not in occlusion) with natural dentition but would be functioning against a denture tooth in the opposing arch.
### Dental Utilization Review Criteria Guidelines, 2017

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<td>IV.</td>
<td>Four (4) dental implants per arch will be authorized for the partially edentulous patient; for the completely edentulous, four (4) in the maxilla and two (2) in the mandibular area. When more than four (4) teeth are missing in the same arch bilaterally, consideration must be given to a removable partial denture as an alternative benefit.</td>
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<td>V.</td>
<td>There must be at least 3 mm of inter-dental space between dental implants and naturally existing teeth to maintain periodontal health and form.</td>
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<td>VI.</td>
<td>If stents are required for dental implant placement, one stent per arch will be allowed.</td>
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<td>VII.</td>
<td>Dental implants will be re-evaluated via intra-oral radiographs or CT scans prior to the authorization of abutments or crowns four to six months after dental implant placement.</td>
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<td>VIII.</td>
<td>After abutments or crowns are seated, a final intraoral radiograph or CT scan must be reviewed by Qualis Health dental reviewers before any further services in that area can be authorized.</td>
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<td>IX.</td>
<td>If an anterior tooth has been extracted due to trauma, gross caries or endodontic failure, with good general and periodontal health and controllable risk factors, an anterior dental implant is justified and will be authorized.</td>
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<td>X.</td>
<td>If bone grafting and augmentation is necessary, there must be a 4-6 months interval with good quality/contrast X-Rays or CT Scan for review by Qualis dental reviewers.</td>
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<td></td>
<td>1. Candidates for implants must be age 18 or older and not pregnant.</td>
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<td>2. Stable periodontal health and overall dental health in the entire mouth must be demonstrated.</td>
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<td>3. Documentation submitted must demonstrate absence of radiographic and clinical calculus, pre-and post-periodontal charting and treatment, and an adult prophylactic/preventive procedure date not to exceed 6 months prior to the request for implant restoration.</td>
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<td>4. Tooth (teeth) to be replaced must have an opposing occlusion.</td>
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<td>5. Authorization to replace wisdom teeth (1,16,17 and 32) will not be approved.</td>
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<td>6. Dental implants that fail will not be replaced. (**).</td>
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<td>7. Four (4) implants per arch will be authorized for the partially edentulous patient, and for the completely edentulous, four (4) in the maxilla and two (2) in the mandibular.</td>
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<td>8. There must be at least 3 mm of inter-dental space between implants and naturally existing teeth.</td>
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<td>9. If stents are required for dental implant placement, one stent per arch will be allowed.</td>
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<td>10. Dental implants will be re-evaluated with X-rays and or CT scans prior to the authorization of abutments or crowns after 4-6 months.</td>
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<td>11. If bone graft augmentation is necessary, there must be a 6 month interval before a dental implant can be placed and good quality/contrast x-rays or CT scans must be submitted for review.</td>
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<td>12. The optimal dimensions of available alveolar bone for most forms of implant placement are: 5mm in width, 13-15 mm in height and 5 mm in length.</td>
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<td>13. All requests for dental implants will be reviewed by dentists</td>
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<td>14. Other Contraindications for dental implants will include:</td>
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<td>a. treatment including but not limited to long-term steroid therapy, radiation therapy to a potential implant site, chemotherapy, hemodialysis, heart surgery (within the last six months), recent Myocardial Infarction, (within past 6 months) or hyperbaric oxygen treatment for osteoradionecrosis.</td>
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<td>b. Concomitant use of anticoagulants or medications that contraindicates implant success, such as bisphosphonates</td>
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<td>c. Known illicit drug use (eg. Crack, methamphetamine, heroin, cocaine or other drugs that can be smoked and/or applied to the intraoral tissues)</td>
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<td>d. Uncontrolled metabolic disorders, chronic renal disease, or a severe systemic disease (including but not limited to leukemia and collagen disorders such as systemic lupus erythematosis and scleroderma).</td>
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<td>e. Uncontrolled buliemia, GERD, or other conditions causing acid reflux</td>
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<td>f. Presence of intra- and peri-oral piercings</td>
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<td>g. Unstable psychiatric or chronic illness as noted above included poorly controlled diabetes mellitus with a current Hemoglobin A1c (HgbA1c&gt;7%).</td>
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<td>h. Any history of dental implant failure or intraoral bone graft failure</td>
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**Dental health and history**

- The patient must have generally healthy, well maintained and stable dentition.
- Documentation provided should show absence of radiographic and clinical calculus, a full-mouth periodontal charting, and an adult oral prophylaxis procedure, the date not to exceed 6 months prior to request for implant restoration.
- Initial documentation should clearly indicate any areas of current facial anesthesia, paresthesia, or dysesthesia as might be encountered in a patient with a past history of trauma, oral-maxillofacial surgical procedures, tumors, anatomical anomalies, etc.
- Tooth (teeth) to be replaced must have an opposing occlusion
- The patient must have no dental habits or oral conditions that preclude the placement of implants, including but not limited to:
  - bruxism, craze lines,
  - severe ulceration or erosive lesions,
  - temporomandibular joint disorder or myofascial pain disorder,
  - history of facial fractures (which may preclude the placement of implants, however this will be considered on a case by case situation).
- The patient should have no history of dental implant failure or intraoral bone graft failure.
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<td>D6010</td>
<td>SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT</td>
<td>Includes second stage surgery and placement of healing cap. Coverage is only for replacement of missing natural teeth. Implants done solely to restore a space beyond the normal complement of natural teeth are not covered.</td>
<td>1. Date of last dental cleaning listed on 719a form box 13</td>
<td>All radiographs submitted must be free of tarter and show mouth is stable w no decay or extractions needed.</td>
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<td>2. Full mouth radiographs (Panorex or CSX) including Periapicals of site requesting dental implant,</td>
<td>A. Dental implants are <strong>not medically appropriate</strong> in the following situations:</td>
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<td>3. Full-mouth periodontal charting, unless patient is completely edentulous</td>
<td>o Presence of local or systemic conditions that may interfere with the normal healing process and subsequent tissue homeostasis.</td>
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<td>4. Requires a tooth number</td>
<td>o Inadequate quality or quantity of alveolar bone and soft tissues.</td>
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<td>5. Clinical justification for the dental implants, including the reasons conventional removable dentures cannot be used to replace the missing teeth;</td>
<td>o The patient currently has active periodontal disease and poor hygiene.</td>
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<td>6. Requests for edentulous patients must indicate date denture or partial denture was completed and any realignments within 2 years. NOTE: if requests for implants is due to ill-fitting dentures patient must have been in dentures for 2 years and had at least 2 realignments.</td>
<td>o Replacement of a second molar if used to extend the functional first molar occlusion, unless the patient has an Orthodontic problem.</td>
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<td>o Replacement of wisdom teeth (1, 16,17 and 32).</td>
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<td>o When maintenance of the tooth/teeth is/are not considered. By this, it is meant that placement of dental implants in an area which is not truly of functional benefit to the patient or in an arch which should actually be edentulated altogether should not be covered. In this case, it will be up to the Qualis dental reviewer to determine if the patient can reasonably and successfully (or at least adequately) function with non-implant-borne dentures.</td>
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<td>o When the teeth are not in occlusion (meeting of the upper and lower teeth when the jaw is closed and the tooth/teeth surfaces come in contact). There is the possibility</td>
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- that the dental implant would be placed in a site unopposed (i.e. not in occlusion) with *natural* dentition but would be functioning against a *denture tooth* in the opposing arch.

B. Four (4) dental implants per arch will be authorized for the partially edentulous patient; for the completely edentulous, four (4) in the maxilla and two (2) in the mandibular area.

C. When more than four (4) teeth are missing in the same arch bilaterally, consideration must be given to a removable partial denture as an alternative benefit.

D. There must be at least 3 mm of interdental space between dental implants and naturally existing teeth to maintain periodontal health and form.

E. If stents are required for dental implant placement, one stent per arch will be allowed.

F. Dental implants will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments or crowns four to six months after dental implant placement.

G. After abutments or crowns are seated, a final intraoral radiograph or CT scan must be reviewed by Qualis Health dental reviewers before any further services in that area can be authorized.

H. If an anterior tooth has been extracted due to trauma, gross caries or endodontic failure, with good general and periodontal health and controllable risk factors, an anterior dental implant is justified and will be
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<tr>
<td>D6056</td>
<td>PREFABRICATED ABUTMENT INCLUDES MODIFICATION AND PLACEMENT</td>
<td>A connection to an implant that is a manufactured component, usually made of machined high noble metal, titanium, titanium alloy or ceramic. Modification of a prefabricated abutment may be necessary and is accomplished by altering its shape using dental burs/diamonds.</td>
<td>1. Periapical radiograph of fully integrated implant 2. Requires a tooth number 3. Arch radiograph showing placed integrated implant 4. IO photo of healed tissue surrounding healing cap of implant</td>
<td>I. If bone grafting and augmentation is necessary, there must be a 4-6 months interval with good quality/contrast X-Rays or CT Scan for review by Qualis dental reviewers.</td>
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<td>D6058</td>
<td>ABUTMENT SUPPORTED PORCELAIN / CERAMIC CROWN</td>
<td>A single crown restoration that is retained, supported and stabilized by an abutment on an implant</td>
<td>1. Periapical radiograph of integrated implant with abutment, and arch radiograph with abutment placed 2. Requires a tooth number 3. IO photo of healed abutment, which shows healthy gingiva surrounding abutment. 4. Periodontal charting, if patient has any remaining teeth present (ie: edentulous patients do not require periodontal charting)</td>
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<td>D6081</td>
<td>SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE</td>
<td>Prior Authorization is required. D6081 is billed one unit per tooth position and once per calendar year.</td>
<td>The dental provider cannot bill for D6081 on the same date of service for the following scenarios: 1) D1110 and D4910 are billed. 2) D4341, D4342,D4240, D4241, are billed for the same quadrant. 3) D6101 has been reimbursed for the same tooth position in a calendar year.</td>
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<tr>
<td>D6085</td>
<td>PROVISIONAL IMPLANT CROWN</td>
<td>One unit per tooth position.</td>
<td>Prior Authorization required same reimbursement rate as D2799.</td>
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| D6101 | DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE | • The implant site must have healed for at least six months and be fully integrated.  
• Direct loading will be considered  
• Implant must have good crown/root ratio  
• Must not have more than two treads above the alveolar crest  
• Implant must not be closer than 1-1.5mm to adjacent roots                                                                 | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.  
2. Pre-op radiographic images of defect and narrative  
3. IO Photo of bony defect area                                                                 |                                                                                                                                                              |
| D6102 | DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE | As for D6101                                                                                           | 1. A Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.  
2. Pre-op radiographic images of defect and narrative  
3. IO Photo of bony defect area                                                                 |                                                                                                                                                              |
| D6103 | BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration | As for D6101                                                                                           | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.  
2. Pre-op radiographic images of defect and narrative  
3. IO Photo of bony defect area                                                                 |                                                                                                                                                              |
| D6104 | BONE GRAFT AT TIME OF IMPLANT PLACEMENT                                      | Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.  
Criteria as for D6101  
Not allowed on same day as other bone grafting procedures.                                                                 | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.  
2. Pre-op radiographic images of defect and narrative  
3. IO Photo of bony defect area                                                                 |                                                                                                                                                              |
| D6110 | IMPLANT SUPPORTED REMOVABLE COMPLETE DENTURE FOR EDENTULOUS ARCH - MAXILLARY ARCH | Removable complete maxillary denture that attaches to abutments  
Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture  
If beneficiary has received a maxillary denture                                                                 | 1. Intra Oral (IO) photo showing healthy gingiva surrounding abutment.  
2. Periapical radiograph of integrated implant w abutment placed                                                                 |                                                                                                                                                              |
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| D6111  | IMPLANT SUPPORTED REMOVABLE COMPLETE DENTURE FOR EDENTULOUS ARCH-MANDIBULAR ARCH | Denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments. | Same as D6110                                                                        | Intra Oral (IO) photo showing healthy gingiva surrounding abutment.  
2. Periapical radiograph of integrated implant w abutment placed |
| D6112  | IMPLANT SUPPORTED REMOVABLE PARTIAL DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY ARCH | Removable Maxillary partial denture that attaches to abutments.  
Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture  
If beneficiary has received a maxillary partial denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments. | Same as D 6110                                                                        | Intra Oral (IO) photo showing healthy gingiva surrounding abutment.  
2. Periapical radiograph of integrated implant w abutment placed  
3. Full mouth periodontal charting |
| D6113  | IMPLANT SUPPORTED REMOVABLE PARTIAL DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR ARCH | Removable Mandibular partial denture that attaches to abutments.  
Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture  
If beneficiary has received a mandibular partial denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments. | Same as D6110                                                                        | Intra Oral (IO) photo showing healthy gingiva surrounding abutment.  
2. Periapical radiograph of integrated implant w abutment placed  
3. Full mouth periodontal charting |
### ORAL SURGERY (PROCEDURES D7140-D7960)

#### General Policies, Procedures D7140-D7960:

1. Diagnostic periapical radiographs are required for all surgical procedures that are submitted for authorization and/or payment except:
   - For procedures performed on soft tissue structures;
   - For Procedure D7320 (alveoloplasty on an edentulous quadrant.) If radiographs are not sufficient to justify a need, (i.e., for soft tissue procedures) additional diagnostic material (photographs or models) and/or a statement of justification must be presented.

2. Submitted periapical radiographs should show all aspects of a suspected pathologic area or neoplasm, the entire crown and apices of all teeth to be excised or extracted. In those cases where the radiograph of the crown of the tooth is not complete but there is sufficient evidence presented to substantiate the need for the surgical procedure, the surgical procedure may be allowed.

3. Oral surgery services to correct longstanding abnormalities of the mandible or maxilla, e.g., prognathia or retrognathia, or skin grafts for denture retention purposes or intersosseous implants for procedures is not a benefit.

4. Extraction of asymptomatic teeth is not a benefit. The following includes, but is not all inclusive of, conditions which may be considered symptomatic when documented:
   - Fully bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length.
   - Teeth, which are involved with a cyst, tumor, or other neoplasm.
   - Unerupted teeth, which are distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth.
   - Misaligned tooth (teeth), which cause the exacerbation of periodontal disease in adjacent teeth/areas.
   - Extractions of primary teeth required to minimize malocclusion or misalignment when there is inadequate space to allow normal eruption of the permanent tooth (teeth).
   - Perceptible radiologic pathology that fails to elicit symptoms.
   - Extractions that are required to complete dentally necessary orthodontic dental services.

5. Routine postoperative visits (within 30 days following surgical procedure) are considered part of, and included in, the global fee for the surgical procedure.

6. Extractions of asymptomatic deciduous teeth that appear by radiographic evaluation ready to exfoliate naturally are not a benefit.

7. The fees for oral surgery procedures include local anesthesia and routine postoperative visits.

8. The fee for extractions includes the excision of associated minor cystic or inflamed tissue.

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<th>Code</th>
<th>Description</th>
<th>Criteria and Benefits</th>
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<tbody>
<tr>
<td>D7285</td>
<td>BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)</td>
<td>For removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery. A benefit: a. for the removal of the specimen only. b. once per arch, per date of service regardless of the areas involved. Not a benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.</td>
<td>1. Radiographs for payment – submit a pre-operative radiograph. 2. A pathology report from a certified pathology laboratory is required for payment. 3. Requires an arch code.</td>
<td>If during the course of the listed endodontic or oral surgery procedures, the provider finds an unexpected or unanticipated lesion that in his/her professional judgment necessitates excision and biopsy, this should be allowed by special report. The processing of the biopsy (i.e. Laboratory and pathologist fees) are a benefit through the patient's Medicaid; this information is given to the laboratory processing the specimen. The medical portion will have codes in place so that these secondary fees can be covered.</td>
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<tr>
<td>BIOPSY OF ORAL TISSUE (D7285-D7286)</td>
<td>General Policies, Procedures D7285-D7286: 1. Procedures D7285 (biopsy of oral tissue, hard) and D7286 (biopsy of oral tissue, soft) are benefits as an independent procedure for collecting tissue specimen(s). 2. Not a benefit in conjunction with the extraction of a tooth or root or excision of any body part or neoplasm in the same area or region on the same day. 3. Please indicate the area of the lesion and submit operative and pathology reports.</td>
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<td>D7310</td>
<td>ALVEOLOPLASTY IN CONJUNCTION WITH EXTRCTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT</td>
<td>The alveoplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.</td>
<td>1. Radiographs for payment – submit radiographs of the involved areas. 2. Requires a quadrant code.</td>
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<td>ALVEOLOPLASTY (D7310-D7320)</td>
<td>General Policies, Procedures D7310-D7320: 1. Alveolectomy (alveoplasty) is a collective term for the operation by which the shape and condition of the alveolar process is improved for preservation of the residual bone. 2. Tuberosity reductions are considered to be included as part of the global fee for an alveoplasty or multiple extractions in the same quadrant. 3. Some form of alveolectomy is indicated in almost every case of multiple extractions and frequently in single extractions as well. Normally alveolectomy procedures necessary in conjunction with the extraction of teeth are included as part of the extraction procedures.</td>
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<td>D7320</td>
<td>ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRCTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT</td>
<td>No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.</td>
<td>1. Radiographs for payment – submit radiographs of the involved areas if photographs do not demonstrate the medical necessity. 2. Photographs for payment– submit photographs of the involved areas. 3. Requires a quadrant code.</td>
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<tr>
<td>D7340</td>
<td>VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)</td>
<td>Benefit allowance includes sutures, local anesthesia and routine post-operative care. Benefits are allowed once in a 60 month (5 year) period per arch Not a benefit: a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch. b. on the same date of service with</td>
<td>1. Radiographs for prior authorization – submit radiographs. 2. Photographs for prior authorization – submit photographs. 3. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed</td>
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<td>extractions (D7111- D7250) same arch. prosthodontic treatment.</td>
<td>4. Requires an arch code.</td>
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<td><strong>EXCISION OF CYST (D7450-D7451)</strong></td>
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<td><strong>General Policies, Procedures D7450-D7461:</strong></td>
<td>1. The appropriate procedure number shall be determined by the measurement of the cystic image on the diagnostic x-ray presented unless otherwise documented by report.</td>
<td></td>
<td>The processing of the biopsy (i.e. Laboratory and pathologist fees) are a benefit through the patient’s Medicaid; this information is given to the laboratory processing the specimen. The medical portion will have codes in place so that these secondary fees can be covered. <strong>See # 4 to the left.</strong></td>
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<td>2. Payment will not be made without an adequate radiograph of the neoplasm in question.</td>
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<td>3. Please identify the area of the lesion and provide the operative and pathology reports.</td>
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<td>4. Biopsy D7286 on same day for same area is not a covered service.</td>
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<td>5. Postoperative care within a thirty (30)-day period following surgery shall be included in the fee for the services.</td>
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<tr>
<td>D7451</td>
<td>REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM</td>
<td>1. Radiographs for payment – submit a radiograph of the cyst or tumor.</td>
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<td>2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.</td>
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<td>3. A pathology report from a certified pathology laboratory is required for payment.</td>
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<tbody>
<tr>
<td>D7460</td>
<td>REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM</td>
<td>1. Radiographs for payment- submit a radiograph of the cyst or tumor.</td>
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<td>2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.</td>
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<td>3. A pathology report from a certified pathology laboratory is required for payment.</td>
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<td>2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.</td>
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<td>3. Requires a quadrant code.</td>
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## EXCISION OF BONE TISSUE (D7471-D7490)

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<tbody>
<tr>
<td>D7471</td>
<td>REMOVAL OF TORUS PALATINUS,</td>
<td>1. A benefit when done in conjunction with the construction, reconstruction, or rel ine of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring at the midline of the hard palate.</td>
<td>1. Photographs for payment – submit pre-operative photographs.</td>
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<tr>
<td>D7472</td>
<td>REMOVE TORUS MANDIBULARIS</td>
<td>2. A benefit once per Quadrant per date of service</td>
<td>2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthetic treatment.</td>
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<td>3. Not a benefit if the condition is:</td>
<td>3. Requires a quadrant code.</td>
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<td>a. Asymptomatic; or</td>
<td>4. The extent and severity of this procedure is difficult to diagnose using x-rays only.</td>
<td>Justification by models, photos, narrative, or other diagnostic modalities may be required.</td>
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<td>b. Will be bypassed by a dental prosthesis.</td>
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**General Policies, Procedures D7471-D7490:**

1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring at the midline of the hard palate.

2. Not a benefit if the condition is:
   a. Asymptomatic; or
   b. Will be bypassed by a dental prosthesis.

3. The extent and severity of this procedure is difficult to diagnose using x-rays only, therefore justification by models, photos, narrative, or other diagnostic modalities may be required.
### SURGICAL INCISION (D7510-D7520)

**Procedure D7960: Frenulectomy also known as Frenectomy or Frenotomy- Separate Procedure not Incidental to Another Procedure.**

1. A benefit where it is documented that:
   a. A short labial frenum interferes with the mobility of the central portion of the lip.
   b. A hypertrophy of the frenum and papilla palatina interferes with the proper fitting and retention of a prosthetic appliance.
   c. A hypertrophy of the frenum and overextension to the papilla palatine produces a diastema in children; or
   d. Where attachment of frenum displaces interdental papilla or marginal gingival with consequent periodontal disease.

2. A benefit in cases of ankyloglossia where there is interference with proper mastication or where frenum interferes with the normal use or function of a prosthetic appliance.

3. Appropriate diagnostic material must be submitted in order to process for payment.

4. Routine postoperative care (within 30 days of surgical procedure) is considered part of and included in the global fee for the procedure.

5. Not payable when provided in conjunction with vestibuloplasty, alveoplasty with ridge extension, or excision of hyperplastic tissue.

**Procedure D7970: Excision of Hyperplastic Tissue**

1. Documentation required.

2. Payable when inflammatory hyperplastic tissue interferes with normal mastication or in an edentulous area where the inflammatory hyperplastic tissue interferes with normal use or function of a prosthetic appliance.

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| D7840 | CONDYLECTOMY         | Surgical removal of all or portion of the mandibular condyle (separate procedure). Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable) should be followed. | 1. Radiographs for prior authorization – submit a appropriate imaging  
2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history. |         |
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<tbody>
<tr>
<td>D7850</td>
<td>SURGICAL DISCECTOMY, WITH/ WITHOUT IMPLANT</td>
<td>Excision of the intra-articular disc of a joint.</td>
<td>1. Radiographs for prior authorization – submit appropriate imaging.</td>
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<td>Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.</td>
<td>2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.</td>
<td>3. An operative report shall be submitted for payment.</td>
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<td>D7860</td>
<td>ARTHROTOMY</td>
<td>Cutting into joint (separate procedure).</td>
<td>1. Radiographs for prior authorization – submit appropriate imaging.</td>
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<td>Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.</td>
<td>2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.</td>
<td>3. An operative report shall be submitted for payment.</td>
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<tr>
<td>D7940</td>
<td>OSTEoplasty – FOR ORTHOGNATHIC DEFORMITIES</td>
<td>Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or a deformity that may be addressed via surgical correction.</td>
<td>1. Radiographs for prior authorization – submit appropriate imaging.</td>
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<td>Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.</td>
<td>2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, and the proposed treatment</td>
<td>3. An operative report shall be submitted for payment.</td>
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<td>D7953</td>
<td><strong>BONE REPLACEMENT GRAFT</strong></td>
<td>Osseous autograft, allograft or non-osseous graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g. clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Membrane, if used, should be reported separately.</td>
<td>1. Radiographs for payment – submit a pre-operative photograph.</td>
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<td>2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.</td>
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<td>3. Requires a tooth number or quadrant code.</td>
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<td>D7960</td>
<td><strong>FRENULECTOMY ALSO KNOWN AS FRENECTOMY OR FRENOTOMY – SEPARATE PROCEDURE NOT IDENTICAL TO ANOTHER</strong></td>
<td>Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual frenum that is associated with a pathological condition, or interferes with proper oral development or treatment. A benefit once per arch per date of service</td>
<td>1. Photographs for payment – submit a pre-operative photograph.</td>
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<td>2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.</td>
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<td>3. Requires an arch code.</td>
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<td>D7972</td>
<td><strong>SURGICAL REDUCTION OF FIBROUS TUBEROSITY</strong></td>
<td>A benefit once per quadrant per date of service. This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service</td>
<td>1. Photographs for payment – submit a pre-operative photograph.</td>
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<td>2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the actual or proposed prosthodontic treatment.</td>
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<td>3. Requires a quadrant code.</td>
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### ORTHODONTIC GENERAL POLICIES (D8000-D8999)

1. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.

2. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

3. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

4. Orthodontic procedures are a benefit only when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

5. The automatic qualifying conditions are:
   a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
   b. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
   c. A deep impinging overbite in which the lower incisors are destroying the soft tissue of
e. the palate,
f. A crossbite of individual anterior teeth causing destruction of soft tissue,
g. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
h. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

6. If the patient’s orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

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| D8080   | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION | These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed appliances. | 1. The following shall be submitted together for prior authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. periodic orthodontic treatment visit(s) (D8670), and
   c. orthodontic retention (D8680), and
   d. the diagnostic casts (D0470)
2. Written documentation for prior authorization for cleft palate and craniofacial anomaly cases shall be submitted:
   a. cleft palate cases require documentation from a credentialed specialist on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or | DHCF pays the dental providers a global fee for the entire orthodontic case. Also, D8080 is a covered benefit. |
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<td>orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. A benefit: a. for handicapping malocclusion, cleft palate and facial growth management cases. b. for patients under the age of 21. c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). d. once per patient per phase of treatment. All appliances (such as bands, arch wires, headgear and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted. This procedure includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.</td>
<td>b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.</td>
<td></td>
</tr>
<tr>
<td>D8090</td>
<td>COMPREHENSIVE DENTAL TREATMENT OF THE ADULT</td>
<td>These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed</td>
<td>1. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed. 2. Completed 719A form should be submitted.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Criteria and Benefits</td>
<td>Required Documentation</td>
<td>Comments</td>
</tr>
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<td>--------------------------------------------------</td>
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<td></td>
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<td>orthodontic appliances. Adjunctive procedures, such as extractions, maxilla-facial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient’s needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.</td>
<td>1. Prior authorization is required for non-emergency procedures.</td>
<td></td>
</tr>
<tr>
<td>D8999</td>
<td>UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT</td>
<td>Used for procedure that: 1. is not adequately described by a code; 2. has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.</td>
<td>2. Radiographs for prior authorization or payment-submit radiographs if applicable for the type of procedure. 3. Photographs for prior authorization or payment-submit photographs if applicable for the type of procedure. 4. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment. 5. Documentation shall include the medical condition and the specific CDT code associated with the treatment. (describe procedure in narrative format)</td>
<td></td>
</tr>
</tbody>
</table>

**ADJUNCTIVE GENERAL POLICIES (D9000-D9999)**

**Anesthesia (D9210-D9248)**

1. General anesthesia (D9223) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

2. Deep sedation/general anesthesia (D9223) and intravenous conscious sedation/analgesia (D9241 and D9242) shall be considered for payment when it is documented why local anesthesia is contraindicated. Such contraindications shall include but are not limited to the following:
   a. a severe mental or physical handicap,
   b. extensive surgical procedures,
   c. an uncooperative child,
   d. an acute infection at an injection site,
   e. a failure of a local anesthetic to control pain.
### Code Description Criteria and Benefits Required Documentation Comments

3. The administration of deep sedation/general anesthesia (D9223), nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable associated procedures. Prior authorization or payment shall be denied if any associated procedures by the same provider are denied.

4. Providers who administer general anesthesia (D9223) and/or intravenous conscious sedation/analgesia (D9241 and D9242) shall have valid anesthesia permits.

5. Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.

6. Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

### ADJUNCT PROCEDURES (PROCEDURES D9110-D9930)

1. General anesthesia is an excluded benefit unless provided in conjunction with authorized oral surgery procedures; such as the surgical extraction of impacted teeth, procedures D7220-D7240.

2. This procedure is only payable to providers holding a valid general anesthesia permit; please include the general anesthesia permit number on the claim form.

<table>
<thead>
<tr>
<th>Code</th>
<th>DEEP SEDATION/GENERAL ANESTHESIA – FIRST 30 MINUTES</th>
<th>Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration. Not a benefit: a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248). b. when any associated procedures on the same date of service by the same provider are denied.</th>
<th>1. Written documentation for payment – shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. 2. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment. 3. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the 719A Form 4. Copy of Anesthesia license on file, if not on file submit a copy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>D9223</td>
<td>DEEP SEDATION/GENERAL ANESTHESIA – EACH ADDITIONAL</td>
<td>Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and</td>
<td>1. Written documentation for payment – shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.</td>
<td>Exception for Howard University Hospital Dentistry, anesthesia services are administered under hospital, not required to submit anesthesia license information</td>
</tr>
</tbody>
</table>
15 MINUTES
remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetic’s effects upon the central nervous system and not dependent upon the route of administration.

[The difference between general anesthesia and intravenous sedation is that the patient cannot support his/her own airway while under general anesthesia.]

Drugs typically used: Fentanyl, Versed or Valium, Sodium Bretival

**General anesthesia** is allowed with these services: (when the procedure is a covered benefit):
- Apicoectomy (D3410-D3426);
- Retrograde filling (D3430);
- Root amputation (D3450);
- Hemisection (D3920);
- Surgical extractions (D7210-D7241);
- Root recovery (D7250);
- Coronectomy (D7251);
- Other oral surgery procedures (D7260-D7291);
- Alveoloplasty (D7310-D7321);
- Vestibuloplasty (D7340-D7350);
- Removal of tumors, cysts and neoplasms (D7410-D7461);
- Excision of bone tissue (D7471-D7490);
- Surgical Incision (D7510-D7560);
- Treatment of fractures-simple (D7610-D7680);
- Treatment of fractures-compound (D7710-D7780);
- Reduction of dislocation of temporo-mandibular joint (D7810-D7877);
- Repair of traumatic wounds (D7910);
- Excision of hyperplastic tissue (D7970).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Criteria and Benefits</th>
<th>Required Documentation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>limitation or contraindication to a local anesthetic agent.</td>
<td>with requests.</td>
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<td></td>
<td>2. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.</td>
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<td></td>
<td></td>
<td></td>
<td>3. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the 719A Form.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>4. Copy of Anesthesia license on file, if not on file submit a copy.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Criteria and Benefits</td>
<td>Required Documentation</td>
<td>Comments</td>
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</tr>
<tr>
<td></td>
<td>Placement of Implant D6010</td>
<td>Special needs patients that is combative during exam/treatment (must be part of waiver program)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Not a benefit:</strong></td>
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<tr>
<td></td>
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<td>a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgiesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>b. when all associated procedures on the same date of service by the same provider are denied.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9420</td>
<td>HOSPITAL OR AMBULATORY SURGICAL CENTER CALL</td>
<td>Care provided outside the dentist's office to a patient who is in hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.</td>
<td>1. The operative report for payment—shall include the total time in the operating room or ambulatory surgical center.</td>
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<tr>
<td></td>
<td></td>
<td><strong>Not a benefit:</strong></td>
<td>2. A benefit for each hour or fraction thereof as documented on the operative report.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. for an assistant surgeon.</td>
<td>3. Documentation of past dental treatment notes, radiographs, IO photos may be requested</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. for time spent compiling the patient history, writing reports or for postoperative or follow up visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9940</td>
<td>OCCLUSAL GUARDS, BY REPORT</td>
<td>Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. ~ Allowed in cases of bruxism only. ~ Occlusal guards submitted in conjunction with TMJ therapy are not covered.</td>
<td>1. IO photographs and radiographs of occlusal / incisal wear</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>2. Arch radiographs</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E – DC DHCF Transmittal No. 09-21:
DHCF Form 1728 - Request for Nursing Facility Level of Care
**Section A: Beneficiary**

- **Last Name:**
- **First:**
- **MI:**
- **Medicaid ID:**
- **SSN:**
- **Birth Date:**
- **Gender:**
  - [ ] M
  - [ ] F

- **Permanent Street Address:**
- **City:**
- **ST:**
- **ZIP:**
- **Phone:**

**Present Location of Beneficiary (If different than above):**

**Date of Request:**

**Section B: Level of Care**

- [ ] Nursing Facility
- [ ] Adult Day Treatment
- [ ] Elderly & Individuals w/Physical Disabilities (EPD) Waiver

**Reason:**

- [ ] Return from hospital after Medicaid bed-hold expired
- [ ] Transfer from EPD Waiver to NF
- [ ] Annual reassessment
- [ ] Initial NF placement
- [ ] Conversion from other payer source to Medicaid Start
- [ ] Initial assessment
- [ ] Initial assessment
- [ ] Transfer from NF to EPD Waiver

*If Medicaid bed-hold days < 16 days no level of care required*

**Section C: Legal Representative**

- **Name:**
- **Street Address:**
- **City:**
- **ST:**
- **ZIP:**

**Section D: Beneficiary Functional Status**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Independent (needs no help)</th>
<th>Supervision or Limited Assistance (needs oversight, encouragement or highly involved, but requiring assistance)</th>
<th>Extensive Assistance or Totally Dependent (may need help, but cannot perform without help from staff or cannot do for self at all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADLs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dressing</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Overall Mobility</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Eating</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Toilet Use</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>ADLs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Management</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Meal Preparation</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Housekeeping</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Money Management</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Using Telephone</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**Beneficiary ventilator dependent?**

- [ ] Yes
- [ ] No

List additional supporting documents here:
Government of the District of Columbia
Department of Health Care Finance

Nursing Facility Level of Care Form 1728

<table>
<thead>
<tr>
<th>Name of Person Completing Form</th>
<th>Title</th>
<th>Phone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION E: CLINICIAN ATTESTATIONS & AUTHORIZATIONS

- [ ] Physician
- [ ] Physician Assistant
- [ ] Nurse Practitioner

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>ST</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Phone: [ ] NPI #: [ ] Date: [ ] Signature: [ ]

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

Print Name: [ ] Title: [ ] Date: [ ]

SECTION F: QUALITY IMPROVEMENT ORGANIZATION AUTHORIZATIONS

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Certification Period (for EPD only)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility</td>
<td>Adult Day Treatment</td>
<td>EPD Waiver</td>
</tr>
</tbody>
</table>

Authorized Signature: [ ] Comments: [ ]

To submit this form electronically after completion, visit the Qualis Health Provider Portal at [www.qualishealth.org](http://www.qualishealth.org). Then select one of the choices in the Healthcare Professional Drop-Down Menu. DC Medicaid or Provider Resources. You can obtain additional assistance in registering for the Qualis Health Provider Portal by contacting ProviderPortalHelp@qualishealth.org.

Revised Oct 19, 2016
Appendix F – CMS PRAF “C”
Category of Concern Codes for Quality Review
The quality review process involves the use of the Centers for Medicare & Medicaid (CMS) Physician Reviewer Assessment Form (PRAF) “C” Category of Concern codes to screen for quality of care. These codes can be applied to any setting of care, including acute inpatient, long term care, residential treatment center care, and outpatient services.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION AND USE</th>
</tr>
</thead>
</table>
| C01      | Apparently did not obtain pertinent history and/or findings from examination  
This category is used for a failure to provide an accurate history; this is also for failure to include information obtained by the performance of an appropriate physical exam. |
| C02      | Apparently did not make appropriate diagnoses and/or assessments  
This category is used for a failure to perform an appropriate assessment and establish a diagnosis. |
| C03      | Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see CO6 or CO9) and procedures (see C07 or C08) and consultations (see C13 and C14)]  
This category is used for a lack of organized, appropriate diagnostic and management plans related to the condition for which the patient was admitted; incomplete, inappropriate, or lack of treatment plan for principal diagnosis. |
| C04      | Apparently did not carry out an established plan in a competent and/or timely fashion (e.g. omissions, errors of technique, unsafe environment)  
This category is used for failure to take necessary precautions; lack of appropriate equipment maintenance; medication errors; technical and/or procedural errors; failure to follow physician’s orders; delayed completion or reporting of studies. |
| C05      | Apparently did not appropriately assess and/or act on changes in clinical/other status results  
This category is used for failure to recognize clinical changes which occur in the patient’s condition; this category also applies if the clinical changes are noted but not acted on. |
| C06      | Apparently did not appropriately assess and/or act on laboratory tests or imaging study results  
This category is used for a failure to provide ongoing monitoring and evaluation of the patient’s laboratory or imaging studies by failing to evaluate and/or act on diagnostic studies. |
| C07      | Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed  
This category is used for failure to document accepted indications for a procedure. |
| C08      | Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)  
This category is used for failure to perform a medically necessary procedure that is indicated by the patient’s condition. |
| C09      | Apparently did not obtain appropriate laboratory tests and/or imaging studies  
This category is used for failure to order diagnostic (laboratory and/or imaging) studies that are deemed appropriate for the patient’s condition. |
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION AND USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>C10</td>
<td>Apparently did not develop and initiate appropriate discharge, follow-up, and rehabilitation plans. This category is used for a lack of follow-up arrangements or plans for conditions continuing to require treatment and/or monitoring prior to or following discharge; failure to develop a plan that reflects an appropriate transition of care; failure to identify additional needed resources; failure to provide appropriate teaching; failure to transmit pertinent information.</td>
</tr>
<tr>
<td>C11</td>
<td>Apparently did not demonstrate that the patient was ready for discharge. This category is used for failure to assure that the patient is stable enough for discharge to the setting into which the patient is being discharged.</td>
</tr>
<tr>
<td>C12</td>
<td>Apparently did not provide appropriate personnel and/or resources. This category is used for lack of sufficient staff to handle patient load; lack of credentialed staff for provision of offered services; equipment unavailable to carry out treatment plan.</td>
</tr>
<tr>
<td>C13</td>
<td>Apparently did not order appropriate specialty consultation. This category is used for those cases in which a specialty consultation that would have been necessary to adequately assess and treat the patient was not ordered. If there is a distinct clinical management concern over and above failure to order the consultation, cite that category as well, even if it is C.03.</td>
</tr>
<tr>
<td>C14</td>
<td>Apparently specialty consultation process was not completed in a timely manner. This category is used when a specialty consultation is not ordered in a timely manner or is not completed in a timely manner. If the only issue is the delay, do not additionally cite C.03. If there is a distinct clinical management concern over and above the delay in ordering or completing the consultation, cite that category as well, even if it is C.03.</td>
</tr>
<tr>
<td>C15</td>
<td>Apparently did not effectively coordinate across disciplines. This category is used when there is poor communication and coordination between specialists or clinicians that adversely impacts the patient's care.</td>
</tr>
<tr>
<td>C16</td>
<td>Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection). This category is similar to category C04 but is more specific to patient safety and protection from injury.</td>
</tr>
<tr>
<td>C17</td>
<td>Apparently did not order/follow evidence-based practices. This category of concern is used when there is a specific aspect of the treatment plan that doesn't follow current guidelines and evidence-based practices.</td>
</tr>
<tr>
<td>C18</td>
<td>Apparently did not provide medical record documentation that impacts patient care. This category is used for poor or missing documentation that makes it difficult to follow the plan of care and patient progress.</td>
</tr>
<tr>
<td>C40</td>
<td>Apparently did not follow-up on patient's noncompliance (NOTE: Only applies to MA or Managed Care patient). This category is used when there is no follow-up on patient compliance with a previously prescribed treatment plan for a patient enrolled in an MA or Managed Care Plan.</td>
</tr>
<tr>
<td>C99</td>
<td>Other quality concern not elsewhere classified. This category is used in exceptional cases. The vast majority of cases should be able to fit into the above listed categories.</td>
</tr>
</tbody>
</table>
Appendix G – Letter: Denial
Member Name
Member Address
City, State, Zip

If you do not speak and/or read English, please call 800-251-8890 between 8:00 a.m. and 5:00 a.m. A representative will assist you.

Si usted no habla y/o lee inglés, por favor llame al 800-251-8890 entre 8:00 a.m.-5:00 p.m. Un representante le asistirá. - SPANISH

如果您不会说或读英语，请在早上8点钟到下午5点钟之间致电800-251-8890，我们的工作人员会协助您。- CHINESE

አማርኛ የማህበር በወላል እንወስዎ ከ8:00 ዓ.ም. እስከ 5:00 ዓ.ም. ከ800-251-8890 ከሚከተሰቡ የተለጠወቅ ያለን⠀- AMHARIC

만일 당신이 영어로 말을 할수 없거나 읽을 수 없을 경우, 오전 8시에서 오후 5시 사이에 800-251-8890으로 전화를 하십시오. 담당자가 도와 드릴 것입니다. - KOREAN

Nếu bạn không nói và/ hoặc đọc tiếng Anh, xin gọi 800-251-8890, 8:00-5:00. Một đại diện sẽ giúp bạn. - VIETNAMESE
DC MEDICAID PLEASE READ CAREFULLY
THIS IS A LETTER ABOUT A DENIAL DECISION

Notice Date

Patient Name
Patient Address
City, State, Zip

Patient Name: Medicaid ID #:
Date of Birth:
Facility Name: Prior Authorization #:
Physician Name: Prior Authorization #:
Admit Date: Discharge Date:
Approved Day(s):
Approved Procedure(s):
Denied Day(s):
Denied Procedure(s):
Diagnosis:

In order to promote high quality health care, Qualis Health has been designated by the D.C. Department of Health Care Finance (DHCF) to review and determine medical necessity of certain medical admissions and surgical procedures provided to D.C. Medicaid beneficiaries. Your request for the medical procedure described above has been denied.

The final decision regarding medical treatment is between you and your physician. Qualis Health will notify D.C. Medicaid, your attending physician and the hospital (facility) of this denial. D.C. Medicaid program will not pay for services denied by Qualis Health.

WHY IS THIS HAPPENING?

Each review is completed by a physician reviewer, using available clinical information. Based on the information available at the time of the review, a determination was made to deny (not pay for) your request for __________________________. This determination was based on the following: [Insert the appropriate
InterQual criteria or other clinical rationale. A copy of the clinical criteria used for the decision will be provided upon your request.

WHAT SHOULD I DO IF I DISAGREE WITH THIS DECISION?
If you disagree with this decision you may request Qualis Health to reconsider its determination. Your request must be submitted in writing and/or telephone with follow up in writing within 21 days to:

Qualis Health
Attn: Care Management Department
PO Box 34800
Washington, DC 20043-4800
Phone: (800) 251-8890
Fax: (800) 731-2314

Please keep a copy of this letter and the envelope in which this letter was sent in the event there are questions about when your request for reconsideration was made.

ARE THERE ANY OTHER ACTIONS I CAN TAKE?
Yes, you may also ask for a fair hearing from the Office of Administrative hearing or the Office of the Health Care Ombudsman. Insert information from the Qualis Health letter.

REQUESTING A FAIR HEARING
You may also ask for a fair hearing from the Office of Administrative Hearings or the Office of Health Care Ombudsman. You have 90 days from the postmark date of this letter to ask for a fair hearing. You can call, write, or visit the Office of Administrative Hearings or the Office of Health Care Ombudsman to ask for a fair hearing.

The contact information for the Office of Administrative Hearings is:

Office of Administrative Hearings
One Judiciary Square
441 4th Street, NW Suite 450 North
Washington, DC 20001
Phone: (202) 442-9094
Fax: (202) 442-4789

The contact information for the Office of Health Care Ombudsman is:

Office of Health Care Ombudsman
441 4th Street, NW, 9th Floor
WHAT IF I NEED HELP ASKING FOR A FAIR HEARING?
For assistance with requesting a fair hearing, you may be able to get free legal services. See the lists below of legal services in the District of Columbia.

Legal Resources

1. **Legal Aid Society of the District of Columbia**
   1331 H Street NW, Suite 350
   Washington, DC 20000
   (202) 628-1161
   
   900 Delaware Ave S
   Washington, DC 20024
   (202) 628-1161
   
   2041 Martin Luther King Jr Ave SE
   Washington, DC 20020
   (Advocates for Justice and Education in the Anacostia Professional Building the: "Big Char")
   (202) 628-1161

2. **Neighborhood Legal Services**
   4609 Polk St NE
   Washington, DC 20032
   (202) 832-6577
   
   680 Rhode Island Ave NE
   Washington, DC 20002
   (202) 832-6577
   (202) 269-5100
   
   2811 Pennsylvania Ave SE
   Washington, DC 20020
   (202) 832-6577

3. **University Legal Services, Protection and Advocacy Program**
   220 I Street NE, Suite 130
   Washington, DC 20002
WHAT HAPPENS AFTER I ASK FOR A FAIR HEARING?
The Office of Administrative Hearings will send you a letter with your hearing date.

WHAT HAPPENS AT THE FAIR HEARING?
The Office of Administrative Hearings will send you a letter which describes the hearing process. This information will be included in the letter with your hearing date.

You may bring a friend, relative, advocate or lawyer who is not an employee of the District of Columbia to assist you at your fair hearing. You may also bring witnesses and any other documents you would like to present.

If you have any questions regarding this letter, please contact Qualis Health at (800) 251-8890.

Sincerely,

John W. Sparks MD
Senior Medical Director

cc: <<Facility Name>>
    <<Physician Name>>
Appendix H – Letter: Reconsideration Upheld, Inpatient
Member Name
Member Address
City, State, Zip

If you do not speak and/or read English, please call 800-251-8890 between 8:00 a.m. and 5:00 a.m. A representative will assist you.

Si usted no habla y/o lee inglés, por favor llame al 800-251-8890 entre 8:00 a.m.-5:00 p.m. Un representante le asistirá. - SPANISH

如果您不会说或读英语，请在早上8点钟到下午5点钟之间致电800-251-8890，我们的工作人员会协助您。- CHINESE

አንፈለም ደንበረሰቡ ያስገወል እስክምልክት ትቀሱ ብርሃን 800-251-8890
ሁ 8:00 ዓ.ም. እስከ 5:00 ዓ.ም. በ 8:00 ዓ.ም. እስከ 5:00 ዓ.ም. እር የሆነ ከስገወል። - AMHARIC

만일 당신이 영어로 말을 할 수 없거나 읽을 수 없을 경우, 오전 8시에서 오후 5시 사이에 800-251-8890 으로 전화를 하십시오. 담당자가 도와 드릴 것입니다。- KOREAN

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi 800-251-8890, 8:00-5:00. Một đại diện sẽ giúp bạn。- VIETNAMESE
DC MEDICAID PLEASE
READ CAREFULLY
THIS IS A LETTER ABOUT AN UPHELD RECONSIDERATION DECISION

Notice Date

Patient Name
Patient Address
City, State, Zip

Patient Name: Medicaid ID #:
Date of Birth: Prior Authorization #:
Facility Name: Prior Authorization #:
Physician Name: Discharge Date:
Admit Date:
Approved Day(s):
Approved Procedure(s):
Denied Day(s):
Denied Procedure(s):
Diagnosis:

We have received your request for a reconsideration. In order to promote high quality health care, Qualis Health has been designated by the D.C. Department of Health Care Finance (DHCF) to review and determine medical necessity of certain medical admissions and surgical procedures provided to D.C. Medicaid beneficiaries. The decision after reconsideration is to uphold the original denial.

The final decision regarding medical treatment is between you and your physician. Qualis Health will notify D.C. Medicaid, your attending physician and the hospital (facility) of this denial. D.C. Medicaid program will not pay for services denied by Qualis Health.

WHY IS THIS HAPPENING?

Each review is completed by a physician reviewer, using available clinical information. Based on the information available, the decision was based on the following: [Insert the appropriate InterQual criteria or other clinical rationale]. A copy of the clinical criteria used for the decision will be provided upon your request.

ARE THERE ANY OTHER ACTIONS I CAN TAKE?
Yes, you may also ask for a fair hearing from the Office of Administrative hearing or the Office of the Health Care Ombudsman. Insert information from the Qualis Health letter.

REQUESTING A FAIR HEARING

You may also ask for a **fair hearing** from the Office of Administrative Hearings or the Office of Health Care Ombudsman. You have **90 days** from the postmark date of this letter to ask for a fair hearing. You can **call, write, or visit** the Office of Administrative Hearings or the Office of Health Care Ombudsman to ask for a fair hearing.

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**Office of Administrative Hearings**
One Judiciary Square
441 4th Street, NW Suite 450 North
Washington, DC 20001
Phone: (202) 442-9094
Fax: (202) 442-4789

The contact information for the Office of Health Care Ombudsman is:

**Office of Health Care Ombudsman**
441 4th Street, NW, 9th Floor
Washington, DC 20001
Telephone: (202) 724-7491
Fax: (202) 535-1216

WHAT IF I NEED HELP ASKING FOR A FAIR HEARING?

For assistance with requesting a fair hearing, you may be able to get free legal services. See the lists below of legal services in the District of Columbia.

**Legal Resources**

1. **Legal Aid Society of the District of Columbia**
   1331 H Street NW, Suite 350
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   (202) 628-1161

   900 Delaware Ave S
   Washington, DC 20024
   (202) 628-1161
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Washington, DC 20020
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(202) 628-1161

2. **Neighborhood Legal Services**
4609 Polk St NE
Washington, DC 20032
(202) 832-6577

680 Rhode Island Ave NE
Washington, DC 20002
(202) 832-6577
(202) 269-5100

2811 Pennsylvania Ave SE
Washington, DC 20020
(202) 832-6577

3. **University Legal Services, Protection and Advocacy Program**
2201 Street NE, Suite 130
Washington, DC 20002
(202) 547-0198 (voice)
(202) 547-2657 (TTY)

**WHAT HAPPENS AFTER I ASK FOR A FAIR HEARING?**

The Office of Administrative Hearings will send you a letter with your hearing date.

**WHAT HAPPENS AT THE FAIR HEARING?**

The Office of Administrative Hearings will send you a letter which describes the hearing process. This information will be included in the letter with your hearing date.

You may bring a friend, relative, advocate or lawyer who is not an employee of the District of Columbia to assist you at your fair hearing. You may also bring witnesses and any other documents you would like to present.

If you have any questions regarding this letter, please contact Qualis Health at (800) 251-8890.

Sincerely,
Letter - Reconsideration Upheld, Inpatient

John W. Sparks MD
Senior Medical Director

c: <<Facility Name>>
<<PhysicianName>>
Appendix I –
Letter: Prior Authorization for EPD Waiver Services
Facility Name
Facility Address
City, State, Zip

If you do not speak and/or read English, please call 800-251-8890 between 8:00 a.m. and 5:00 a.m. A representative will assist you.

Si usted no habla y/o lee Inglés, por favor llame al 800-251-8890 entre 8:00 a.m.-5:00 p.m. Un representante le asistirá. - SPANISH

如果您不会说或读英语，请在早上8点钟到下午5点钟之间致电800-251-8890，我们的工作人员会协助您。- CHINESE

አናዳን ይግባኝ መንጋዊ መደበት ከፈር ምር 800-251-8890 ያለ 8:00 ወ.ም. እስከ 5:00 ወ.ም. እስከ ይህ መንጋዊ ከጠቀም ያሰጥበት። - AMHARIC

만일 당신이 영어로 말을 할수 없거나 읽을 수 없을 경우, 오전 8시에서 오후 5시 사이에 800-251-8890으로 전화를 하십시오. 담당자가 도와 드릴 것입니다。- KOREAN

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi 800-251-8890, 8:00-5:00. Một đại diện sẽ giúp bạn。- VIETNAMESE
<<Group_Name>> PLEASE
READ CAREFULLY
THIS IS A LETTER ABOUT PRIOR AUTHORIZATION FOR EPD WAIVER SERVICES

Notice Date

Facility Name
Facility Address
City, State, Zip

Patient Name: Medicaid ID#:

Date of Birth:

RE: Prior Authorization for EPD Waiver Services

Dear Facility Name,

Your authorization request on behalf of Medicaid Beneficiary, Patient Name, Medicaid ID #, has been approved for the following services.

Servicing Provider:
Authorization #:

Thank you,

Qualis Health
Utilization Review Team

cc: Facility Name