Guide to participation in the

CoverKids Program

Information and Support for Dentists and Dental Office Staff

Renaissance appreciates the commitment to oral health and celebrates the role dental providers play in increasing access to care for Tennessee residents.

Participation in the Renaissance CoverKids Network provides quality dental care and oral health education to CoverKids members.

Please review the information in this guide to better understand how the CoverKids program works, responsibilities as a participating provider, important program requirements, and details on where additional information for problem-free claims submissions can be found. The goal is to make the provider experience with Renaissance as efficient as possible through courteous service and decreased administrative burden.

Renaissance looks forward to working together to make sure that the relationship between Renaissance and the CoverKids program is successful for dental providers and members.

This provider manual is subject to periodic updates; please ensure that you are using the most recent version which can be found online at www.rendentalofficetoolkit.com.

The provider manual also contains a Revision History log in Appendix B with the version number, revision date, and description of revision.

Do you need help?

We have free auxiliary aids and services, like large print, to communicate effectively with you. Call us at 866-864-2526 (TRS: 711)

If you speak a language other than English, help in your language is available for free. We have free interpretation and translation services to help you.

Spanish: Español

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-864-2526 (TRS/TTY:866-503-0264).

Arabic: ربيةلعا

وظةملحا: اذا متتكلا ةللغا ربيةلعا اتمدخ ةدعالمسا ويةللغا رةفومتكلا انجام. اتصل مقبر:1-866-864-2526

Chinese: 繁體中文

注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-866-864-2526

Vietnamese: Tiếng Việt

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-864-2526

Korean: 한국어

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-866-864-2526 번으로 전화해 주십시오.

French: Français

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-864-2526.

Amharic: አማርኛ

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-864-2526.

Gujarati: ગુજરાતી

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો

1-866-864-2526.

Laotian: ພາສາລາວ

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-864-2526.

German: Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-864-2526.

Tagalog: Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-864-2526.

Hindi: हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।1-866-864-2526 पर कॉल करें।

Russian: Русский

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-864-2526.

Japanese: 日本語

「日本語を話す方は、通訳や翻訳などの言語支援サービスを無料で利用できます」

Persian: فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-864-2526 تماس بگیرید.

The Beneficiary Support System (BSS) helps people who are enrolled in the CHOICES, Employment and Community First (ECF) CHOICES, and the Katie Beckett program. They also help people who want to enroll into

these programs. For help call 888-723-8193.

The TennCare Program does not discriminate against people because of their race, color, national origin including limited English proficiency and primary language, age, disability, religion, or sex. If you need reasonable modifications or think you were treated differently, or discriminated against you can file a grievance (complaint) with TennCare's Office of Civil Rights Compliance at HCFA.fairtreatment@tn.gov, https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html, 310 Great Circle Road Floor 3W, Nashville, TN 37243, or calling 615-507-6474 (TRS 711). Need help filing a grievance? Call TennCare Connect at 855-259-0701.

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Section 1

Welcome to the Renaissance CoverKids Network

Thank you for participating in the Renaissance CoverKids Network. Dental practices play a critical role in ensuring that persons who receive dental benefits under the CoverKids program have access to the diagnostic, preventive, and therapeutic dental treatment needed to achieve and maintain good oral health, which is critical to overall health and well-being.

To help members and providers have the best possible experience with Renaissance and the CoverKids program, this easy-to-understand guide will provide information to help deliver member services in accordance with the provisions of the CoverKids program and the generally accepted standards of dental practice.

The guide is organized into sections that walk through the clinical and administrative processes needed to:

- Navigate the Renaissance CoverKids Network credentialing, re-credentialing, and participation requirements.
- Understand the rights and responsibilities of both the members and providers.
- Appropriately verify patient eligibility
- or the lack thereof.
- Know what dental services are or are not covered.
- Understand claim processing policies, document requirements, and guidelines for planned and completed services (including those services requiring prior authorization).
- Follow CoverKids guidelines related to the interaction and treatment of eligible members.
- Enter and handle appropriate patient treatment records in accordance with applicable privacy and security standards.
- Submit and follow up on claims in the appropriate manner.
- Understand the information contained in Explanation of Benefit (EOB) forms.
- Follow the appropriate steps in the case of adverse claim decisions.
- Understand how to handle suspected cases of fraud, waste, or abuse.
- Access additional information when needed.

Portions of this manual may be periodically modified to reflect updated policies or changes in the program or dental procedure codes and recorded in the Revision History log in Appendix C with the date and a brief description of the change. Alterations will be consistent with the requirements of the provider participation agreement, and the most up-to-date version can be found through the Dental Office Toolkit™ at https://www.rendentalofficetoolkit.com.

Program Objective

The primary objective of the CoverKids Program is to create a comprehensive dental care system offering quality dental covered services that are medically necessary to eligible Tennessee residents. Renaissance emphasizes early intervention and promotes access to necessary dental care, thereby improving health outcomes for Tennessee residents.

Are you building a "Dental Home" for your members?

Effective November 1, 2025, Renaissance will be implementing the Dental Home program in Tennessee for CoverKids members. The primary Dental Home is a place where a child's oral health care is delivered in a complete, accessible, and family-centered manner by a licensed dentist. This concept has been successfully employed by primary care physicians in developing a "Medical Home" for their members, and the "Dental Home" concept mirrors this approach for primary dental and oral health care. Members will be assigned to a dental home through a tiered review process, considering previous claims history, claims history of a sibling and/or family member, network adequacy requirements, and quality ranking of the dentist. If expanded or specialty dental services are required, the general dentist is not expected to deliver the services if they do not have the expertise to do so, but to coordinate the referral and to monitor the outcome. Provider support is essential to effectively employ the Dental Home program for CoverKids Program Members. With assistance and support from dental professionals, a system for improving the overall health of children in the CoverKids Program can be achieved.

Section 2

Support Services Contact Information – Where to Find Additional Information and Help

Renaissance

Mailing address Renaissance Gov. Prog. Inquires P.O Box 1505 Farmington Hills, MI 48333-1505
Inquiries Renaissance Inquiries P.O. Box 1505 Farmington Hills, MI 48333-1505
Claims Renaissance Claims P.O. Box 2720 Farmington Hills, MI 48333-2720
Provider Appeals & Grievances P.O. Box 1505 Farmington Hills, MI 48333-1505

Important Contact Information and Links

- Customer Service .....866-864-2526 (TTY users dial 711)
- Provider Records.....800-971-4143
- Professional Relations 800-864-2526
- Renaissance Website.....tenncare.renaissancebenefits.com
- Join Our Network.....https://www.renproviderportal.com/pact-ui/login
- Provider Website .....https://www.rendentalofficetoolkit.com
- Dental Office Toolkit™ .....https://rendentalofficetoolkit.com
- NPI ..... NPPES NPI Registry
- Claims Submission .....https://www.rendentalofficetoolkit.com
- Credentialing.....ProviderExcellence@renaissancefamily.com
- Peer-to-Peer.....tenncare.renaissancebenefits.com
- Continuing Education .....tenncare.renaissancebenefits.com
- ***Fraud and Abuse*****.....**tenncare.renaissancebenefits.com
- Fraud and Abuse Hotline.....1-800-971-4139

Customer Service

Customer service representatives are available for eligible CoverKids members Monday through

Friday from 7 a.m. to 5 p.m. CT. A self-service member portal and automated system is available 24/7.

Members may contact Customer Service for the following:

- Benefits (also available via http://www.renmemberportal.com/mp/rengp/ and telephone automated system 866-864-2526)
- Claim processing
- Claim status (also available http://www.renmemberportal.com/mp/rengp/ and telephone automated system 866-864-2526)
- Eligibility (also available via http://www.renmemberportal.com/mp/rengp/ and telephone automated system 866-864-2526)
- Filing a claim
- Grievances and appeals
- Referral to dental professionals for utilization management questions
- Report fraud, waste, and abuse

Any calls where Protected Health Information (PHI) is discussed are required to be authenticated. Please be prepared with the following:

- The dentist or office name
- Dentist tax ID number
- Medicaid member ID number
- Member name, date of birth, and address

Renaissance Provider Records

Please contact provider records at 800-971-4143 or ProviderExcellence@renaissancefamily.com if any of the following apply:

- Change of office address or phone number
- Have a change in credentialing information
- Are a new dentist opening an office or have a new associate dentist joining the practice
- Change the tax identification number (TIN)
- Have questions about the participation agreement, credentialing and re-credentialing
- Would like to schedule an office visit with a Renaissance professional relations representative regarding office training needs, network participation, claims processing guidelines, attachment requirements, or any other area of concern
- Need information regarding network participation

Provider Data Accuracy and Validation

It's important that Renaissance has accurate information about the participating dental practices for CoverKids. This allows Renaissance to better support its providers and members.

Additionally, accurate information assists with timely and accurate claims processing. Invalid information can negatively affect provider services and member access to care.

As a Renaissance provider, review the dental practice listing in Renaissance's online provider directory

regularly to ensure the information is updated. Whenever possible, notify Renaissance in writing at least 30 days in advance of practice changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition or termination of a dentist within an existing clinic/practice
- Change in tax ID and/or NPI number
- Opening or closing the dental practice to new members, including those with special needs
- Change in any other information that may affect member access to care

Please email practice updates to ProviderExcellence@renaissancefamily.com. Or contact a provider records representative if dental practice information needs to be updated or corrected at 800-971-4143.
Renaissance is required to audit and validate its network data and provider directories on a routine basis. As part of its validation efforts, Renaissance may reach out to participating providers through various methods, such as letters, telephone campaigns, face-to-face contact, etc. Please provide timely responses to these communications.

Section 3

Credentialing and Recredentialing for Dentists

Renaissance has the sole right to determine which dentists (DDS or DMD), they shall accept and allow to continue as participating providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, monitoring, discipline, and termination of participating providers.

How to Begin and Maintain Participation in the Renaissance Tennessee CoverKids Network

Providers in the Renaissance Provider Network are selected and credentialed based on established criteria reflecting professional standards for education, training, and licensure. Dentists must have and maintain the appropriate dental license, malpractice coverage, Drug Enforcement Agency (DEA) certificate (if required), and specialty license, diploma, certificate, or permit, as applicable.

Please see below for a brief description of how to get started:
https://www.tn.gov/content/dam/tn/tenncare/documents/TenncareIndividualMedicalServicesRoadmap.pdf

Before providing services to members, TennCare requires providers to be enrolled with the State of Tennessee. Providers who are not already enrolled with the State of Tennessee must apply and obtain a Medicaid Identification (ID) number. Further information for completing TennCare enrollment can be found at How to apply.

Additionally, prior to participation in the Renaissance CoverKids network, the following are required:

- Obtain a National Provider Identifier (NPI) number, as mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Must have an individual NPI number and a billing NPI number. To apply for an NPI, do one of the following:
    - Complete the application at https://nppes.cms.hhs.gov
    - Call 1-800-465-3203 to request an application from NPPES
- Enroll as a provider with the State of Tennessee: https://pdms.tenncare.tn.gov/Account/Login.aspx

Providers who are already part of the TennCare provider network must report the assigned Medicaid ID number and applicable NPI number(s) to Renaissance as soon as possible to obtain credentialing through Renaissance and remain in the network.

Please submit the number to: ProviderExcellence@renaissancefamily.com

For Dentists Not Currently Participating with Renaissance

Dentists who choose to begin participating with Renaissance should go to Renaissance's website at https://renaissancebenefits.com/tenncare/ and fill out request form to receive more information. In addition to the TennCare requirements listed above, dentists must provide Renaissance with the forms and information required for credentialing and enrollment as a participating dentist.

Credentialing with Renaissance

Dentists applying to participate in the Renaissance CoverKids Network must accurately and thoroughly complete the Confidential Credentialing Application and provide the following credentialing elements as applicable to the dentist and the dentist's practice:

- Proof of graduation from an accredited dental school and completion of specialty training, as applicable.
- A copy of an active state issued dental license.
- Board certification status.
- Clinical privileges in good standing at the hospital designated as the primary admitting facility, if any.
- Individual NPI Number (NPI Type 1).
- Business NPI Number (NPI Type 2), if applicable.
- W-9 Form.
- Dentist Authorized Signature Form.
- A copy of a Federal DEA license, if applicable.
- A copy of a liability declaration page showing at least the minimum required malpractice liability coverage.
- Disclosure of any licensing board actions, malpractice claims and other adverse personal or professional background information.
- Federally mandated ownership control form.
- Work history, including a minimum of the most recent five years of work history as a health professional.

Renaissance's credentialing and recredentialing processes comply with National Committee for Quality Assurance (NCQA) standards, applicable federal civil rights laws, and do not discriminate in the treatment of dentists in the enrollment, credentialing and recredentialing processes on the basis of race, color, national origin, disability, age, religion, sexual orientation, gender or gender identity, or any other protected class.

Renaissance's credentialing process seeks to mitigate delays in the credentialing process through the application of recognized industry standards and excellent customer service.

Network application and credentialing information should be submitted as described in the participation information received from Renaissance. Please notify our provider records staff immediately of any changes in the above credentialing elements at 800-971-4143 or ProviderExcellence@renaissancefamily.com.

Recredentialing Information with Renaissance

As a participating provider with Renaissance, re-credentialing is required every 36 months to maintain participation.

Renaissance's secure and confidential online Provider Application & Credentialing Toolkit (PACT) is available to complete recredentialing electronically. PACT offers a seamless recredentialing experience for providers. Providers can easily manage applications within the PACT dashboard with an intuitive user interface that ensures accurate information is being recorded. Reactive questions and clear instructions streamline the recredentialing workflow for dentists and administrators alike. With PACT:

- When recredentialing is due, an automatic electronic e-mail notification will be sent from Renaissance that includes a link to PACT.
- Recredentialing forms auto-populate with existing dentist information.

- Upload required documentation with the recredentialing form.
- Submit recredentialing information with a single click.
- If additional information is needed after submission, providers will receive an email linking back to PACT, where clear comments and instructions for further edits will be displayed. A provider's existing application can be easily corrected and resubmitted to seamlessly resume the recredentialing process.

Access PACT by going to the web page at https://www.renproviderportal.com/pact-ui/login. If the dental provider is new to PACT, navigate to the PACT website home screen, select 'Click here to register' and enter the dental provider NPI number to begin the account creation process.

Please notify Renaissance's provider records staff immediately of any changes in recredentialing elements at 800-971-4143 or via email at ProviderExcellence@renaissancefamily.com.

Appeal of Credentialing/Recredentialing

If Renaissance declines to include a dentist in its network(s), the reason for the decision will be provided to the dentist(s) in writing. Renaissance also provides dentists with an appeals mechanism in cases where participation in a Renaissance network has been denied or terminated. The dentist must request an appeal of the credentialing decision in writing within 30 days of notification of the decision to the applicant. Concerns should be communicated to Renaissance at 800-971-4143 or ProviderExcellence@renaissancefamily.com.

Nothing in this credentialing plan limits Renaissance's discretion to accept or discipline participating providers. No portion of this credentialing plan limits Renaissance's right to permit restricted participation by a dental office or Renaissance's ability to terminate a provider's participation in accordance with the participating provider's written agreement instead of this credentialing plan.

Exclusions and Limitations

Renaissance will not accept providers into the CoverKids networks who have been:

- Excluded by the United States Department of Health and Human Services
- Excluded by the Office of the Inspector General
- Excluded by the State of Tennessee (TennCare)

Renaissance must credential each provider location and is not required to credential all of a provider's locations. Renaissance and TennCare have the final decision-making power regarding network participation. Renaissance will notify TennCare of all disciplinary actions enacted upon participating providers.

Section 4

Provider Responsibilities and Rights

Important Information About Participation in the Renaissance CoverKids Network

Providers are Responsible for:

- Treating members with respect, fairness, and dignity, including HIPAA-compliant privacy standards.
- Notifying the member in writing if a recommended service or supply is not a covered service and obtain a written waiver from the member prior to rendering such service that indicates the member was aware that such service or supply is not a covered service, and that the member agrees to pay for such service or supply.
- Compliance with this Provider Manual, policies and procedures, and terms of the Provider Agreement.
- Not discriminating against members based on race, color, national origin, age, sex, religion, mental or physical disability, limited English proficiency, marital status, arrest record, conviction record, healthcare coverage, military involvement or any other protected class. Members and providers have a right to report or file a discrimination complaint. If a member complains, they have the right to keep getting care without fear of bad treatment from providers or Renaissance. You can file a complaint online or learn more about your rights.
- Following all state and federal laws regarding member care, patient rights, and those applicable to disease and infection control.
- Making covered services available on a timely basis, based on medical appropriateness.
- Providing urgent care within 48 hours and routine care within 3 weeks of determining the need for treatment.
- Ensuring that the office wait time does not exceed forty-five (45) minutes.
- Making arrangements for emergency dental care to be available for members of the dental practice 24/7, including vacations and holidays.
- Providing members an understandable notice of the office privacy rights and responsibilities.
- Informing members and responsible persons about potential risks and/or benefits of recommended treatment and available alternatives prior to beginning treatment.
- Allowing members or responsible persons to be involved in making decisions about dental treatment when patient input is appropriate.
- Ensuring that dental services delivered are medically necessary and within established guidelines for evidence-based, quality standards of dental practice.
- Maintaining complete records of treatment on all members according to State of Tennessee regulatory requirements and the applicable standards of the dental profession.
- Not charging members for missed appointments.
- Confirming member eligibility on the date of service.
- Submitting claims for services performed on members within 120 days after services are provided, including all documentation necessary to review, process and finalize the claims.
- Always informing members and responsible persons of the cost of non-covered services that are recommended and obtaining a signed private-pay agreement from responsible persons before beginning treatment. https://www.rendentalofficetoolkit.com

- When required, providing in a thorough and timely manner any information required for Renaissance to carry out claims processing or conduct quality assurance reviews and/or in-office audits.
- Dentists participating in Medicaid programs administered by Renaissance, are required under the Patient Protection and Affordable Care Act (ACA) and federal regulations at 42 CFR 447.26 to report provider preventable conditions to Renaissance. Renaissance is prohibited from paying for provider preventable conditions. Under existing law, examples of a provider preventable condition are the wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.
- Providing members with access to and free copies of their medical records when requested, or if the member is being transferred to another office.
- Providing records to the DMB and/or TennCare upon request and at no charge, if the provider is under review/audit
- Following Renaissance clinical policy guidelines and reporting responsibilities.
- Allowing a member to stop treatment when the member requests it and accompany the requested action with information about the implications of stopping care. This should be documented in the member's record as well.
- Allowing members (with written documentation) to appoint a family member or other representative to participate in care decisions.
- Answering member questions honestly and in an understandable manner.
- Allowing members the ability to obtain a second opinion and how to access healthcare services appropriately.
- Notifying Renaissance if members have other insurance coverage.
- Reporting improper payments or overpayments to Renaissance.
- Accepting from Renaissance as payment in full for covered services the lesser of:
    - (1) the applicable amount set forth in the Renaissance fee schedule; or
    - (2) submitted fee.
- Reporting to appropriate channels possible fraud and abuse by a member or provider.
- Providing convenient hours of operation that do not discriminate against CoverKids members. The hours of operation for treating CoverKids members must be no less than the hours for other members with commercial insurance or for noninsured members who pay directly for dental care.

Rights as a Participant in the Renaissance Tennessee CoverKids Network

As a participating Renaissance CoverKids dentist, providers have the right to:

- Access and review any credentialing/recredentialing information supplied to Renaissance.
- Free access to members' benefits and eligibility information.
- Communicate with and advise members about oral health status, dental care, and treatment options.
- Have access to language interpretive services arranged by Renaissance at no cost to the dental practice or members (see Section 11 for details).
- Recommend dental treatment to members even if the treatment is not a covered service under CoverKids dental plans administered by Renaissance (when recommending non-covered services to a patient in one of these programs, a signed pre-service private pay agreement must be obtained as

described in Section 12 under “Reimbursement for services not covered by CoverKids dental plans administered by Renaissance.

- Submit and receive claims information electronically through Renaissance’s claim processing system that allows for automated processing and adjudication of claims, as well as access to claims status and patient benefit and eligibility information.
- Receive prompt and accurate claims processing and direct payment from Renaissance in accordance with all applicable state and federal prompt payment laws.
- Not be subjected to discrimination with respect to participation, reimbursement, or indemnification as a provider who is acting within the scope of their license or certification under applicable State law, solely on the basis of such license or certification. Not be subjected to discrimination for serving high-risk members or if a provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting TennCare or Renaissance from limiting a provider’s or subcontractor’s participation to the extent necessary to meet the needs of members. This provision is not intended and shall not interfere with measures established by TennCare that are designed to maintain quality of care practice standards and control costs. In addition, as a participant in a program receiving federal funds, providers shall not be subjected to discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law.
- Have access to information on how Renaissance decides whether a service is covered and/or medically necessary, and who in Renaissance’s office makes the decision.
- Access to a complaint resolution process with timely responses that may be used to file, as appropriate, an inquiry, grievance, or appeal when there is a disagreement with an action taken by Renaissance, including disapproval of a request for a prior authorization, non-payment of a claim, denial/termination from a Renaissance network, or other complaints.
- Timely response from Renaissance to inquiries, grievances, appeals, and/or administrative hearings.
- Safeguarding by Renaissance of the confidential information in patient records with access allowed only in accordance with applicable federal and state regulations and legal requirements.
- Make recommendations about these responsibilities and rights or Renaissance’s policies and procedures.
- Exercise these rights without adversely affecting the way Renaissance treats the provider.
- Have access to Renaissance UM staff when seeking information about the UM process and/or to help understand a Renaissance decision to deny care or coverage or whether to appeal a decision.

Section 5

Member Rights and Responsibilities

What Renaissance CoverKids Members Are Entitled to and Responsible for

Renaissance CoverKids members have the right to:

- Be treated with fairness, respect, and an appreciation of the need to maintain privacy and dignity.
- Be free from discrimination based on age, ancestry, claims experience, color, disability, expectation and receipt of frequent or high-cost care, sex, genetic information, health status, medical condition

(including pregnancy and physical or mental illness), medical or dental history, national origin or religion, or any other protected class.

- Be furnished health care services in accordance with the applicable sections of
- Chapter 42 of the Code of Federal Regulations. See 42 CFR §438.206 through §438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the condition and ability to understand in accordance with the applicable sections of Chapter of the Code of Federal Regulations. See 42 CFR §438.10.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, including the freedom to exercise their rights without fear of retaliation. This does not refer to the appropriate use of protective stabilization when indicated, and with the member's or legal representative's written consent.
- Be free from segregation in any way from other persons receiving dental services.
- Have free choice of general dentists and dental specialists participating with Renaissance consistent with the rules of their dental plan or program.
- Know the names and credentials of the dental health care providers delivering services.
- Receive assistance if difficulties in accessing dental care arise that the patient cannot resolve alone.
- Have timely barrier-free access to appropriate dental care consistent with Renaissance network standards. Under the Americans with Disabilities Act, a federal law that prohibits discrimination in access to services and employment against persons who are disabled, a disabled individual has a right to reasonable accommodation to facilitate access to a dental office and appropriate dental treatment. Reasonable accommodation may involve removing physical barriers, modifying an office policy or procedure that limits access to a disabled person or providing auxiliary aids and services, such as sign language interpreters, assistive listening devices, large print materials, etc.
- Receive appropriate dental care services, consistent with applicable standards for access, periodicity of treatment, and quality, that are provided in a prompt, dignified, responsible, and culturally competent manner. If needed, receive free language interpreter/translation services in a language specified by the member.
- Available services 24 hours a day, seven days a week when such availability is medically necessary.
- Have a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- Participate with practitioners in decisions regarding necessary health care, including the right to refuse treatment.
- Receive detailed information on emergency and after-hours dental care coverage, including when to seek emergency dental care, how and where to obtain emergency dental care and post-stabilization services after an emergency problem is stabilized, that any hospital or other appropriate setting may be used, and that emergency dental care does not require prior approval.
- Participate in decisions regarding necessary dental care, including expressing preferences about treatment options, requesting a second opinion, or refusing treatment.
- Receive full and understandable information about any financial responsibilities before dental treatment is started. Relevant information includes, but is not limited to, knowing which dental services are covered under the dental plan or program, as well as applicable prohibitions against being

charged for non-covered services unless a written agreement is in place to pay for services before treatment is rendered.

- As appropriate to the dental plan or program, receive a notice in a timely manner after a claim for dental benefits is filed with information on what is and what will not be covered by the dental plan and the reason for Renaissance's determination.
- Voice complaints, grievances, or appeals about the organization or the care it provides.
- Make inquiries to Renaissance for help with questions or concerns.
- Utilize Renaissance's grievance procedures to resolve problems including, but not limited to, complaints about dental plan administration or the quality of the care received.
- Utilize Renaissance's appeal procedures to file an appeal if disagreement with a decision about claim payment or coverage exists.
- Request and receive a copy of dental records in the manner prescribed by federal and state law, and request that the records be amended or corrected if the patient believes the records are inaccurate.
- Have the privacy of personal and health information protected as required by federal and state laws and regulations.
- Make recommendations about the policies and services of the dental plan and/or rights and responsibilities under the plan.
- Exercise these rights without adversely affecting the way that Renaissance or participating dentists treats the patient.
- As appropriate to the dental plan or program, contact involved government agencies or health plans with any questions or complaints.

Member Responsibilities

Renaissance CoverKids members or other responsible persons have the responsibility to:

- Follow the rules, policies, and procedures of the CoverKids dental plan administered by Renaissance.
- Provide information (to the extent possible) needed by Renaissance, its providers, and other healthcare providers so they can deliver appropriate care.
- Be familiar with what the dental plan or program does and does not cover.
- Show the dental plan, health plan, or program identification card to appropriate dental practice staff before receiving services.
- Not allow anyone else to use the assigned patient's dental plan, health plan, or other program identification card.
- Inform the dentist and Renaissance when a change of address, phone number, or other information is necessary.
- Make appointments for routine dental checkups as recommended by the dentist.
- Keep dental appointments or cancel them in advance, with appropriate notice as dictated by dental office policy.
- Provide the dentist with full information about past medical and dental histories and current dental problems.
- Tell the dentist if there is a change in medical or dental conditions.

- Ask questions if the patient does not understand current dental health status or recommended dental care.
- Follow the treatment plan agreed upon with the treating dentist, including the dentist's advice about post-operative care, personal oral care, and nutrition.
- Understand and use the appropriate grievance or appeals process as the first step in resolving complaints about coverage, benefit payment, dental plan administration, or the quality of the care received.
- Make prompt payment for services not covered by the dental plan or program if a written private-pay agreement was signed prior to non-covered services being performed by the dentist.
- Treat other dental members and dental practice staff with respect.
- Report any observed fraud, waste, or abuse.
- Comply with all rules and regulations pertaining to the provision of dental treatment for children in foster care.

Section 6

Member Enrollment and Eligibility

How to Verify Patient Eligibility for the CoverKids Dental Plan Administered by Renaissance

Renaissance does not perform enrollment functions for members. TennCare, a branch of the Tennessee State Government, determines member eligibility. Eligibility data is updated to Renaissance daily. On each date of service, providers are responsible for verifying member eligibility on the Dental Office Toolkit™ (DOT) or by phone on the Interactive Voice Response (IVR) system. The TennCare Provider Eligibility Portal is the source of truth for all eligibility and may be checked at:

https://mylogin.tenncare.gov/

If eligibility is not confirmed on the date of service before treatment begins for members who may be enrolled in the CoverKids dental plan, and the provider delivers services to an ineligible patient, Renaissance will not reimburse for services and the provider cannot bill the patient for the services. Please set up a process where the eligibility for all Renaissance CoverKids members is checked at each appointment. Due to possible eligibility status changes, the information provided by Renaissance does not guarantee payment.

In addition to the provider NPI number(s), the following information is necessary to verify eligibility:

Member details:

- Member Medicaid identification number or Social Security number
- Member date of birth
- Member name
- Date of service

Access and verify patient eligibility in the following ways:

- View member benefits and eligibility via the Dental Office Toolkit™ (DOT) at https://www.rendentalofficetoolkit.com/. When accessing DOT, the following information is available:
    - Look up patient benefit information
    - Submit prior authorizations
    - Submit claims, review the status of submitted claims or view claims history
    - Access account activity
    - Sign up for direct deposit
- Customer service representatives are available Monday through Friday, from 7 a.m. to 5 p.m. CT at 866-864-2526 to assist

Renewal/Re-Enrollment

Member eligibility redetermination, renewal of eligibility, or re-enrollment—Renaissance is not involved in this process. A renewal is a periodic redetermination of eligibility after initial eligibility has been established. As a reminder, providers are expected to verify member eligibility each time before a service is rendered.

Member Disenrollment

Members may choose to disenroll from the CoverKids dental program. Retaliatory action against a patient for disenrolling from the program is not allowed. Please verify a patient's eligibility and participation with Renaissance before providing services.

Section 7

Caring for Renaissance CoverKids Members

Responsibilities for Patient Interaction, Treatment, Record Keeping and Privacy

What is Renaissance Doing to Address Barriers to Care?

To address barriers to care and provide high quality health care to all members Renaissance is taking steps to support practices with delivering high quality dental outcomes for all patient populations.
For example:

- Renaissance has adopted the culturally and linguistically appropriate services (CLAS) recommendations of the U.S. Department of Health and Human Services as a guideline in the development of the cultural competency program. Information on Renaissance's cultural competency program can be found at Cultural Competency | Renaissance. Additionally, Renaissance's website has additional features that provide participating dentists with on-demand tools and educational materials for many different topics, including cultural competency, program requirements, and special needs care.
- Renaissance encourages participating dentists to address the care and service provided to CoverKids members with diverse values, beliefs, and backgrounds in a culturally sensitive manner.
- Renaissance's materials for Members and responsible persons are written at a 5th grade reading level to facilitate the level of communication and understanding between members, dentists, and Renaissance.
- Renaissance provides communication and translation services. (See "Communicate effectively with all Medicaid members" below).
- Renaissance monitors and evaluates the level of cultural competency throughout the Renaissance CoverKids Network through an evaluation of the dental services provided by participating dentists and via communications with Medicaid Members and responsible persons.

Take Advantage of Renaissance's Free Cultural Competency Training

Cultural competency refers to the ongoing and intentional attainment of skills that allow an individual to function effectively when interacting with people who have different backgrounds and experiences. Cultural competency is an important skill for dental providers to develop. As a dentist participating in the Renaissance Tennessee Network, free training on cultural competency is provided to meet contractual requirements with Renaissance for annual cultural competency training.

For your convenience, this module is combined with a free training module on fraud, waste, and abuse (FWA) prevention and detection, which is required by U.S. Centers for Medicare and Medicaid (CMS) administration regulations. Once both training modules are completed, submit a cultural competency and FWA training acknowledgment form, which satisfies the annual training requirements. The training modules and form can be accessed through Renaissance's online annual provider training webpage at:
tenncare.renaissancebenefits.com

Effective Communication with CoverKids Members

Utilizing the members' primary spoken (or signed) language, Renaissance will help provide services to Medicaid members in a culturally and linguistically appropriate manner. Renaissance provides a language interpretation service to all dentists participating in the Renaissance CoverKids Network at no cost. If there is a language barrier with a patient, Renaissance can either conference an interpreter into a three-way call between the provider and patient, or a speaker phone in a HIPAA complaint location can be used if a non-English speaking Medicaid patient is in the office. Sign language interpretation is also available and can be scheduled ahead of time by calling Renaissance at
866-864-2526 (TTY users dial 711).

Members with cognitive impairments may also require communication accommodations. Cognitive impairment can be seen in a variety of congenital conditions or those acquired later in life, such as a

developmental problem or difficulties secondary to acquired health problems (e.g., brain injury, stroke, brain tumor, anoxia and mental health disorder). The National Institutes of Health offers some ideas for communicating with cognitively impaired members of any age at the following link: https://www.nia.nih.gov/health/health-care-professionals-information/assessing-cognitive-impairment-older-members

Please refer to the following link on this website on treating members with special needs: tenncare.renaissancebenefits.com

Discrimination

Members must receive culturally competent care, and they have the right to receive health care, free from discrimination on the basis of their age, sex, race, color, religion, physical or mental disability, national origin, economic status or payment source, type/degree of illness or condition, or any other classification that is protected by federal and state laws and regulations.

Providers shall comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Patient Protection and Affordable Care Act, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, and conscience and religious freedom protections in the provision of equal opportunities for members and participants. These requirements include providers having policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures, and for regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equity and eliminate bias with generating assessment results. Provider's staff members shall receive annual training on the provider's: policies on how to deliver services in nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. Providers' new hires must receive this training within thirty (30) days of joining the provider's workforce.

Providers must cooperate with Renaissance and TennCare during discrimination complaint investigations. In addition, providers must assist members in obtaining discrimination complaint forms and with submitting the forms to TennCare. More information about civil rights compliance, including forms, policies, and notices is available on TennCare's Office of Civil Rights Compliance's ("OCRC") webpages for members and providers.

TennCare's Non-Discrimination Compliance Office Contact Information:

Division of TennCare, TennCare,
Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W
Nashville, TN 37243 615-507-6474 (TRS 711)
HCFA.fairtreatment@tn.gov

TennCare Discrimination Complaint Form

English TennCare Discrimination Form: TennCare Discrimination Complaint Form
Spanish TennCare Discrimination Form – Formulario de queja por discriminación de TennCare
Arabic TennCare Discrimination Form – TennCare نموذج شكوى التمييز لبرنامج

Use Best Practices for Treating Members

Prior to treating a patient, make sure to develop and record the appropriate diagnoses, prepare a written

treatment plan, and provide treatment in an appropriate sequence (e.g., pain/infection control, treatment of extensive caries, endodontic treatment, periodontal treatment, restorative, and prosthetic treatment), then recall members at appropriate intervals, consistent with the patient's needs and the AAPD periodicity schedule, as applicable. As dental caries is of particular concern, it is best practice to perform a caries risk assessment for each Medicaid patient and take individual caries risk status (e.g., high, medium, low) into account when developing each patient's treatment and maintenance plan. The ADA has a caries risk assessment (CRA) method and form on the organization website for use in the dental office:

- ADA CRA reference:

https://www.ada.org/resources/ada-library/oral-health-topics/caries-risk-assessment-and-management
Prior to treatment, make sure to (1) review treatment plans and options with the patient or responsible persons, and then (2) obtain the appropriate written informed consent documenting that the patient, or responsible person/representative, understands the risks, benefits, and alternatives to the proposed dental care and agrees to treatment.

The timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the treating dentist based on the patient's needs.

How to Support Continuity of Care with Good Patient Records

Good clinical recordkeeping helps track the patient's dental needs, provide the right care at the right time, follow up on the patient's post-treatment progress, plan the patient's future treatment needs, obtain reimbursement from insurance payers, and communicate effectively with other health care professionals in coordinating the patient's dental and medical treatment.

Medicaid records shall be:

- Of sufficient quality to fully disclose and document the extent of services provided to individuals receiving Medicaid assistance.
- Documented at the time the services are provided or rendered, and prior to associated claim submission.

All providers shall maintain, for a period of ten (10) years from the date Medicaid services are provided to a member, such medical or other records as are necessary to fully disclose and document the extent of the services provided. A copy of a claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement.

Providers must maintain records that are independent of claims for reimbursement. Please see the following link for information that should be included in the dental record:
https://www.ada.org/resources/practice/practice-management/documentation-patient-records

If a Renaissance, CoverKids, or CMS authority requests access to the patient's treatment records, participating dentists must make the records available in a timely manner. Requests for access to a participating dentist's records may be for the purposes of examination, audit, investigation, contract administration, or any other purpose(s) deemed necessary for contract compliance, enforcement, or performance of regulatory functions, subject to compliance with applicable law or regulations.

Protect Members' Privacy

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and implementing regulations) is a federal law intended to provide better access to health insurance, limit fraud and abuse, ensure privacy of health care information and reduce administrative costs. Renaissance maintains policies and procedures to ensure compliance with HIPAA and associated regulations by company personnel and participating dentists.

Since electronic transactions are significantly more cost effective than paper, HIPAA includes a major provision (Administrative Simplification) to encourage the use of electronic transactions while safeguarding patient privacy. HIPAA created a standard for electronic transmissions used in the health care industry and established standards governing the privacy/security of health information.

Protected Health Information (PHI) may only be used or disclosed as permitted by law, and only the minimum amount necessary to accomplish tasks.

PHI is individually identifiable health information that is transmitted or maintained in an electronic medium, or by other means including written records and oral communications. Individually identifiable information includes patient name, Social Security number, date of birth, street address, driver's license number, telephone or fax numbers, email address, health plan beneficiary number, or account number.

As a participating dentist in the Renaissance CoverKids Network, compliance with the following PHI confidentiality requirements is mandatory, including: (1) abiding by all applicable federal and state laws regarding confidentiality and disclosure of medical/dental records or other health and enrollment information, (2) ensuring that medical/dental information is released only in accordance with such federal or state laws and regulations, or pursuant to court orders or subpoenas, (3) maintaining patient records and information in an accurate and timely manner, (4) ensuring timely access by members to records and information that pertain to the patient and (5) safeguarding the privacy of any information that identifies a particular member, including implementation of written procedures that specify: (a) for what purposes a members information will be used within the practice and, (b) to whom and for what purposes it will disclose the information outside the practice.

Renaissance maintains a notice of privacy practices for members that indicates the ways Renaissance may use and disclose members' PHI, individual member rights regarding PHI and Renaissance's legal responsibilities regarding PHI. The notice also contains information about the process maintained by Renaissance with respect to individuals' right to express written concerns with the company's privacy policies and procedures. The notice is distributed as required and is updated as information changes. Renaissance's notice of privacy practices can be accessed at: tenncare.renaissancebenefits.com

This information is for instructional purposes only and does not constitute legal advice. Please contact legal counsel for advice with respect to the interpretation of HIPAA and its applicability to the dental practice.

Follow the links below for more information on each subject:

- HIPAA: HIPAA for Professionals | HHS.gov
- Administrative Simplification: HIPAA, Administrative Simplification, and ACA FAQs | Guidance Portal
- TennCare's Office for Civil Rights Compliance

Section 8

Medical Necessity

To be medically necessary, a service must satisfy each of the following criteria: (a) It must be recommended by a licensed healthcare provider practicing within the scope of his or her license who is treating the member; (b) It must be required in order to diagnose or treat an member's condition; (c) It must be safe and effective; (d) It must not be experimental or investigational; and (e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the member's medical condition. Additionally, "Medical Necessity" is defined by Tennessee Code Annotated, Section 71-5-144: Medical Necessity and shall describe a medical item or service that meets the criteria set forth in that statute.

Section 9

General Clinical Criteria

i. Providers must use the most current and appropriate ADA Code(s) on Dental Procedures and Nomenclature (CDT) when submitting requests for prior-authorization or retro-authorization.

ii. Failure to submit required documentation in requests for authorization may result in a denied request and denied payment of a claim related to that request.

iii. Renaissance may require a second opinion or prior authorization for requests of more than 4 stainless steel crowns per patient.

iv. If a participating provider is an outlier regarding overutilization of a certain procedure that does not require prior authorization like stainless steel crowns, Renaissance may at its discretion impose prior authorization of the said procedure for the individual provider.

v. Reimbursement for procedures includes local anesthesia in fee.

vi. Radiographs must be labeled with the member's name, DOB, and proper left/right orientation.

vii. In cases where the dental procedure does not meet Renaissance's treatment standards, Renaissance can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after Renaissance reviews the circumstances.

viii. All dental materials used for treatment of TennCare members should meet current ADA guidance and federal regulations.

ix. Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns (including prefabricated stainless-steel crowns) may require a second opinion as determined by Renaissance.

If acceptable radiographs are available from another source, dentists should use those images rather than exposing a patient to more radiation, but only if those radiographs are current and representative of the current oral conditions. When such images are not available, dentists should obtain the appropriate initial and recall radiographs required for the diagnosis and treatment of a member in accordance with the current version of "Guidelines for Prescribing Dental Radiographs" published by the ADA and the FDA.

Please see the link below: https://www.ada.org/resources/practice/practice-management/radiographic-imaging

Section 10

Clinical Criteria and Covered Services Tables

Covered Services List

Procedures Covered by the CoverKids Program Administered by Renaissance

This section provides a list of dental procedures covered by the CoverKids dental plan administered by Renaissance. Standard benefit limitations under the program are listed where applicable in the "Benefit Limitations" column. The "Routine Review/Prior Authorization Required" column identifies whether a procedure is routinely reviewed, also known as post-service, pre-payment review (PPR) or prior authorized. Definitions for both pre-payment review and prior authorization can be found in the glossary, with additional detail below. If documentation must be submitted for a routinely reviewed procedure, it is listed in the "Documentation Required" column. If prior authorization (PA) is required to support medical necessity, appropriateness of care, and subsequent payment, it will be indicated as such with a "PA" in the "Prior Authorization/Routine Review Required" column along with the documentation required.

Binding prior authorization involves the advanced approval of specific dental procedures, services, or dental appliances through the application of medical necessity and appropriateness of care parameters defined in specific evidence-based clinical criteria. As opposed to basic pre-treatment estimates, which explain if a service is covered by a dental plan, and what typical plan payments would be for the service in question, several procedures require prior authorization review and approval before services may be rendered and paid for. Renaissance is not able to pay claims for services in which prior authorization is required, but not obtained, by the provider.

For services noted as post-service, pre-payment review, the provider must submit the applicable documentation before the claim can be paid. Pre-payment review allows the provider to render the appropriate services to members without the requirement for prior authorization. Claims requiring pre-payment review are reviewed after the service is rendered, ensuring the service delivered was medically necessary, within the standards of evidence-based practice guidelines, and of acceptable quality.

In accordance with the American Academy of Pediatric Dentistry (AAPD) Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents, dental providers should refer to the "Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling" Schedule. The AAPD intends these recommendations to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents. The schedule may be assessed at https://www.aapd.org/globalassets/media/policies_guidelines/bp_recdentperiodschedule.pdf, with services listed below:

Periodicity of Examination, Preventative Dental Services, Anticipatory Guidance and Oral Treatment for Children (as updated by the TennCare)

- Birth-12 Months
  - 1. Complete the clinical oral assessment and appropriate diagnostic tests to assess oral growth and development and/or pathology.
  - 2. Provide oral hygiene counseling for parents, guardians, and caregivers, including the implications of the oral health of the caregiver.
  - 3. Remove supra- and subgingival stains or deposits as indicated.
  - 4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe

systemic fluoride supplements if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
    - 5. Assess appropriateness of feeding practices, including bottle and breastfeeding, and provide counseling as needed.
    - 6. Provide dietary counseling related to oral health.
    - 7. Provide age-appropriate injury prevention counseling for orofacial trauma.
    - 8. Provide counseling for non-nutritive oral habits (digit, pacifiers, etc.).
    - 9. Provide diagnosis and required treatment and/or appropriate referral for any oral diseases or injuries.
    - 10. Provide anticipatory guidance for parent/guardian.
    - 11. Consult with the child's physician as needed.
    - 12. Based on evaluation and history, assess the patient's risk for oral disease.
- 12 - 24 Months
    - 1. Repeat procedures listed above every six months or as indicated by individual patient's needs/susceptibility to disease.
    - 2. Review patient's fluoride status, including any childcare arrangements which may impact or systemic fluoride intake and provide parental counseling.
    - 3. Provide topical fluoride treatments every six months or as indicated by the individual patient's needs.
- 2 - 6 Years
    - 1. Repeat procedures listed above every six months or as indicated by individual patient's needs/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
    - 2. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated by individual patient's needs.
    - 3. Scale and clean the teeth every six months or as indicated by the individual patient's needs.
    - 4. Provide topical fluoride treatments every six months or as indicated by the individual patient's needs.
    - 5. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs.
    - 6. Provide counseling and services (athletic mouth guards) as needed for orofacial trauma prevention.
    - 7. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
    - 8. Provide diagnosis and required treatment and/or appropriate referral for and oral diseases, habits, or injuries as indicated.
    - 9. Assess speech and language development and provide appropriate referral as indicated.
- 6 - 12 Years
    - 1. Repeat procedures listed above every six months or as indicated by individual patient's needs/susceptibility to disease.
    - 2. Provide substance abuse counseling (smoking, smokeless tobacco, etc.).
- 12 - 18 Years
    - 1. Repeat procedures listed above every six months or as indicated by individual patient's needs/susceptibility to disease.
    - 2. At an age determined by patient, parent and dentist, refer the patient to a general dentist for continuing oral care.

Renaissance CoverKids benefits consist of both State Plan (contractually defined) approved services as well as any medically necessary service for eligible members under the age of 18.

Diagnostic Clinical Criteria

Diagnostic Criteria:

- Diagnostic services include the oral examinations and radiographs needed to assess oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health. Comprehensive and periodic evaluations include, but are not limited to, evaluations of all hard and soft tissue of the oral cavity; periodontal charting; recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships; and typically, temporomandibular joint and oral cancer screenings. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist.

Qualifying Criteria:

- Diagnostic services such as radiographic images are necessary for clinical reasons, aiding in treatment planning and delivery of comprehensive care. Radiographic images are adjunctive to diagnostic services and should be prescribed in accordance with the guidelines of the Food and Drug Administration in conjunction with the American Dental Association (ADA). Current guidance from the ADA can be found at: X-rays/Radiographs | American Dental Association.
- All radiographs must be of diagnostic quality, properly mounted and labeled with proper left/right orientation, dated, and identified with the member's name.
- Radiographs not diagnostic in quality will not be reimbursed for, or if already paid for, Renaissance will recoup the funds previously paid.

Reimbursement Criteria:

- Multiple oral evaluations (D0120, D0140, D0150, etc.) by the same provider or provider group on the same date of service are not payable.
- Reimbursement for some or multiple radiographs of the same tooth or area may be denied if Renaissance determines the number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure.
- The maximum amount paid for individual radiographs taken within 30 days will be limited to the allowance for a full-mouth series.
- Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
- Reimbursement for bitewing and intraoral-periapical radiographs is not covered for the same date of service as a full-mouth comprehensive series of radiograph images. The complete series is inclusive of bitewing and intraoral-periapical radiographs.
- Periapical radiographs submitted without a tooth number may be denied.
- Charges for duplication (copying) of radiographic images for insurance purposes are disallowed.
- Radiographic images used intraoperatively or considered a component of the primary procedure are not payable.
- Any reimbursement already made for an inadequate service may be recouped after the Renaissance consultant reviews the circumstances.

***Charges for diagnostic services that do not meet acceptable standards of care regarding diagnostic quality or are not recommended in accordance with the AAPD periodicity schedule, or are not in alignment with the American Dental Association's principles on the safe use of radiographs in dentistry and recommendations for prescribing dental radiographs, are not collectable from a Renaissance Medicaid patient by a participating dentist.*

Click here to learn more about diagnostic clinical guidance and criteria: Renaissance - Clinical Criteria

CDT	Benefit Limitations	Area of	Prior Authorization	Documentation

Code/ Description		Mouth	(PA) or Routine Review (PPR) Required Pre-Payment Review	Required for Services Requiring Review
Diagnostic **| D0100-D0999** Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity, with applicable documentation for medical necessity, including: D0160, D0170, D0180, D0277, D0310, D0320, D0321, D0322, D0350, D0415, D0426, D0431, D0460, D0461, D0470,. This list is also available at: https://rendentalofficetoolkit.com				
D0120 periodic oral evaluation - established patient	Age 0-18. One of (D0120, D0150, D0160) per 6 months		No	No
D0140 Limited oral Evaluation – problem focused	Age0-18 Two of (D0140) per 12 months per provider or location Not reimbursable on the same day as D0120,D0150,D0160, or D9430. Not used In conjunction with routine dental services. Not Intended for follow up care		No	No
D0150 comprehensive oral evaluation - new or established patient	Age 0-18. One of (D0150) One per lifetime per provider or location. One of (D0120, D0150, D0160) per 6 months per provider or location. Cannot be billed within the 6-month period by provider of the same specialty. Cannot be billed on the same day as D0140, by the same provider.		No	No
D0210 intraoral - comprehensive series of radiographic images	Age 6-18 One of (D0210, D0330, D0367) per 36 months per patient		No	No
D0220 intraoral - periapical first radiographic image	Age 0-18. One of (D0220) per date of service		No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
D0230 intraoral - periapical each additional radiographic image	Age 0-18. Seven of (D0230) per 12 months		No	No
D0270 bitewing single radiographic image	Age 2-18. One of (D0270, D0272, D0274, D0277) per 12 months per patient.		No	No
D0272 bitewings two radiographic images	Age 2-18. One of (D0270, D0272, D0273 or D0274) per 12 months.		No	No
D0274 bitewings - four radiographic images	Age 10-18. One of (D0270, D0272, D0274, D0277) per 12 Months per patient.		No	No
D0330 panoramic radiographic image	Age 6-18. One of (D0210, D0330, D0367) per 36months per patient.		No	No
D0340 cephalometric radiographic image	Age 0-18. Reimbursable every two years (24 months) if clinically indicated for orthodontic treatment purposes.		No	No
D0367 cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	Age 6-18. One of (D0210, D0330, D0367) per 36 months per patient.		No	No

Preventive Clinical Criteria

Diagnostic Criteria:

- Diagnostic radiographs and narrative to support medical necessity determination (for space maintainers) are required.
- Caries risk assessment and/or documentation of caries with narrative of medical necessity for use of fluoride treatments and silver diamine fluoride application.

Qualifying Criteria:

- **Fluoride varnish**
  - Dentist has established a credible caries risk assessment that requires the need for fluoride varnish treatment, including but not limited to the following indications:
    - For moderate to high caries risk members with a medical or cognitive impairment that limits cooperation with a tray or rinse delivery method
    - Xerostomia
    - For members in inactive orthodontic treatment
    - For members receiving head and neck radiation therapy
  - Clinical situations that may not meet criteria and/or pose a risk to the patient include the following contraindications:
    - Individuals with a low caries risk who consume optimally fluoridated water or who receive routine fluoride treatments through a dental office
    - Should not be used if there are noticeable sores in the mouth or on the gums
    - Should not be used if there is an allergy to one of the ingredients or to pine nuts
    - Bronchial asthma
- **Silver Diamine Fluoride (SDF)**
  - Dentist has established a credible caries risk assessment and diagnosis of caries that require the need for silver diamine fluoride treatment, with the following indications:
    - As conservative treatment for active, non-symptomatic carious lesions
    - Operating Room (OR) diversion as an alternative to placing young children under general anesthesia in a medical facility
    - Treat dental hypersensitivity
    - Stabilize uncontrolled caries for members at high risk of experiencing new lesions
    - Treat vulnerable tooth structure
    - Caries that are difficult or impossible to treat with traditional restorations
    - Instances when standard restorative treatment is difficult to perform
    - Treat members with limited or no access to restorative dental care
    - Treat members with limited life expectancy
  - Clinical situations that may not meet criteria and/or pose a risk to the patient include the following contraindications:
    - An allergy to silver
    - Mucosal irritation, including oral ulcerations, desquamative gingivitis, or mucositis
    - Carious lesions that have symptoms of irreversible pulpitis
    - Pregnant women
    - During the first six months of breastfeeding

Reimbursement Criteria:

- The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment unless the procedure is medically necessary for proper treatment of the member, applicable clinical criteria (indications and contraindications) are met, and all supporting documentation is submitted. Any reimbursement already made for an inadequate service may be recouped after the Renaissance consultant reviews the circumstances.

***Charges for preventive therapy with resultant adverse treatment outcomes are not collectable from a TennCare patient by a participating dentist.*

Click here to learn more about preventive clinical guidance and criteria: Renaissance - Clinical Criteria

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Preventive – D1000-D1999				
D1110 prophylaxis – adult	Age 13-18. One of (D1110, D1120) per 6 months. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Includes any additional scaling.		No	No
D1120 prophylaxis – child	Age 0-12 One of (D1110, D1120) per 6 months.		No	No
D1206 topical application of fluoride varnish	Age 0-18. One of (D1206, D1208) per 6 months.		No	No
D1208 topical application of fluoride - excluding varnish	Age 4-18. One of (D1206, D1208) per 6 months.		No	No
D1351 sealant - per tooth	Age 0-18. One of D1351 per 1 Lifetime per tooth. Occlusal surface only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	teeth 1-3, 14-19, 30-32	No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Preventive – D1000-D1999				
D1354 interim caries arresting medicament application - per tooth	Age 0-18. Four of (D1354,D2991) per 1 Lifetime per patient per tooth. Limit of 6 teeth per date of service. Only 2 of the 4 per tooth applications can be done within 6 weeks of each other. Not allowed if had D2000 series code on same tooth in prior 12 months. D2000 series code on same tooth not allowed for 4 weeks after D1354.	teeth 1 - 32, 51-82, A - T, AS-TS	No	No
D1510 space maintainer - fixed-unilateral, per quadrant	Age 2-12. One of D1510 per 1 lifetime per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	Per quadrant (10, 20, 30, 40, UR, LR, UL, LL)	PPR	Evidence of premature primary tooth loss leading to undesirable tooth movement preventing normal eruption of permanent teeth.
D1516 space maintainer - fixed-bilateral, maxillary	Age 2-12. One of (D1516, D1526) per 1 lifetime. Indicate missing tooth numbers and arch (01, 02, LA, UA) on claim.		PPR	Evidence of at least one tooth missing in separate quadrants of the same arch.
D1517 space maintainer - fixed-bilateral, mandibular	Age 2-12. One of (D1517, D1527) per 1 lifetime. Indicate missing tooth numbers and arch (01, 02, LA, UA) on claim.		PPR	Evidence of at least one tooth missing in separate quadrants of the same arch
D1526 space maintainer - removable-bilateral, maxillary	Age 2-12. One of (D1516, D1526) per 1 lifetime. Indicate missing tooth numbers and arch/quadrant on claim.		PPR	Evidence of at least one tooth missing in separate quadrants of the same arch

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Preventive – D1000-D1999				
D1527 space maintainer - removable-bilateral, mandibular	Age 2-12. One of (D1517, D1527) per 1 lifetime. Indicate missing tooth numbers and arch/quadrant on claim.		PPR	Evidence of at least one tooth missing in separate quadrants of the same arch
D1551 re-cement or re-bond bilateral space maintainer – maxillary	Age 2-18. Not covered within 6 months of initial placement by same provider.		No	No
D1552 re-cement or re-bond bilateral space maintainer – mandibular	Age 2-18. Not covered within 6 months of initial placement by same provider.		No	No
D1553 re-cement or re-bond unilateral space maintainer - per quadrant	Age 2-18. Not covered within 6 months of initial placement by same provider.	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No

Restorative Clinical Criteria

Diagnostic Criteria

- Current pre-operative radiographs of diagnostic quality clearly showing adjacent and opposing teeth: pathology and/or caries must be present.
- Periapicals or bitewings acceptable. Panoramic or other types of radiographs that do not clearly show the tooth to be treated, adjacent and/or opposing teeth, along with pathology and extent of caries present, may not be accepted.
- Establishment of a credible caries risk assessment and diagnosis of caries that require the need for definitive restorative treatment, as applicable under the indications listed below.

Qualifying Criteria

- Direct Restorations

- Direct restorations include non-esthetic direct restoration materials such as amalgam and esthetic direct restoration materials such as composite resin, glass ionomer cement, resin modified GIC, and compomers.
- Direct restorations are indicated for the following:
  - Replace tooth structure lost to caries or trauma
  - Replace restorative material lost while accessing pulp chamber for endodontic therapy
  - Replace existing restorations that exhibit recurrent decay, fracture, or marginal defects
  - Glass ionomer restorations may be indicated for the following:
    - When teeth cannot be isolated properly to allow placement of resin restorations
    - As an alternative to resin sealants when the teeth cannot be properly isolated (patient cooperation, partially erupted teeth)
    - Class I, II, III and V restorations on primary teeth
    - Class III and V restorations on permanent teeth that cannot be isolated in high-risk members
    - As a caries control plan for high-risk members using atraumatic techniques
- Direct restorations are not indicated for the following:
  - Teeth with a hopeless prognosis
  - Incipient enamel only lesions extending less than halfway to the dentinoenamel junction (DEJ)
  - Teeth that are sound as defined by ADA Caries Classification system (Dental Caries Management Clinical Practice Guidelines | American Dental Association)
  - Primary teeth that are near exfoliation or less than 50% of the tooth root remains

- Crowns
  - Criteria for crowns include permanent teeth needing multi-surface restorations or where other types of restorations have a poor clinical outcome.
  - A permanent anterior tooth with loss of tooth structure due to initial caries, recurrent caries, restoration failure, and/or tooth/restoration fracture with structure loss involving four or more surfaces and at least 50% of the incisal edge or cuspal tip, where direct restorations would have a poor prognosis.
  - A permanent premolar tooth with loss of tooth structure due to initial caries, recurrent caries, restoration failure, and/or tooth/restoration fracture with structure loss involving **three or more surfaces** and **one or more cusps** must be fractured or missing.
  - A permanent molar tooth with loss of tooth structure due to initial caries, recurrent caries, restoration failure, and/or tooth/restoration fracture with structure loss involving **four or more surfaces** and **two or more cusps** must be fractured or missing
  - Members are eligible for crowns on teeth 3, 14, 19, and 30 at age 16.
  - Members are eligible for crowns on teeth 2,15, 18, and 31 at age 18.
  - Members are eligible for crowns on teeth (4-13; 20-29) at age 18.
  - A tooth with successful prior endodontic treatment and an endodontic access opening that has removed an extensive amount of tooth structure such that a crown is required to support the remaining tooth structure.

- When replacing a crown, open margin with obvious recurrent decay, fracture, or other structural failure must be documented.
- Crowns must be opposed by a natural tooth, complete denture or will serve as an abutment for a partial denture.
- Crowns are not indicated under the following circumstances:
  - A lesser means of restoration is possible.
  - Tooth has sub-osseous and/or furcation caries.
  - Tooth has advanced periodontal disease.
  - Tooth is a primary tooth, unless permanent tooth is congenitally missing.
  - Crowns are being planned to alter vertical dimension.
  - Tooth has no apparent destruction due to caries or trauma
- Criteria for authorization of crowns after endodontic treatment:
  - Include a dated post-endodontic radiograph.
  - Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
  - The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
  - Crown must be opposed by a tooth or denture or is an abutment for a partial denture.
  - The patient must be free from active periodontal disease.
  - The permanent tooth must be at least 50% supported in bone.

- Core build ups (only covered for 1915(c) Waiver/ECF Choices members)
  - Presence of greater than 50% bone support
  - Absence of sub-osseous decay and/or furcation involvement
  - Absence of adequate tooth structure to support crown
  - Clinically acceptable root canal fill (if applicable)

Reimbursement Criteria

- A dated post-operative radiograph must be kept in the patient's record for completed indirect restorative procedures like crowns.
- Composite and amalgam restorations are reimbursable based upon total number of restored surfaces. For example, non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three-surface restoration. Each claim line for restorative services must relate to only one tooth number. Local anesthesia is included in the fee for all restorative services.
- Any restorations done on the same tooth by the same provider or provider location within a 12-month period may be subject to post review.
- Billing and reimbursement for crowns are based on the seat/cementation date. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

***Charges for restorative services with resultant adverse treatment outcomes are not benefits of the program and are not collectable from a TennCare patient by a participating dentist. Post-cementation radiographs must*

be in the patient's chart and available for review upon request. Absence of radiographic evidence required for confirming the quality of restoration(s) in a patient's chart may result in the recovery of prior payments for the service

Click here to learn more about restorative clinical guidance and criteria: [Renaissance - Clinical Criteria]

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Restorative – D2000-D2999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances and with applicable documentation for medical necessity, including: D2750, D2799, D2910, and D2980. This list is also available at: https://rendentalofficetoolkit.com				
D2140 amalgam - one surface primary or permanent	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335,D2390, D2391, D2392, D2393, D2394) per 36 months per tooth, per surface.	teeth 1-32, A–T	No	No
D2150 amalgam - two surface primary or permanent	Age 1-11 (primary), Age 5-18 (permanent) One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 months per tooth, per surface.	teeth 1-32, A–T	No	No
D2160 amalgam - three surfaces, primary or permanent	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390 D2391, D2392, D2393, D2394) per 36 months per tooth, per surface.	teeth 1-32, A–T	No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Restorative – D2000-D2999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations,				

prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances and with applicable documentation for medical necessity, including: D2750, D2799, D2910, and D2980. This list is also available at: https://rendentalofficetoolkit.com

D2161 amalgam - four surfaces, primary or permanent	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 months per tooth, per surface.	teeth 1-32 A–T	No	No
D2330 resin - 1 surface, anterior	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 months per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	teeth 6-11, 22-27, C-H, M-R,	No	
D2331 resin – 2 surfaces, anterior	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 months per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	teeth 6-11, 22-27, C-H, M-R,	No	No
D2332 resin - 3 surfaces, anterior	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36months per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	teeth 6-11, 22-27, 6-11, 22-27	No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Restorative – D2000-D2999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances and with applicable documentation for medical necessity, including: D2750, D2799, D2910, and D2980. This list is also available at: https://rendentalofficetoolkit.com				
D2335 resin - 4 + surfaces involving incisal angle, anterior	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 months per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	teeth 6-11, 22-27, C-H, M-R,	No	No
D2390 resin-based composite crown, anterior	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36months per tooth, per surface.	teeth 6-11, 22-27, C-H, M-R	No	No
D2391 resin - based composite - 1 surface, posterior	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36months per tooth, per surface.	Teeth 1-5, 12-21, 28-32, A, B, I-L, S, T	No	No
D2392 resin - based composite - 2 surfaces, posterior	Age 1-11 (primary), Age 5-18 (permanent) One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	Teeth 1-5, 12-21, 28-32, A, B, I-L, S, T	No	No
D2393 resin - based composite - 3 surfaces, posterior	Age 1-11 (primary), Age 5-18 (permanent). One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	Teeth 1-5, 12-21, 28-32, A, B, I-L, S, T	No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Restorative – D2000-D2999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances and with applicable documentation for medical necessity, including: D2750, D2799, D2910, and D2980. This list is also available at: https://rendentalofficetoolkit.com				
D2394 resin – based composite – 4 or more surfaces, posterior	Age 1-11 (primary), Age 5-18 (permanent) One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	Teeth 1-5, 12-21, 28-32, A, B, I-L, S, T	No	No
D2740 crown - porcelain/ceramic	Age 16-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 months per tooth.		PA	pre-operative radiograph(s)
D2751 crown - porcelain fused to predominantly base metal	Age 16-18. One of (D2740, D2751, D2752,D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 months per tooth		PA	pre-operative radiograph(s)
D2752 crown - porcelain/fused to noble metal	Age 16-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 months per tooth		PA	pre-operative radiograph(s)
D2790 crown - full cast high noble metal	Age 16-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 months per tooth.		PA	pre-operative radiograph(s)
D2791 crown - full cast predominantly base metal	Age 16-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 months per tooth.		PA	pre-operative radiograph(s)
D2792 crown - full cast noble metal	Age 16-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, per 60 months per tooth.		PA	pre-operative radiograph(s)
D2920 re-cement or re-bond crown	Age 0-18. Not billable within 6 months of initial placement.	teeth 1–32, A–T	No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Restorative – D2000-D2999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity including: D2750, D2799, D2910, and D2980. This list is also available at: https://rendentalofficetoolkit.com				
D2928 prefabricated porcelain/ceramic crown – permanent tooth	Age 0-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2928,D2930, D2931, D2932, D2933) per 60 months per tooth.	teeth 1-32	No	No
D2930 prefabricated stainless steel crown - primary tooth	Age 0-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2928,D2930, D2931, D2932, D2933) per 60 months per tooth	teeth A–T	No	No
D2931 prefabricated steel crown – permanent tooth	Age 0-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2928,D2930, D2931, D2932, D2933) per 60 months per tooth	teeth 1–32	No	No
D2932 prefabricated resin crown	Age 0-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2928,D2930, D2931, D2932, D2933) per 60 months per tooth	teeth 1-32, C-H, M-R	No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Restorative – D2000-D2999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D2750, D2799, D2910, and D2980. This list is also available at: https://rendentalofficetoolkit.com				
D2933 prefabricated stainless steel crown with resin window	Age 0-18. One of (D2740, D2751, D2752, D2790, D2791, D2792, D2928,D2930, D2931, D2932, D2933) per 60 months per tooth	teeth 1-32, C-H, M-R	No	No
D2940 protective restoration	Age 0-18. One of (D2940) per tooth per lifetime. Not reimbursable on primary teeth. No definitive restorative treatment billable for a minimum of 14 days after D2940.	teeth 1–32	No	No
D2950 core buildup, including any pins when required	Age 6-18. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed.		PA	pre-operative radiographs
D2951 pin retention - per tooth, in addition to restoration	Age 6-18. Maximum of 3 pins. Not reimbursable in conjunction with code D2950.	teeth 1–32	No	No
D2952 cast post and core in addition to crown	Age 6-18. One of (D2950, D2952, D2954) per 60 months per patient per tooth.		PA	endodontic fill radiographs
D2954 prefabricated post and core in addition to crown	Age 6-18. One of (D2950, D2952, D2954) per 60 months per patient per tooth.		PA	endodontic fill radiographs
CDT Code/ Description	**Benefit Limitations**	**Area of Mouth**	**Prior Authorization (PA) or Pre-Payment Review (PPR) Required**	**Documentation Required for Services Requiring Review**

Restorative – D2000-D2999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D2750, D2799, D2910, and D2980. This list is also available at: https://rendentalofficetoolkit.com				
D2991 application of hydroxyapatite regeneration medicament – per tooth	Age 0-18. Four of (D1354, D2991) per 1 lifetime per tooth. Six of (D1354, D2991) per 1 day per patient. Not allowed if had D2000 series code on same tooth in prior 12 months. (D2000 series code on same tooth not allowed for 4 weeks after D1354 or D2991	teeth 1-32, 51-82, A-T, AS-TS	No	No

Endodontic Clinical Criteria

Diagnostic Criteria:

- Current pre-operative radiographs of diagnostic quality clearly showing adjacent and opposing teeth: pathology and/or caries must be present
- Periapicals or Panorex acceptable. Panoramic or other types of radiographs that do not clearly show the tooth to be treated, adjacent and/or opposing teeth, along with pathology and extent of caries present, may not be accepted.

Qualifying Criteria:

- Dentist has established (and documented) a credible endodontic diagnosis and need for treatment prior to initiating endodontic therapy.
- Tooth must be clinically restorable with good prognosis; endodontic therapy on non-restorable/poor prognosis teeth is not reimbursable.
- A tooth may be deemed non-restorable if one or more of the following clinical issues are present:
  - There is less than 50% bone support.
  - There is extensive loss of coronal structure.
  - There is evidence of furcation caries or lack of bony support.
  - The apex/apices present with extensive loss of bone due to an unresolved endodontic infection.
- Situations that **do not meet criteria** are as follows:
  - Root canal therapy for third molars, unless they are an abutment for a partial denture.
  - Root canal therapy is in anticipation of placement of an overdenture.
  - Filling material not accepted by the Federal Food and Drug Administration.
  - Gross periapical or periodontal disease is demonstrated radiographically (caries sub-crestal or to the furcation, deeming the tooth non-restorable)
- **Complete root canal therapy includes treatment plan, all appointments, temporary fillings, obturation and fill of all canals, all radiographs, and necessary follow-up care.**

Reimbursement Criteria:

  - A dated post-operative radiograph must be submitted showing properly condensed/obturated canal(s), for review for payment. Billing and reimbursement for all root canals are based on the fill date.

****Charges for endodontic therapy with resultant adverse treatment outcomes such as incomplete root canal obturation, access cavity/root perforations, and non-treatment of a patent root canal are not benefits of the program and are not collectable from a TennCare patient by a participating dentist.**

Click here to learn more about endodontic clinical guidance and criteria: Renaissance - Clinical Criteria

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Endodontics – D3000-D3999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D3110, D3120,D3332, D3471, D3472, and D3473. This list is also available at: https://rendentalofficetoolkit.com				
D3220 therapeutic pulpotomy (excluding final restoration)	Age 0-18 One of (3220) per 1 lifetime per tooth	teeth 1-32, A-T	No	No
D3221 pulpal debridement, primary and permanent teeth	Age 0-18 One of (D3221) per 1 lifetime per tooth. Not to be used by provider completing endodontic treatment.	teeth 1-32, A-T	No	No
D3222 partial pulpotomy for apexogenisis-permanent tooth with Incomplete root development	Age 0-18. One per tooth per lifetime. Cannot be done in conjunction with root canal therapy.		PA	pre-operative radiograph(s)
D3230 pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	Age 0-10. One per tooth per lifetime. Cannot be done in conjunction with root canal therapy.		PA	pre-operative radiograph(s)
D3240 pulpal therapy (resorbable filling) -posterior, primary tooth (excluding final restoration)	Age 0-10. Cannot be done in conjunction with root canal therapy. One per tooth per lifetime.	teeth A, B, I–L, S, T	PA	pre-operative radiographs(s)
D3310 endodontic therapy, anterior tooth (excluding final restoration)	Age 6-18. One of (D3310) per 1 lifetime per tooth.		PA	pre-operative radiograph(s)
D3320 endodontic therapy, premolar tooth (excluding final restoration)	Age 6-18 One of (D3320) per 1 lifetime per tooth.		PA	pre-operative radiograph(s)
D3330 endodontic therapy, molar tooth (excluding final restoration)	Age 6-18. One of (D3330) per 1 lifetime per tooth.		PA	pre-operative radiograph(s)

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Endodontics – D3000-D3999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D3110, D3120, D3320, D3332, D3421, D3471, D3472, and D3473. This list is also available at: https://rendentalofficetoolkit.com				
D3346 retreatment of previous root canal therapy – anterior	Age 6-18. One of (D3346) per 1 lifetime per tooth.		PA	pre-operative radiograph(s)
D3347 retreatment of previous root canal therapy – premolar	Age 11-18. One of (D3347) per 1 lifetime per tooth.		PA	pre-operative radiograph(s)
D3348 retreatment of previous root canal therapy – molar	Age 6-18. One of (D3348) per 1 lifetime per patient per tooth.		PA	pre-operative radiograph(s)
D3351 apexification/ recalcification - initial visit	Age 5-12. One of (D3351) per 1 lifetime per tooth. Includes first phase of complete root canal therapy. Maximum of two visits per tooth (initial and final).		PA	pre-operative radiograph(s)
D3352 apexification/ recalcification - interim	Age 5-12. One of (D3352) per 1 lifetime per tooth. For visits in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs.		PA	pre-operative radiograph(s)
D3353 apexification/ recalcification - final visit	Age 5-12. Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy.)		PA	pre-operative radiograph(s)

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Endodontics – D3000-D3999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D3110, D3120, D3320, D3332, D3471, D3472, and D3473. This list is also available at: https://rendentalofficetoolkit.com				
3410 Apicoectomy-anterior	Age 6-18 One of (D3410) per lifetime per tooth	6-11,22-27	PPR	pre-operative radiograph(s)
D3421 Apicoectomy premolar	Age 11-18 one of (D3421) per lifetime per tooth	5,12,13,20,21,28,29	PPR	pre-operative radiograph(s)
D3425 apicoectomy/ periradicular surgery - molar (first root)	Age 6-18. One of (D3425) per 1 lifetime per tooth.	teeth 1-3, 14-19, 30-32	PPR	pre-operative radiograph(s)
D3426 apicoectomy/ periradicular surgery (each additional root)	Age 6-18. Three of (D3426) per 1 lifetime per tooth.	teeth 1–5, 12-21, 28–32	PPR	pre-operative radiograph(s)
D3430 retrograde filling - per root	Age 6-18. One of (D3430) per 1 lifetime per tooth. Reimbursable only in addition to apicoectomy, maximum of three roots per tooth.		PA	pre-operative radiographs

Periodontic Clinical Criteria

Diagnostic Criteria

- Pre-operative radiographs (full-mouth series or bitewings and periapicals)
  - Panoramic radiographs are not diagnostic for a periodontal evaluation
- Letter of medical necessity documenting periodontal diagnosis, as detailed in the Qualifying Criteria below.
- Oral photographic images if applicable
- Periodontal charting performed within 12 months, including six-point probing, furcation, mucogingival relationship, bleeding, case type and oral hygiene status required.

Diagnostic criteria, consistent with professional standards, must demonstrate: (1) clinical loss of periodontal attachment and/or (2) radiographic evidence of crestal bone loss or changes in crestal lamina dura and/or (3) radiographic evidence of root surface calculus.

Qualifying Criteria

- Scaling and Root Planing
    - Therapeutic procedures for members who require scaling and root planing due to bone loss and subsequent loss of attachment. Instrumentation of the exposed root surface to remove deposits is an integral part of this procedure. Indicated for any of the following:
        - Localized or generalized mild or moderate chronic Periodontal Disease - Periodontal probing depths 4 mm up to 6 mm with clinical attachment loss of up to 4 mm; radiographic evidence of bone loss and tooth mobility may be present. In molars, furcation involvement should not exceed Class 1.
        - Localized or generalized severe chronic Periodontal Disease - Periodontal probing depths greater than 6 mm with attachment loss greater than 4 mm; radiographic evidence of bone loss and tooth mobility are present.
        - Refractory or recurrent Periodontal Disease
        - Periodontal abscess
    - Scaling and Root Planing is not indicated for the following:
        - For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss
        - Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue)
        - As a sole treatment for refractory chronic, aggressive, or advanced Periodontal Diseases
    - CDT D4341:
        - Four (4) or more teeth in the quadrant are affected
        - Abnormal pocket depths in several sites
        - Radiographic evidence of root surface calculus or radiographic evidence of significant loss of bone support
    - CDT D4342:
        - 1-3 teeth in quadrant are affected
        - Abnormal pocket depths in several sites
        - Radiographic evidence of root surface calculus or radiographic evidence of significant loss of bone support
- Periodontal Maintenance
    - Periodontal maintenance is indicated for the following:
        - To maintain the results of surgical and non-surgical periodontal treatment
        - As an extension of active periodontal therapy at selected intervals
    - Periodontal maintenance is not indicated for the following:
        - No history of Scaling and Root Planing (SRP) or surgical procedures
        - Gingivitis

Reimbursement Criteria

- No payment is made for scaling and root planing performed in conjunction with gingivectomy, gingivoplasty, or periodontal surgery, regardless of coverage type.
- Periodontal Maintenance is not covered if performed in conjunction with prophylaxis or within 30 days of scaling and root planing.
- Periodontal Maintenance is not covered if no scaling or root planing was performed within the previous 24 months.

****Charges for periodontic therapy with resultant adverse treatment outcomes are not benefits of the program and are not collectable from a TennCare patient by a participating dentist. A treatment plan with a poor and/or uncertain periodontal, restorative, or endodontic outcome may be denied due to the unfavorable prognosis of the involved tooth/teeth. Special consideration/exception may be made by submission of a narrative report.**

Click here to learn more about periodontic clinical guidance and criteria: Renaissance - Clinical Criteria

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Periodontics – D4000-D4999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D4249, D4260, D4261, D4263, D4264, D4265, D4266, D4273, D4322, D4323, D4381, and D4910. This list is also available at: https://rendentalofficetoolkit.com				
D4210 gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	Age 0-18. One of (D4210, D4211) per quadrant per patient per 24 months. A minimum of (4) teeth in the affected quadrant. Only for the correction of severe hyperplasia or hypertrophy associated with drug therapy or congenital defects.	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	PA	narrative of medical necessity, periodontal charting, intraoral photos (if available) and pre-operative radiographs.

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Periodontics – D4000-D4999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D4249, D4260, D4261, D4263, D4264, D4265, D4266, D4273, D4322, D4323, D4381, and D4910. This list is also available at: https://rendentalofficetoolkit.com				
D4211 gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Age 0-18. One of (D4210, D4211) per quadrant per 24 months. 1 to 3 teeth in the affected quadrant. Only for the correction of severe hyperplasia or hypertrophy associated with drug therapy or congenital defects.	1-32	PA	narrative of medical necessity, periodontal charting, intraoral photos (if available) and pre-operative radiographs.
D4341 periodontal scaling and root planing - four or more teeth, per quadrant	Age 14-18. One of (D4341, D4342) per 24 months per quadrant. A minimum of four (4) affected teeth in the quadrant.	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	PA	periodontal charting, pre-operative radiographs, and periodontal diagnosis and/or narrative of medical necessity with claim.
D4342 periodontal scaling and root planing - one to three teeth per quadrant	Age 14-18. One of (D4341, D4342) per 24 months per quadrant. One (1) to three (3) affected teeth in the quadrant.	1-32	PA	periodontal charting, pre-operative radiographs, and periodontal diagnosis and/or narrative of medical necessity with claim.

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Periodontics – D4000-D4999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D4249, D4260, D4261, D4263, D4264, D4265, D4266, D4273, D4322, D4323, D4381, and D4910. This list is also available at: https://rendentalofficetoolkit.com				
D4355 full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	Age 14-18. One of (D4355) per 1 lifetime. Not allowed within 12 months following D1110, D4341, or D4342. Not billable on same day as exam, or within 12 months of D0120 or D0150.		No	Note: No documents required, but photographs showing at least 50% of the dentition with large amounts of calculus present must be in the patient records.

Removable Prosthodontic Clinical Criteria

Diagnostic Criteria

- Panoramic radiograph series (even if edentulous) or full-mouth radiograph series
- Narrative/Treatment plan must include teeth to be extracted, and for partials include teeth to be replaced by partial
- Photographs, if necessary to support diagnosis and medical necessity
- For flexible partials, requires the submission of documented medical testing for allergic reaction to other denture materials.

Qualifying Criteria

- Removable Complete or Partial Dentures are indicated for:
  - Replacement of missing teeth lost due to disease, trauma, or injury.
  - Severely impaired masticatory function due to loss of teeth
  - Missing at least one anterior tooth
  - Replacement of a minimum of 3 to 4 permanent, posterior teeth based on one of the following conditions:
    - **A total of 4 posterior teeth in the arch or**
    - **A total of 3 adjacent posterior teeth in the arch**

- Adequate and sufficient alveolar bone support of the remaining teeth in the arch is demonstrated; a minimum of 50% bone support is required.
- Recipients with good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Recipients with no untreated caries or active periodontal disease in the abutment teeth

  * If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
  * A new prosthesis will not be reimbursed within in 24 months of a reline or repair of the existing prosthesis

- Removable Complete and Partial Dentures are not indicated for the following:
  - For members with chronic poor oral hygiene and unsuitable abutment teeth
  - When there has been extensive bone atrophy resulting in an inadequate edentulous ridge
  - Poor neuro-muscular control
  - Unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis)
  - If there is an existing prosthesis less than 5 years old and in serviceable condition
  - If the recipient cannot accommodate and properly maintain the prosthesis (lodge, gag reflex, potential for swallowing the prosthesis, severe disability).
  - If the recipient has a history or an inability to wear a prosthesis due to psychological or anatomical reasons.
  - If a partial denture, less than 5 years old, is converted to a temporary or permanent complete denture.
- Complete and Partial Denture Rebase and Reline Procedures
  - Denture Rebasing is indicated for the following:
    - When changes to the residual ridge result in loss of denture stability, retention, or occlusal disharmony
    - When replacing or rearranging teeth on a partial denture
    - When the base has fractured or cracked
  - Denture Rebasing is not indicated for the following:
    - When the prosthesis is broken or worn to the extent that replacement is warranted
    - When the occlusion or structural integrity of the denture teeth are no longer functional
    - When a Reline is sufficient
  - Denture Relining is indicated for the following:
    - When changes to the residual ridge result in loss of denture stability, retention, or occlusal disharmony
  - Denture Rebasing AND Relining are not indicated for the following:
    - When the prosthesis is broken or worn to the extent that it is no longer functional and replacing the appliance is warranted
    - Unresolved soft tissue hyperplasia or stomatitis

- Repairs:
    - 6 months post-delivery for complete and partial dentures:
        - 2 repairs per denture per year
        - Relines will be reimbursed one per denture every 6 months.
        - Adjustments will be reimbursed one per denture per year.

Reimbursement Criteria

- Payment for a denture or denture service includes all necessary follow-up corrections and adjustments for a period of six months.
- Providers will be reimbursed for complete dentures and partial dentures on delivery date of the appliance (also known as “seat date”).
- Claims for Immediate Denture must show extractions on the same date of service. Before rendering any patient edentulous the Dentist or Oral Surgeon must ensure that dentures have been authorized.

As part of any removable prosthetic service, dentists are expected to provide proper patient instruction on care of the prothesis.

****Charges for removable prosthodontic therapy with resultant adverse treatment outcomes are not benefits of the program and are not collectable from a TennCare patient by a participating dentist.**

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Prosthodontics, Removable – D5000-D5999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D5130, D5140, D5225, D5226, D5227, D5228, D5725,D5765, D5820, D5821, D5850, D5851 and D5862. This list is also available at: https://rendentalofficetoolkit.com				
D5110 complete denture - maxillary	Age 0-18. One of (D5110) per 60 month(s) per patient.		PA	initial dentures: Full mouth radiographs or panorex with claim. Subsequent dentures (when edentulous): date of prior placement and narrative of medical necessity.
D5120 complete denture - mandibular	Age 0-18. One of (D5110) per 60 month(s) per patient.		PA	initial dentures: Full mouth radiographs or panorex with claim. Subsequent dentures (when edentulous): date of prior placement and narrative of medical necessity.
D5211 maxillary partial denture - resin base	Age 8-18. One of (D5211, D5213,D5282) per 60 months.		PA	full mouth radiographs or panorex
D5212 mandibular partial denture - resin base	Age 8-18. One of (D5212, D5214, D5283) per 60 months		PA	full mouth radiographs or panorex

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review

Prosthodontics, Removable – D5000-D5999
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D5213 maxillary partial denture - cast metal framework with resin denture bases	Age 8-18. One of (D5211, D5213, D5225, D5227,D5282) per 60 months.		PA	full mouth radiographs or panorex
D5214 mandibular partial denture - cast metal framework with resin denture bases	Age 8-18. One of (D5212, D5214, D5283) per 60 months.		PA	full mouth radiographs or panorex
D5282 removable unilateral partial denture cast metal – maxillary	Age 8-18. One of (D5211, D5213, D5225,D5227,D5282) per 60 months.		PPR	full mouth radiographs or paneer
D5283 removable unilateral partial denture cast metal – mandibular	Age 8-18. One of (D5212, D5214,D5283) per 60 months.		PPR	full mouth radiographs or panorex
D5511 repair broken complete denture base, mandibular	Age 8-18. Not covered within 6 months of placement.		No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review

Prosthodontics, Removable – D5000-D5999
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available at: https://rendentalofficetoolkit.com				
D5512 repair broken complete denture base, maxillary	Age 8-18. Not covered within 6 months of placement.		No	No
D5520 replace missing or broken teeth - complete denture (each tooth)	Age 8-18. Not covered within 6 months of placement. Must include tooth number to receive reimbursement.	teeth 1-32	PPR	narrative of medical necessity with claim
D5611 repair resin partial denture base, mandibular	Age 8-18. Not covered within 6 months of placement.		No	No
D5612 repair resin partial denture base, maxillary	Age 8-18. Not covered within 6 months of placement.		No	No
D5621 repair cast partial framework, mandibular	Age 8-18. Not covered within 6 months of placement.		No	No
D5622 repair cast partial framework, maxillary	Age 8-18. Not covered within 6 months of placement.		No	No

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available at: https://rendentalofficetoolkit.com				
D5630 repair or replace broken retentive/clasping materials - per tooth	Age 8-18. Not covered within 6 months of placement. Must include tooth number to receive reimbursement	teeth 1-32	PPR	narrative of medical necessity with claim
D5640 replace broken teeth (per tooth)	Age 8-18. Not covered within 6 months of placement. Must include tooth number to receive reimbursement.	teeth 1-32	PPR	narrative of medical necessity with claim
D5650 add tooth to existing partial denture	Age 8-18. Not covered within 6 months of placement. Must include tooth number to receive reimbursement	teeth 1-32	PPR	narrative of medical necessity with claim
D5660 add clasp to existing partial denture	Age 8-18. Not covered within 6 months of placement. Must include tooth number to receive reimbursement	teeth 1-32	PPR	narrative of medical necessity with claim
D5730 reline complete maxillary denture (chairside)	Age 0-18. One of (D5730, D5750) per 36 months. Not covered within 6 months of placement.		No	No
D5731 reline complete mandibular denture (chairside)	Age 0-18. One of (D5731, D5751) per 36 months. Not covered within 6 months of placement.		No	No
D5741 reline mandibular partial denture (chairside)	Age 0-18. One of (D5741, D5761) per 36 months. Not covered within 6 months of placement.		No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Prosthodontics, Removable – D5000-D5999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances ,may be subject to				

prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D5130, D5140, D5225, D5226, D5227, D5228, D5640, D5725, D5740, D5761, D5765, D5820, D5821, D5850, and D5862. This list is also available at: https://rendentalofficetoolkit.com				
D5750 reline complete maxillary denture (laboratory)	Age 0-18. One of (D5730, D5750) per 36 months. Not covered within 6 months of placement.		No	No
D5751 reline complete mandibular denture (laboratory)	Age 0-18. One of (D5731, D5751) per 36 months. Not covered within 6 months of placement		No	No
D5760 reline maxillary partial denture (laboratory)	Age 0-18. One of (D5740, D5760) per 36 months. Not covered within 6 months of placement		No	No
D5761 reline mandibular partial denture (laboratory)	Age 0-18. One of (D5741, D5761) per 36 months. Not covered within 6 months of placement		No	No

Fixed Prosthodontic Clinical Criteria

Diagnostic Criteria

- Diagnostic radiographs and narrative to support medical necessity determination are required
- Periapicals or bitewings acceptable. Panoramic or other types of radiographs that do not clearly show the tooth to be replaced, adjacent and/or opposing teeth, along with current periodontal and endodontic status of the teeth, including pathology and extent of caries present, may not be accepted
- Establishment of a credible caries risk and diagnosis of caries that require the need for definitive restorative treatment, as applicable under the indications listed below.

Qualifying Criteria

- Fixed Partial Dentures are indicated:
  - When any or all of the indications for removable appliance therapy are present and the patient cannot tolerate a removable appliance due to documented physical or neurological disorder
  - Fixed Partial Dentures must be deemed medically necessary, not cosmetic
  - Replacement of missing teeth lost due to disease, trauma, or injury
  - Severely impaired masticatory function due to loss of teeth
  - Adequate and sufficient alveolar bone support of the abutment, a minimum of 50% bone support is required.
  - Recipients with good periodontal health and a favorable prognosis where continuous deterioration is not expected.
  - Recipients with no untreated caries or active periodontal disease in the abutment teeth

  *If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Fixed Partial Dentures are not indicated for the following:
  - For members with chronic, poor oral hygiene and unsuitable abutment teeth

If the recipient is unable to accommodate and properly maintain the prosthesis due to factors such as poor retention, a pronounced gag reflex, risk of aspiration or swallowing the device or sever physical or cognitive disability- or if there is a documented history of psychological or physiological intolerance to wearing a prosthesis.

  - When the abutment tooth is a primary tooth
  - Unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis)
  - If there is an existing prosthesis less than 5 years old and in serviceable condition

Reimbursement Criteria for Fixed Partial Dentures

- Payment for a fixed partial denture service includes all necessary follow-up corrections and adjustments for a period of six months.
- Billing and reimbursement for fixed partial dentures are based on the seat/cementation date. The fee includes the temporary fixed partial denture that is placed on the prepared tooth and worn while the permanent fixed partial denture is being fabricated for permanent teeth.

Dental implants are indicated:

- When replacement of missing teeth is medically necessary, but adjacent teeth are healthy and do not require preparation for a fixed bridge.
- Support for fixed or removable prosthesis to improve retention, stability and or function is medically necessary.
- Restoration of oral function, including mastication and speech

Dental implant placement is not indicated:

- When uncontrolled systemic disease exists, including but not limited to: uncontrolled diabetes, severe cardiovascular disorders or disease, and immunosuppressive conditions.
- When active cancer or recent chemotherapy/radiation therapy is in progress.
- When various habits or risks exist that place the patient at a higher risk for implant failure e.g. alcoholism, smoking, bruxism, periodontal disease.

. Reimbursement Criteria for Implants

- Implants will not be approved and/or reimbursed unless medical necessity requirements are met and the attached form is completed in detail.

- Implants will not be approved and/or reimbursed for elective purposes, cosmetic reasons, or if an alternative treatment service that is a covered benefit and more cost effective, such as a removable partial denture, would meet medical necessity requirements.

- Payment for an implant service includes all necessary follow-up visits, including revisions, adjustments, recementations, or other necessary services for a minimum period of six months.

- Billing and reimbursement for implant services are on the placement date and/or seat/cementation date for an implant abutment or crown. The fee includes any temporary prosthesis or related services while the permanent abutment, crown or other prosthesis is being fabricated.

****Charges for fixed prosthodontic therapy with resultant adverse treatment outcomes are not benefits of the program and are not collectable from a TennCare patient by a participating dentist.** *Charges for fixed prosthodontic services with resultant adverse treatment outcomes are not benefits of the program and are not collectable from a TennCare patient by a participating dentist. Post-cementation radiographs must be in the patient's chart and available for review upon request. Absence of radiographic evidence required for confirming the quality of restoration(s) in a patient's chart may result in the recovery of prior payments for the service.*

Click here to learn more about removable prosthodontic clinical guidance and criteria: criteria: Renaissance - Clinical Criteria.

CDT Code/Description	Benefit Limitations	Area of Mouth	Prior Authorization	Documentation Required for Services

			(PA) or Routine Review (PPR) Required	Requiring Review
Implant Services D6000-D6999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, may be subject to prior authorization or prepayment review and only considered with applicable documentation for medical necessity, including: D6013, D6040,D6049, D6050, D6055, D6056, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6080, D6081, D6082, D6083, D6084, D6086, D6087, D6088, D6090, D6091, D6092 ,D6093 ,D6094, D6097, D6098, D6099, D6100, D6101, D6102, D6103, D6104, D6105, D6106, D6107, D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117, D6120, D6121, D6122, D6123, D6180, D6191, D6192, D6194, D6195, D6197, D6205, D6210, D6211, D6212, D6214, D6241, D6242, D6243, D6245, D6250, D6251, D6252,D6280, D6545, D6548, D6549, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740,D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, D6920, D6930, D6940, D6950, D6980, D6985 This list is also available at: https://rendentalofficetoolkit.com				
D6010 surgical placement of implant body: endosteal implant	Age 18 One surgical placement of Implant body : endosteal Implant per 60 Month(s) Per patient per tooth.		PA	Narrative of medical necessity pre-operative x-ray(s)
D6057 custom abutment -includes placement	Age 18 One Implant supported crown per 60 Months per patient per tooth		PA	Narrative of medical necessity pre-operative x-ray(s)
D6058 abutment supported porcelain/ceramic crown	Age 18 One Implant supported crown per 60 Month(s) Per patient per tooth		PA	Narrative of medical necessity pre-operative x-ray(s)
D6066 Implant supported porcelain fused to metal crown (high noble alloys)	Age 18 One Implant supported crown per 60 Month(s) Per patient per tooth		PA	Narrative of medical necessity pre-operative x-ray(s)
D6240 pontic-porcelain fused to high noble metal	Age 18 One Implant supported pontic per 60 Month(s) Per patient per tooth		PA	Narrative of medical necessity pre-operative x-ray(s)
D6245 prosthodontic fixed pontic porcelain/ceramic	Age 18 One Implant supported fixed pontic per 60 Month(s) Per patient per tooth		PA	Narrative of medical necessity pre-operative x-ray(s)

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review

Prosthodontics - Fixed D6000-D6999

Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D6010, D6056, D6057, D6059, D6065, D6066, D6069, D6191, D6192, D6241, D6242, D6245, D6740,D6750, D6751, ,D6752,D6930, D6950,D6985

This list is also available at: https://rendentalofficetoolkit.com

D6740 Pontic Porcelain-fused to high noble	Age 18 One (D6240,D6750) per 60 Month(s) Per patient per tooth.	1-32	PA	Narrative of medical necessity pre-operative x-ray(s)
D6750 Retainer crown-porcelain fused to high noble	Age 18 One~~ of~~ (D6240,D6750) per 60 Month(s) Per patient per tooth.	1-32	PA	Narrative of medical necessity pre-operative x-ray(s)

Oral and Maxillofacial Surgery Clinical Criteria

Diagnostic Criteria

- Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Bitewings, periapicals, or panorex are acceptable.
    - Radiographic documentation must demonstrate the definitions of complete bony, partial bony, and soft tissue impaction if billed.
- Narrative of medical necessity is required for authorization of alveoloplasty.

Qualifying Criteria

- Extractions:
    - A tooth may be removed only if it cannot be saved because it is broken down, poorly supported by the alveolar bone, and/or affected by a pathological condition.
        - Note - Extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given, except in an absolute emergency. Documentation must be provided to support the absolute emergency removal of teeth.
    - Non-surgical extractions:
        - No prior authorization is required
        - Removal of erupted tooth or exposed root (elevation and/or forceps removal)
        - Includes removal of tooth structure, minor smoothing of socket bone, and closure, as necessary
    - Surgical Extraction:
        - Surgical removal of tooth requires removal of bone and/or sectioning of tooth, and includes elevation of mucoperiosteal flap if indicated
        - Surgical removal of soft tissue impaction will not require removal of bone, but will require elevation of mucoperiosteal flap
    - Prophylactic removal of disease-free unerupted third molars is **not** a covered benefit for CoverKids members. Impaction alone, absent pathology does not meet medical necessity requirement for approval. Un-erupted third molars must show pathology or demonstrate by

radiographic evidence both an aberrant tooth position beyond normal variations and substantial (≥ 50%) root formation to qualify for extraction.

- Discomfort from natural tooth eruption not caused by pathology or an aberrant tooth position will not qualify an un-erupted third molar extraction for authorization.
- When at least a single third molar meets the criteria above, the DBM (or a dental professional employed by TennCare or its contractor) may, at their clinical discretion and on a case-by-case basis, approve the extraction of additional unerupted third molar teeth to avoid risk from multiple exposures of the member to moderate sedation, deep sedation, or general anesthesia.
- Routine incision and drainage is not considered a separate benefit if the extraction serves in this function.
- Excision of lesion in conjunction with extraction is considered part of the extraction procedure.
- Excision of lesion that is not tooth related on same date of service requires a narrative and radiographic documentation of a hard tissue cyst/lesion or photographic evidence of soft tissue cyst/lesion.
- Removal of unerupted third molars requires prior authorization.

- Alveoloplasty in conjunction with extractions
  - D7310 – 4 or more teeth or tooth spaces per quadrant
  - D7311 – 1-3 teeth or tooth spaces per quadrant
- Alveoloplasty not in conjunction with extractions
  - D7320 – 4 or more teeth or tooth space per quadrant
  - D7321 – 1-3 teeth per quadrant
    - Narrative supporting necessity for prosthetic placement

Alveoloplasty will not be authorized following surgical extractions.

Reimbursement Criteria

- Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.
- Extraction includes local anesthesia, suturing if needed, and routine post-operative care.
- Patient informed consent must be obtained for all extractions.
- If the crown of the tooth has been fractured or destroyed by caries, and the removal of the root is performed, the appropriate ADA code should be used (i.e., D7140 – extraction, erupted tooth, or exposed root; or D7210 surgical extraction of retained root per indications). D7250 is not reimbursable to dentist or dental group that performed initial extraction, within 90 days of initial extraction.

****Charges for oral and maxillofacial surgery services with resultant adverse treatment outcomes are not benefits of the program and are not collectable from a TennCare patient by a participating dentist.**

Click here to learn more about oral and maxillofacial surgery clinical guidance and criteria: Renaissance - Clinical Criteria

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Oral and Maxillofacial Surgery – D7000-D7999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D7241, D7252, D7259, D7284,D7520, D7880, and D7953. This list is also available at: https://rendentalofficetoolkit.com				
D7140 extraction - erupted or exposed root (elevation and/or forceps removal)	Age 0-18. One of (D7140) per 1 lifetime per tooth.	Age 0-10: teeth A, C, H, J, K, T Age 0-5: teeth O, P Age 0-6: teeth E, F, N, Q Age 0-7: teeth D, G, AS-TS Age 0-9: teeth B, I, L, M, R, S Age 0-18: teeth 1-32, 51-82	No	No
D7210 surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Age 6-18. One of (D7210) per 1 lifetime per tooth.	Age 6-18: teeth 1-3, 5, 12, 14-19, 30-32, 51-53, 55, 62, 64-69, 80-82	No	No

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Oral and Maxillofacial Surgery – D7000-D7999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D7241, D7252, D7259, D7284, D7286, D7520, D7880, and D7953. This list is also available at: https://rendentalofficetoolkit.com				
D7220 removal of impacted tooth - soft tissue	Age 14-18. Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.		PA	pre-operative radiograph(s)
D7230 removal of impacted tooth - partially bony	Age 14-18. Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.		PA	pre-operative radiograph(s)
D7240 removal of impacted tooth - completely bony	Age 14-18. Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.		PA	pre-operative radiograph(s)

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Oral and Maxillofacial Surgery – D7000-D7999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D7241, D7252, D7259, D7284, D7286, D7520, D7880, and D7953. This list is also available at: https://rendentalofficetoolkit.com				
D7250 surgical removal of residual tooth roots	Age 6-18. One of (D7250) per lifetime, per tooth. Will not be paid to the dentist or group that removed the tooth. Removal of asymptomatic tooth not covered.		PA	pre-operative radiograph(s)
D7270 tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	Age 6-18. One of (D7270) per lifetime, per tooth. Includes splinting and/or stabilization. Images of the area and a detailed explanation of the findings and treatment must be maintained in the member's clinical record.	teeth 1-32	PPR	statement of medical necessity with supporting images.
D7280 surgical access of an unerupted tooth	Age 12-18. One of (D7280) per lifetime, per tooth. Must include tooth number to receive reimbursement.	teeth 1-32	PPR	statement of medical necessity with supporting images.
D7283 placement of device to facilitate eruption of impacted tooth	Age 12-18. One of (D7283) per lifetime, per tooth. Must include tooth number to receive reimbursement.	teeth 1-32	PA	
D7285 biopsy of oral tissue - hard (bone, tooth)	Age 0-18. One per date of service. Pathology report must be maintained in the member's clinical record.		PA	pathology report
D7286 biopsy of oral tissue - soft	Age 0-18. One per date of service. Pathology report must be maintained in the member's clinical record.		PA	pathology report

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Oral and Maxillofacial Surgery – D7000-D7999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D7241, D7252, D7259, D7284, D7286, D7520, D7880, and D7953. This list is also available at: https://rendentalofficetoolkit.com				
D7310 alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Age 0-18. One of (D7310, D7311) per 1 lifetime per quadrant. Minimum of four extractions in the affected quadrant. Not allowed with surgical extractions in the same quadrant.	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	PPR	statement of medical necessity, panoramic radiograph or other images of quadrant
D7311 alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Age 0-18. One of (D7310, D7311) per 1 lifetime per quadrant. Not allowed with surgical extractions in same quadrant.	1-32	PPR	statement of medical necessity, panoramic radiograph or other images of quadrant
D7320 alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Age 0-18. One of (D7320) per 1 lifetime per quadrant. No extractions performed in an edentulous area.	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	PPR	statement of medical necessity, panoramic radiograph or other images of quadrant
D7410 excision of benign lesion up to 1.25 cm	Age 0-18. One of (D7410) per date of service. Pathology report must be maintained in the member's clinical record.		PPR	pathology report

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Oral and Maxillofacial Surgery – D7000-D7999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D7241, D7252, D7259, D7284, D7286, D7520, D7880, and D7953. This list is also available at: https://rendentalofficetoolkit.com				
D7510 incision and drainage of abscess - intraoral soft tissue	Age 0-18. Not allowed on same date as extraction.	teeth 1-32, 51-82, A-T, AS-TS.	PA	narrative of medical necessity
D7961 buccal/ labial frenectomy (frenulectomy)	Age 11-18. One of (D7961) per lifetime. The frenum may be excised when the tongue has limited mobility; for large diastemas when the frenum interferes with a prosthetic appliance; or when it is etiology of periodontal tissue disease.		PA	statement of medical necessity with supporting images including pre-operative intra-oral photographs
D7962 lingual frenectomy (frenulectomy)	Age 11-18. One of (D7962) per lifetime. The frenum may be excised when the tongue has limited mobility.		PA	statement of medical necessity with supporting images including pre-operative intra-oral photographs

Orthodontic Clinical Criteria

Diagnostic Criteria

- Recent (within 6 months) cephalometric and panoramic image of diagnostic quality
- Current intra-oral images clearly documenting the qualifying criteria reported, including but not limited to:
  - Maxillary and mandibular occlusal views
  - Frontal view, right lateral views, left lateral view. Note: Images must display sufficient cheek retraction or properly visualize all teeth
  - Images of the measured malocclusions reported (e.g. overbite, overjet, open bites, etc.)
  - Extraoral images - (straight facial view, right and left profiles) teeth should be in centric occlusion with lips relaxed when not smiling
- Images of mounted orthodontic study models in occlusion (frontal and lateral), or equivalent through OrthoCAD (frontal,left and right lateral views)
- A definitive diagnosis and comprehensive treatment plan with timeline supported by copies of the patient treatment records
- A completed Malocclusion Severity Assessment Form and TennCare Orthodontic Readiness Necessity Form are required as part of the authorization process
- Evidence in the form of a letter from a Speech Pathologist or Licensed Physician to support of Handicapping Malocclusion contributing to the inability to eat, speak, chew, or prove nutritional deficiency.
- If there is a plan for orthognathic surgery, please detail in narrative and include traced and measured cephalometric radiograph.

Qualifying Criteria

To be considered for ortho one **MUST have one** of the following:

(1) a craniofacial anomalies,
(2) malocclusions caused by trauma,
(3) a handicapping malocclusion, or
(4) craniofacial imbalance.

AND

be caused by one of the following:

- Fully erupted set of permanent teeth, with at least ½ to ¾ of the clinical crown exposed unless tooth is impacted or congenitally missing
- Overjet equal to or greater than 9.0 mm.
- Reverse overjet equal to or greater than 3.5 mm.
- Anterior crossbite of two (2) teeth with evidence of gingival recession
- Posterior crossbite with no functional occlusal contact.
- Lateral or anterior open bite equal to or greater than 4 mm.
- When there Is crowding greater than 8.0 mm or more in the maxillary arch only
- Impinging overbite with either palatal trauma or mandibular anterior gingival trauma.
- One or more impacted teeth with eruption that is impeded (excluding third molars).
- Anterior Impactions where eruption is impeded but extraction Is not Indicated (excluding third molars)

- Defects of cleft lip and palate or other craniofacial anomalies or trauma.
- Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars).

If none of the conditions listed above exist, but the member's condition results in a qualifying MSA score of 28 or above, Renaissance may approve the requested orthodontic services.

- Note: Orthodontics is a once in a lifetime benefit.

Reimbursement Criteria

The purpose of the diagnostic and qualifying criteria is to guide determinations of medical necessity, which is a key factor in making coverage decisions.

Orthodontics for cosmetic purposes Is not a covered benefit.

Members must be referred to a participating licensed orthodontist or pediatric dentist board eligible or certified In orthodontics .

Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member; or face possible termination of their provider agreement. Providers cannot bill prior to services being performed.

If the case is approved, the provider will receive a prior authorization confirming approval. This authorization includes one Comprehensive treatment of the adolescent dentition and up top 23 periodic orthodontic treatment visits. Orthodontic retention, D8680, must be billed separately after completion of the case.

Providers may bill for one periodic treatment visit, D8670, per calendar month aligned with the delivery of services. The 23 months of adjustment are included under the procedure code D8080.

Any periodic treatment not performed will not be reimbursed. TennCare members must not be charged for missed appointment or broken brackets.

If the case is denied, the provider will receive an EOB indicating the denial. The member will also receive written notification of the denial. To receive reimbursement for records review in denied cases, the provider must submit a claim using the code D8660.

The date of the service should reflect the date the treatment plan, radiograph, photographs and diagnostic models were completed by the provider.

Continuation of Care cases may have different requirements for diagnosis and treatment, as well as reimbursement, including the following:

- Original banding date
- Orthodontic Continuation of Care Submission Form

- A detailed paid-to-date history showing dollar amounts for initial banding and periodic orthodontic treatment fees.
- A copy of member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fee.
- If the Member started treatment under commercial insurance or fee for service, must receive the original banding date and a detailed payment history. It is the provider's and Member's responsibility to get the required information. Cases cannot be set-up for possible payment without complete information.

***Charges for orthodontic services with resultant adverse treatment outcomes are not benefits of the program and are not collectable from a TennCare patient by a participating dentist.*

Click here to learn more about orthodontic services clinical guidance and criteria: Renaissance - Clinical Criteria.

CDT Code/ Description	Benefit Limitations	Area of Mouth	Prior Authorization (PA) or Pre-Payment Review (PPR) Required	Documentation Required for Services Requiring Review
Orthodontics – D8000-D8999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D8020, D8030, D8210, D8220, and D8660. This list is also available at: https://rendentalofficetoolkit.com				
D8080 comprehensive orthodontic treatment of the adolescent dentition	Age 12-18. One of (D8080) per 1 lifetime. Includes pre-orthodontic treatment visit, radiographs, treatment plan, diagnostic models, initial banding, one set of retainers and a maximum of 23 months of adjustments. Please submit provider signed ortho readiness necessity form, completed MSA form, and OrthoCAD submission form if applicable.		PA	study models, panorex or periapical radiographs, narrative of medical necessity/treatment plan
D8670 periodic orthodontic treatment visit	Age 12-18. Twenty-three of (D8670) per 1 lifetime. One of (D8670) per 1 calendar month(s). Please submit orthodontic continuation of care submission form.		PA	

D8680 orthodontic retention (removal of appliances)	Age 12-18. 1 of (D8680) per lifetime after completed orthodontic treatment.		No	No

Adjunct General Services Clinical Criteria

Diagnostic Criteria (for nitrous oxide use)

- Clinical narratives and recent (6 months or less) radiographic documentation for the dental procedures to be performed (photographs and/or appropriate charting, if warranted).
- Associated patient treatment record entries, including a definitive diagnosis and detailed treatment plan (including any entries related to failed attempts at local anesthesia and/or other behavioral management efforts.)
- Referring dentist reports, if applicable

Qualifying Criteria

- Nitrous Oxide (Anxiolysis)
    - Nitrous oxide may be indicated for the following:
        - Ineffective local anesthesia
        - Anticipatory or situational anxiety
        - Individuals with special needs
        - Extensive and/or complex services
        - Behaviorally challenged or uncooperative individuals
        - Management of a severe gag reflex
    - Nitrous oxide is contraindicated for, but not limited to, the following situations:
        - Nasal obstruction
        - Severe underlying medical conditions
        - Upper respiratory tract infections or other acute respiratory conditions
        - Severe emotional disturbances or severe behavioral disorders
        - Chemical dependencies
        - Claustrophobia
        - Pregnancy – not recommended electively, especially in the first trimester

Reimbursement Criteria

- Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.
- Nitrous oxide inhalation analgesia is only payable to providers who possess a personal permit for its administration from the applicable State Board of Dentistry and administer it in a State Board approved facility if permit required.
- Nitrous oxide will not be considered strictly for member or dentist convenience. Nitrous oxide is not reimbursable when used in conjunction with sedation or general anesthesia service codes, regardless of whether it is covered by the benefit plan.

Diagnostic Criteria (for anesthesia/sedation)

- A narrative describing medical necessity for sedation or general anesthesia with details such as diagnosis, treatment plan, and any related anesthesia or behavioral management notes.
- Recent (6 months or less) radiographic documentation for the dental procedures to be performed (photographs and/or appropriate charting, if warranted).
- ASA physical status classification (Included In narrative)
- Completed Hospital Readiness Form(If applicable)

Qualifying Criteria

- Anesthesia and sedation
  - Documented extreme anxiety or fear or evidence of resistance to conventional behavior management techniques.
  - Physical compromising conditions such as inability to obtain adequate analgesia with local anesthesia, allergy to local anesthetics or other known contraindications to local anesthesia.
  - Management of a gag reflex.
  - Medically compromising conditions such as diseases and conditions with severe spasticity, closed head trauma, or stroke-causing inability to cooperate with directions.
  - Behavioral/intellectual/psychological compromising conditions such as developmental disability disorders characterized by significant limitations in intellectual functioning, adaptive behavior, and/or physical functioning.
  - Long, extensive, complex, and/or radical dental procedures necessary to treat a patient's dental condition(s) such as surgical removal of teeth involving multiple quadrants or treatment where unexpected patient movement may compromise treatment results, such as the removal of a third molar tooth in intimate contact with the inferior nerve.
  - Members should be evaluated individually, and the most effective and least invasive form of sedation should be utilized by the medical and/or dental provider.
- Anesthesia/sedation may be contraindicated if:
  - A patient has predisposing medical and/or physical conditions that would make general anesthesia unsafe (including allergies to any of the sedative agents to be used).
  - The patient is cooperative and has minimal treatment needs.
  - Provided for the convenience of the patient or dentist.
  - None of the services to be provided warrant sedation.
  - The parent, guardian, or legally appointed representative object to the provision of such.

Reimbursement Criteria

Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request

Renaissance will review and process prior authorization request for dental treatment plans to determine medical necessity for procedures performed In a hospital or ambulatory surgical center. Renaissance shall NOT assume financial responsibility for facility fees or anesthesia related charges associated with services rendered In Inpatient, outpatient, or free-standing surgical centers.

Upon approval, Renaissance will Issue a prior authorization number to the provider. The number can be submitted directly to the members managed care organization (MCO) to be Included on the UB-92 or HCFA 1500 claim form, If applicable.

****Charges for adjunct general services with resultant adverse treatment outcomes are not benefits of the program and are not collectable from a TennCare patient by a participating dentist.**

Click here to learn more about adjunct general services clinical guidance and criteria: Renaissance - Clinical Criteria

Click here to learn more about adjunct general services clinical guidance and criteria:
Tenncare.renaissancebenefits.com/clinical-criteria

CDT Code/ Description	Benefit Limitations	Prior Authorization (PA) or Routine Review (PPR) Required	Documentation Required for Services Requiring Review
Adjunctive General Services – D9000-D9999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D9110, , D9430,D9610, D9612, D9630, D9910, D9911, D9930, D9944, D9945, D9951, and D9971. This list is also available at: https://rendentalofficetoolkit.com			
D9222 intravenous deep sedation/general anesthesia - first 15 minutes	Age 0 –18 per day. D9230, D9239, D9243, D9248, D9920 are not payable on the same date of service as D9222, D9223. General anesthesia provided in the dentist's office reimbursed only for members younger than 21 years old. When the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead, the appropriate CPT code must be billed on a professional claim (CMS-1500 claim form).	PA	Written narrative detailing the type of anesthesia to be used, rationale of medical necessity, radiographs, treatment plan, recorded treatment time documented in record, Sedation/General Anesthesia Scoring Tool, sedation record included with claims
D9223 intravenous deep sedation/general anesthesia – each subsequent 15-minute increment	Age 0 –18 See above in D9222. Five (5) units of (D9223) per date of service. A maximum of 6 units (1 ½ hrs.) are payable per date of service. Additional units beyond six for (D9222, D9223) per date of service (greater than 1 ½ hrs. Anesthesia time) are subject to prepayment review for medical necessity. Dental Office Setting Age 0-18 only	PA	Written narrative detailing the type of anesthesia to be used, Rationale of medical necessity, Radiographs, Tx plan, Recorded treatment time documented in record, Sedation/General Anesthesia Scoring Tool, Sedation Record included with claims

D9224 Administration of general anesthesia with advanced airway- first 15 minute increment, or any portion therof	Age 0 –18 per day. D9230, D9239, D9243, D9248, D9920 are not payable on the same date of service as D9222, D9223. General anesthesia provided in the dentist's office reimbursed only for members younger than 21 years old. When the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead, the appropriate CPT code must be billed on a professional claim (CMS-1500 claim form).	PA	Written narrative detailing the type of anesthesia to be used, Rationale of medical necessity, Radiographs, Tx plan, Recorded treatment time documented in record, Sedation/General Anesthesia Scoring Tool, Sedation Record included with claims
D9225 Administration of general anesthesia with advanced airway- each subsequent 15-minute increment, or any portion therof	Age 0 –18 per day. D9230, D9239, D9243, D9248, D9920 are not payable on the same date of service as D9222, D9223. General anesthesia provided in the dentist's office reimbursed only for members younger than 21 years old. When the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead, the appropriate CPT code must be billed on a professional claim (CMS-1500 claim form).	PA	Written narrative detailing the type of anesthesia to be used, Rationale of medical necessity, Radiographs, Tx plan, Recorded treatment time documented in record, Sedation/General Anesthesia Scoring Tool, Sedation Record included with claims

CDT Code/Description	Benefit Limitations	Prior Authorization (PA) or Routine Review (PPR) Required	Documentation Required for Services Requiring Review
Adjunctive General Services – D9000-D9999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, , may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D9110, D9430,D9610, D9612, D9630, D9910, D9911, D9930, D9944, D9945, D9951, and D9971. This list is also available at: https://rendentalofficetoolkit.com			
D9230 inhalation of nitrous oxide/ analgesia, anxiolysis	Age 0 -18 per day. Only covered for members 18 years old and younger. Only one type of anesthesia (general, IV, or non-IV) per date of service.	No	No
D9239 intravenous moderate (conscious) sedation/analgesia - first 15 minutes	Age 0 –18. 1 per day. (D9239, D9243) reimbursable when provided services rendered in a dental office only. Only one type of anesthesia (general, IV, or non-IV) per date of service.	PA	Narrative of medical necessity. Sedation log must be retained in the member's file for at least three years but is not required to be submitted with claims.
D9243 intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	Age 0-18 Five of (D9243) per 1 Day(s) Per patient. Not allowed in conjunction with D9223, D9230, or D9248. .	PA	Narrative of medical necessity. Sedation log must be retained in the member's file for at least three years but is not required to be submitted with claims.
D9244 In office administration of minimal sedation – single drug- enteral	Age 0 –18. 1 per day. Narrative of medical necessity must be retained in the member's file for at least three years but is not required to be submitted with claims. Only one type of anesthesia (general, IV, or non-IV) per date of service.	PA	Narrative of medical necessity. Sedation log must be retained in the member's file for at least three years but is not required to be submitted with claims. Not payable if submitted with other sedation services on the same DOS.

D9245 Administration of moderate sedation-enteral	Age 0 –18. 1 per day. Narrative of medical necessity must be retained in the member's file for at least three years but is not required to be submitted with claims. Only one type of anesthesia (general, IV, or non-IV) per date of service.	PA	Narrative of medical necessity. Sedation log must be retained in the member's file for at least three years but is not required to be submitted with claims. Not payable if submitted with other sedation services on the same DOS.
D9246 Administration of moderate sedation-non intravenous parenteral- first 15-minute increment, or any portion therof	Age 0 –18. 1 per day. Narrative of medical necessity must be retained in the member's file for at least three years but is not required to be submitted with claims. Only one type of anesthesia (general, IV, or non-IV) per date of service.	PA	Narrative of medical necessity. Sedation log must be retained in the member's file for at least three years but is not required to be submitted with claims. Not payable if submitted with other sedation services on the same DOS.
D9247 Administration of moderate sedation-non intravenous parenteral- each subsequent 15-minute increment, or any portion therof	Age 0 –18. 1 per day. Narrative of medical necessity must be retained in the member's file for at least three years but is not required to be submitted with claims. Only one type of anesthesia (general, IV, or non-IV) per date of service.	PA	Narrative of medical necessity. Sedation log must be retained in the member's file for at least three years but is not required to be submitted with claims. Not payable if submitted with other sedation services on the same DOS.

CDT Code/Description	Benefit Limitations	Prior Authorization (PA) or Routine	Documentation Required for Services

		Review (PPR) Required	Requiring Review
Adjunctive General Services – D9000-D9999 Only the most commonly submitted D codes are listed in the Benefit Grid, along with benefits and limitations, prior authorization or pre-payment review requirements, age limitations, and necessary documentation for claims submission. Other D codes may be covered under specific clinical circumstances, may be subject to prior authorization or pre-payment review, and only considered with applicable documentation for medical necessity with applicable documentation for medical necessity, including: D9110, D9430,D9610, D9612, D9630, D9910, D9911, D9930, D9944, D9945, D9951, and D9971. This list is also available at: https://rendentalofficetoolkit.com			
D9420 Hospital or Ambulatory surgical center Call	Age 0 –18. I per day For procedures rendered in an operating room(OR) or ambulatory surgical center (ASC) Sedation is not to be billed separately from facility fee	PA	Hospital Readiness Form, narrative of medical necessity, place of service in a hospital or ambulatory setting, ASA classification, treatment plan, radiographs, etc. to be included in claim
D9440 Office visit- after Regularly scheduled hours	Two of (9110, D9440) allowed per 12 months		

Section 11

Clinical Criteria References

Specific Criteria – Service-specific clinical criteria used in utilization review determinations may be found at: Renaissance - Clinical Criteria. These documents contain the specific authoritative references used in creating Renaissance's criteria.

The following criteria generally apply to the planning and provision of dental services and procedures:

- Appropriate informed consent must be obtained from members or authorized representatives prior to providing dental services and procedures.
- The provision of dental treatment must be preceded by an appropriate clinical evaluation, the development of a diagnosis and the creation of a treatment plan. Treatment plans must be appropriate to individual patient needs, be consistent with documented diagnoses and have treatment appropriately sequenced.
- If acceptable radiographs are reasonably available from another source, practitioners should use those images rather than exposing a patient to more radiation. When such images are not available, practitioners should obtain the appropriate radiographs required for the diagnosis and treatment of a patient in accordance with *The Selection of Members for Dental Radiographic Examinations* published by the American Dental Association and the U.S. Food and Drug Administration and *Optimizing radiation safety in dentistry* published by the American Dental Association.
- Clinicians must employ appropriate infection control procedures as described in the 2003 *Guidelines for Infection Control in Dental Health-Care Settings* and the 2016 *Summary of Infection Prevention Practices in Dental Settings* from the U.S. Centers for Disease Control and Prevention.
- Patient dental records must legibly document appropriate information including, but not limited to:
    - Patient identification information including the patient's full name, birth date, address, telephone number, emergency contact and authorized representative (if any)
    - Medical and dental history
    - Patient complaints
    - Thorough charting of the patient's existing oral health care status
    - The result of any diagnostic tests
    - A comprehensive diagnosis and treatment plan
    - All dental procedures performed upon the patient, including the date of service, identity of the treating clinician and thorough description of the procedure
    - Treatment progress notes
    - The date, dosage and amount of any medication or drug prescribed, dispensed or administered to the patient
    - Appropriate informed consent
    - Any other documentation required to completely document the quantity, quality, appropriateness and timeliness of dental services and procedures provided
- Dental services and procedures must be covered by a member's dental plan and be completed to be eligible for benefit payment. Non-covered services and incomplete procedures are not eligible for

benefit payment. When dental care is interrupted or terminated due a change in a patient's treating clinician or the death of a patient, any involved claim will be reviewed to determine what benefit coverage, if any, is available for services completed or in progress.

- Dental services and procedures determined not to be medically necessary or clinically appropriate are not eligible for benefit payment.
- When planning the provision of dental service and procedures, practitioners should consider the likely prognosis and whether a successful treatment outcome may reasonably be expected. Benefits for services and procedures determined to have a poor endodontic, periodontal, structural, restorative or prosthodontic prognosis may not be considered eligible for benefit payment.

Section 12

Prior Authorization

In the administration of CoverKids dental benefits covered by a particular TennCare plan, Renaissance covers all State-required services through an NCQA compliant utilization management program based on the generally accepted standards of dental practice. However, in order to appropriately manage health care costs and/or assure medical necessity, certain CDT codes may require approval before services can be rendered. The prior authorization process is the means by which Renaissance manages the utilization of services through the application of medical necessity, appropriateness of care, and benefit coverage eligibility standards.

Common dental procedures generally do not require prior authorization, however, for those services as defined by the specific program, certain CDT codes require that a provider submit a prior authorization request, and that they receive a determination prior to those services being rendered. Other services may require routine review, but unlike those requiring binding prior authorization, the provider may render the associated service before submitting the request. In the instance of prior authorization, the submission of the requested material and clinical documentation is used by Renaissance in the determination of medical necessity and/or the appropriateness of care as related to the requested service. In doing so, this helps providers address claim issues early and to avoid possible delays related to denials and appeals.

It is important to be aware that failure to request required prior authorization before beginning treatment may result in rejection of reimbursement for a procedure. Another key point to keep in mind is that a prior authorization may not be valid if a patient has lost eligibility for benefits as of the date that services approved on an authorization notice are performed. That is another reason why it is important to confirm patient eligibility at each appointment prior to delivering care.

Renaissance will respond to requests for prior authorization within 14 calendar days (abbreviated to 7 calendar days effective January 1, 2026) for any request that is not for an urgent dental care procedure. Urgent dental care procedures are defined as procedures that must be provided without delay in order to control pain, treat infections, and/or to provide treatment to prevent a dental problem from causing permanent damage to a patient's health.

In emergency situations, where oral health conditions involve severe pain, uncontrolled bleeding, traumatic injuries, or infections requiring immediate attention, providers are urged to render the appropriate treatment and contact Renaissance within 3 calendar days and then submit the appropriate claim. If such urgency is not required, Renaissance will respond to prior authorization requests for urgent dental care procedures within 48 hours of receiving the request.

Effective 01/01/26, Renaissance will respond to requests for prior authorization within 7 calendar days for any standard (non-urgent) prior authorization requests and the current prior authorization deadline for expedited (urgent) prior authorizations requests will remain unchanged at 72 hours.

Prior authorizations are valid for 180 calendar days after issuance, after which a new prior authorization request must be submitted. If a prior authorization is not approved, Renaissance will provide information explaining the reason(s) along with information on how to appeal the adverse decision. Appeals of adverse prior authorization decisions must be submitted to Renaissance within
60 calendar days of the date of the determination (see Section 13 for more information on submitting appeals).

Providers are not allowed to bill the eligible patient or Renaissance if services begin before prior authorization is determined and are at financial risk and may not balance bill the member if the utilization management

reviewer determines the clinical review criteria have not been met.

Prior authorization requests may be submitted electronically through a clearinghouse, or through Renaissance's Dental Office Toolkit™, using the current version of the ADA dental claim form, which can be found at: https://www.ada.org/publications/cdt/ada-dental-claim-form

In the Header Information box at the top left of the claim form, under "1. Type of Transaction", check the box labeled "Request for Predetermination/Preauthorization". If a prior authorization request involves an urgent dental care procedure, write "Urgent PA Request" in the "35. Remarks" box on the claim form. The Dental Office Toolkit™ may also be used to check on the status of prior authorization requests. Make certain that all the required documentation listed is included for a given code and include any other information that is important for Renaissance's professional reviewers to see when making a prior authorization determination. If Renaissance needs more information to process a request for prior authorization, providers will receive documentation of the specific information necessary to process the request.

For those services not requiring prior authorization but require pre-payment review, providers will submit an in-for-pay (IFP) claim, with the required clinical documentation, after the treatment has been rendered. If the associated medical necessity criteria have been met and the treatment was appropriate to the preoperative condition, payment will most likely be made (when submitted IFP with a date of service) if all other eligibility standards are satisfied.

In all instances, the Renaissance utilization management procedures are based on appropriate care and service, and do not reward those involved for issuing denials, nor offer incentives to encourage inappropriate utilization.

Section 13

Grievances and Appeals

Renaissance adheres to state and federal law and to program requirements related to processing inquiries and appeals.

Note:

Copies of Renaissance policies and procedures can be requested by contacting Customer Service at: 866-864-2526

(Member Appeal Process)

If a provider receives a notice from Renaissance advising that provider's prior authorization request has been denied, the TennCare dental member will have also received the notice of adverse benefit determination (NABD) that details the member's appeal rights.

In the event that a dental service prior authorization request is denied by Renaissance, the TennCare dental member has the right to appeal the denial to TennCare. With the member, member parent, or member guardian's authorization, a provider may file a TennCare service appeal on the member's behalf. The NABD instructs how to file such an appeal with TennCare.

Once a member appeal is filed, TennCare will conduct an appeal as required under state and federal law. If TennCare's dental reviewer upholds the adverse benefit determination, the member may have a State Fair Hearing as provided for under state and federal law. If the State Fair Hearing decision overturns Renaissance's denial, Renaissance will be instructed by TennCare to approve provision of the service under appeal.

PLEASE NOTE:

TennCare process does not handle provider appeals (post-service appeals) which have not resulted in an adverse benefit determination affecting the TennCare dental member's receipt of a benefit. For example, payment disputes between the provider and Renaissance must NOT be filed as TennCare member appeals. If resolution of the issue under dispute does not affect whether the TennCare dental member will receive a service (or reimbursement of a service), then the appeal should be filed as a Provider Appeal.

See section below for an explanation of the Provider Appeal process.

Rights and Responsibilities Regarding Member Appeals

TennCare dental members have the right to appeal any adverse benefit determination taken by Renaissance. An adverse benefit determination is anything that denies, reduces, terminates, delays, or suspends a TennCare dental covered service, as well as any acts or omissions which impair the quality, timeliness, or availability of TennCare dental covered services.

Appeals involving denials of authorizations for care for TennCare dental members may be filed by the member or by anyone (including the treating provider) acting on the member's behalf. Dental providers play an important role in the appeal process for TennCare dental members. Among providers' responsibilities is the obligation to supply at no cost to TennCare or Renaissance, those medical and dental records necessary to substantiate the member's appeal.

Rights and Responsibilities Regarding Member Appeals

TennCare Dental Members have the right to appeal any Adverse Benefit Determination taken by Renaissance. An adverse benefit determination is anything that denies, reduces, terminates, delays, or suspends a TennCare

dental covered service, as well as any acts or omission which impair the quality, timeliness, or availability of TennCare dental covered services.

Appeals involving denials of authorizations for care for TennCare dental members may be lodged by the member or by anyone (including the treating provider) acting on the member's behalf with the member's consent. Dental providers play an important role in the appeal process for TennCare dental members. Among providers' responsibilities is the obligation to supply, at no cost to TennCare or Renaissance, those medical and dental records necessary to substantiate the member's appeal.

Member Grievances

A grievance is an expression of dissatisfaction (other than an adverse benefit determination) with any aspect of the operations, activities, or behavior of a CoverKids health plan, or its providers, regardless of whether remedial action is requested. The member must file the grievance either verbally or in writing with Renaissance. Member grievances can include, but are not limited to:

- Access to services.
- Care and treatment by a provider or staff.
- The administration of the program.

A member or member's representative with the member's written consent can file a grievance orally or in writing, at any time. With each grievance, the member or representative should provide all supporting information that will aid in the investigation by Renaissance. A member or member representative can request assistance in filing a grievance by contacting Renaissance Customer Service at 866-864-2526.

Renaissance adheres to all Tennessee, federal, and managed care requirements related to processing grievances. After receipt, appropriate Renaissance personnel:

- Documents the substance of the grievance.
- Investigate the issue(s), including any aspect of clinical care.
- Compiles their findings.
- May request patient treatment records and/or associated clinical documentation.
- If applicable, works with the appropriate dental professional(s) to review and then,
- Obtains a resolution.
- The appropriate persons are notified (including the member and provider) and the issue is maintained on file.

Upon receipt of a grievance Renaissance provides the member with an acknowledgment of receipt either orally or in writing within five (5) business days. Renaissance provides grievance resolution to the member and provider (if the grievance was against the provider) as expeditiously as possible but no later than ninety (90) days from the date the grievance is received by Renaissance.

Renaissance's process for handling member grievances against providers and/or Renaissance is as follows:

1. The member grievance process shall only be for grievances as defined in Section 2. Renaissance and the Providers shall ensure that all member appeals, as defined in Section 12, are addressed through the appeals process, rather than through the grievance process.
2. Renaissance and the provider shall allow a member to file a grievance either orally or in writing at any time.
3. Provider shall forward a copy of any written member grievance the provider receives to Renaissance within one (1) business day of receipt from member. The provider shall forward to Renaissance a full and complete written version of any grievance received orally from a member within one (1) business day of receipt from the member. All such transmissions of member

grievance to Renaissance shall be made electronically, via secure email or facsimile transmission.

4. Within five (5) business days of receipt of the grievance, Renaissance shall provide written notice to the member and the provider (if the grievance was against the provider) that the Grievance has been received and the expected date of resolution. However, if Renaissance resolves the grievance and verbally informs the member, and provider if appropriate, of the resolution within five (5) business days of receipt of the grievance, Renaissance shall not be required to provide written acknowledgement of the complaint to the member, and provider if appropriate.
5. Renaissance shall resolve and notify the member and the provider (if the grievance was against the Provider) in writing of the resolution of each grievance as expeditiously as possible but no later than ninety (90) days from the date the complaint is received by Renaissance. The notice shall include the resolution and the basis for the resolution. However, if Renaissance resolved the grievance and verbally informed the member and provider, if appropriate, of the resolution within five (5) business days of receipt of the grievance, Renaissance shall not be required to provide written notice of resolution to either the member or the provider (if the grievance was against the provider).
6. Renaissance and providers shall assist members with the grievance process.
7. Renaissance shall resolve each member grievance with assistance from the affected provider, as needed, and provider shall comply with Renaissance's request for assistance. The resolution process includes various methods of determining the cause of, and the appropriate resolution of, a grievance, including, but not limited to, use of a corrective action plan (CAP). A CAP is a plan to correct provider's noncompliance with the provider agreement (including noncompliance resulting in member grievance) that the provider prepares on his/her own initiative, or at Renaissance's request, to submit to Renaissance for review and approval. The provider shall respond timely to the CAP request and take all CAP actions that have been approved by Renaissance. Failure to comply with a request to provide a CAP or the terms and conditions of an approved CAP may result in actions against the provider, including termination of the affected provider's provider agreement by Renaissance. The various components of a CAP are as follows:
    a. Notice of Deficiency: If Renaissance determines that the provider is not in compliance with a requirement of the provider agreement (including, but not limited to, issues relating to a member's grievance) Renaissance will issue a notice of deficiency identifying the deficiency and request a CAP detailing how the provider intends to correct the deficiency. The Notice of Deficiency will also contain the deadline for the proposed CAP to be forwarded to Renaissance and may also contain recommendations or requirements the provider must include or address in the CAP.
    b. Proposed CAP: Upon receipt of a Notice of Deficiency, the provider shall prepare a proposed CAP and submit it to Renaissance for approval within the time frame specified by Renaissance. The proposed CAP shall comply with all recommendations and requirements of the Notice of Deficiency and contain a proposed time by which the noncompliance will be corrected.
    c. Approved CAP Implementation: Renaissance will review the proposed CAP and work with the provider to revise it as needed. Once approved, the provider shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the CAP, to Renaissance's satisfaction.
    d. Notice of Completed CAP: Upon satisfactory completion of the implemented CAP, Renaissance shall provide written notice to the provider. Until written approval is received by the provider, the approved CAP will be deemed to not have been satisfactorily

completed.

8. Renaissance shall track and trend all member grievances, timeframes and resolutions and ensure remediation of individual and/or systemic issues.
9. Upon request, Renaissance shall submit reports regarding member grievances to TennCare.
10. Member grievances pertaining to discrimination shall be handled in accordance with the separate nondiscrimination process. Discrimination complaints must be reported within 6 months from the date of event.

Mail to: Renaissance Gov. Prog. Inquiries
P.O. Box 1505
Farmington Hills, MI 48333-1505
Call: 1-866-864-2526 (TTY:711)

Provider Appeal Process

Participating providers that disagree with claims processing determinations made by Renaissance may submit a written notice of disagreement to Renaissance that specifies the nature of the issue. The provider appeal form can be used for this purpose. The appeal must be sent within 60 days from the date of the original determination.

All provider appeals received timely by Renaissance will be reviewed by the Complaints and Grievances Department for review and reconsideration, which includes review by a clinical professional. The department will respond in writing with its decision to the provider.

Tennessee Department of Commerce and Insurance Complaint Process

The TDCI Provider Complaint process is a courtesy provided to dental providers who have a complaint against Renaissance. This process is free.

Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from Renaissance, miscommunication, or confusion around Renaissance policy and procedures, etc.

When a provider complaint is received, the TDCI TennCare Oversight Division will forward the complaint to Renaissance for investigation. Renaissance is required to respond in writing to both the provider and the TennCare Oversight Division by a set deadline to avoid assessment of liquidated damages or other appropriate sanction. If the provider is not satisfied with Renaissance's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to, requesting a claims payment dispute be sent to an Independent Reviewer for resolution or pursuing other available legal or contractual remedies. Instructions and current copies of the forms can be obtained on the state's website at Provider Complaint: TennCare and CoverKids Programs.

TDCI TennCare Provider Independent Review of Disputed Claims

In addition to the above process, providers may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Dental Provider Independent Review of Disputed Claims process.

The Independent Review process was established by statute (Tennessee Code Annotated § 56-32-126(b)(2)) to resolve claims disputes when a provider believes a TennCare Managed Care Company (MCC) such as Renaissance has partially or totally denied claims incorrectly. A failure to send a provider a remittance advice or other written or electronic notice

Either partially or totally denying a claim within sixty (60) days of Renaissance's receipt of the claim is

considered a claims denial.

There is a $750.00 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCC is responsible for paying the fee.

Conversely, if the independent reviewer finds in favor of the MCC, the provider is responsible for reimbursing the MCC the amount of the fee.

The independent review process is only one option a provider has in order to resolve claim payment disputes with a TennCare MCC. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.

Provider Appeal Process:

A provider appeal is a request from the treating dentist to reconsider an adverse benefit determination. Provider appeals must be received within 60 calendar days of the service date.

To request an appeal, you must:

- Submit a written request to have the claim reviewed.
- Provide documentation that supports the reason you feel the claim should have been paid.

Upon receipt of a provider appeal, Renaissance will respond to the appeal request via EOB.

Provider Appeals can be sent to:

Renaissance Provider Appeals

ATTN: TennCare Appeals

P.O. Box 1505

Farmington Hills, MI 48333-1505

Appeal requests must include:

- The member's name, member ID number, and date of birth
- The provider's name and Renaissance provider billing number.
- The place, date, and type of service that had a non-certification determination for medical necessity appeals.
- The reason why the determination should be reconsidered.
- Any additional available medical information to support reasons for reversing the determination or support medical necessity.

All appeals are reviewed by an independent panel knowledgeable about the policy, legal, and clinical issues involved in the matter subject to the appeal; individuals who have not been involved in any previous consideration of the matter; and all information and material submitted by the provider that bears directly upon an issue involved in the matter is considered.

If disagreement exists with the determination on an appealed claim's EOB statement, request a peer-to-peer call with a Renaissance consulting dentist.

Peer-to-Peer Call Process

It is Renaissance's policy to provide a treating practitioner with the opportunity to have a peer-to-peer discussion with a licensed dentist peer reviewer about a claim submitted by the practitioner that was disapproved by Renaissance based on an adverse medical necessity or adverse clinical appropriateness

decision.

Renaissance notifies practitioners about the opportunity for a peer-to-peer discussion with a licensed dentist peer reviewer in the explanation of benefits denial notifications of dental claims where adverse medical necessity or adverse clinical appropriateness decisions have been made. Peer-to-peer discussions are not available for claim denials based on client contract exclusions, limitations, benefit exhaustion, and other reasons not involving an adverse medical necessity or adverse clinical appropriateness determination.

The goal of peer-to-peer discussions is to provide the treating practitioner with a better understanding of the specific clinical basis for an adverse decision, to facilitate presentation of new or additional information and, if possible, to resolve the disagreement before pursuing other available avenues for resolution of the dispute. A peer-to-peer discussion is not considered part of the appeal process.

Renaissance's process for facilitating peer-to-peer discussions follows these steps:

  - A practitioner may schedule a peer-to-peer discussion with a Renaissance licensed dentist peer reviewer by going to: tenncare.renaissancebenefits.com and following the instructions to submit a peer-to-peer request form. The instructions guide the practitioner to provide all the information needed for a productive discussion.
  - A peer-to-peer call request must be sent within 30 days of the appealed denial notice.
  - Upon receipt of a request for a peer-to-peer call and all the information required for the discussion has been received:

- Renaissance staff will contact your office to schedule the call within a reasonable time period between the practitioner and a Renaissance licensed dentist peer reviewer. Peer-to-peer discussions will be limited to a duration of thirty minutes unless approved in advance by the Dental Director due to an atypical clinical situation.
- A practitioner may receive one peer-to-peer discussion per episode of treatment unless the practitioner has new, pertinent information that is applicable to a second conversation

The peer-to-peer call will be recorded by Renaissance for quality purpose.

Arbitration Process

An arbitration process is available for claim disputes and other issues pertaining to the provider participation agreement. To initiate arbitration, please submit the request to:

Mail:
Renaissance
ATTN: Focused Review
P.O. Box 1600
Farmington Hills, MI 48333

Upon receipt of request, Renaissance will provide the arbitration documentation within 15 days.

Provider Grievance Process

A grievance is an expression of dissatisfaction (other than a claim denial) with any aspect of the operations, activities, or behavior of a TennCare Children's health plan, or its members, regardless of whether remedial action is requested. The provider must file the grievance in writing.

With each grievance, provide all supporting information that will aid in the review by Renaissance. Renaissance

adheres to all Tennessee state; federal and managed care requirements related to processing grievances. After receipt, appropriate Renaissance personnel:

- Document the substance of the grievance.
- Investigate the issue(s), including any aspect of clinical care.
- Compiles the findings
- May request patient treatment records and/or associated clinical documentation
- If applicable, works with the appropriate dental professional(s) to review and then;
- Obtains a resolution, after which;
- The appropriate persons are notified (including the member and provider) and the issues are maintained on file.

Renaissance provides grievance resolution with determination within 30 calendar days.

Grievances Submission Options:

Mail to:
Renaissance Grievances
ATTN: TennCare Children's Grievances
P.O. Box 1505
Farmington Hills, MI 48333-1505

Section 14

Claim Submission

When to Submit a Claim?

Claims must be submitted to Renaissance when:

- Covered services are performed on a patient –
    - Services are completed on the date that all steps of a procedure are finished. Some procedures may require more than one appointment before completion. Treatment is complete:
        - For appliances, dentures, and partial dentures—on the delivery date.
        - For root canals, oral surgery, and periodontal treatment—on the date of the final procedure that completes treatment.
        - For direct restorative and indirect restorations—on the day of completion and/or seat date.
        - Orthodontics – at completion of full treatment plan, but claim must be submitted at time of initial banding/bracketing.

Which claim form should be used?

The current version of the ADA claim form must be used for all covered services rendered to members, for procedures which a prior authorization or pre-payment review is required, requested or when a charge is made. Each claim form may contain charges for only one patient.

How to fill out a claim?

Renaissance requires specific information to be included with each claim. Failure to include that information may delay claim processing. The information on a claim must match the information in Renaissance's records or the claim will be rejected.

On the claim form, indicate whether the claim transaction is a statement of actual IFP services (include a date of service on all applicable lines), or a prior authorization.

All claims must include:

- Practice business name and address (billing dentist or dental entity).
- Tax identification number (billing dentist or dental entity).
- Treating dentist name.
- Treating dentist state license number.
- Treating dentist individual NPI – Type 1.
- NPI Type 2, if applicable.
- Service office address.
- Dentist's signature if a paper claim is submitted.
- Patient's first and last names (legal names; nicknames are not accepted may cause claim processing delays).
- Patient's date of birth.

- Members Social Security number
- The amount claimed through Medicaid for each specific service rendered.
- Place of Treatment (Place of Service)

Each claim must properly document the treatment performed using the current ADA CDT procedure codes. All CDT codes have a procedure name (nomenclature), and many have a description of the procedure that helps identify the correct code for documentation.
Depending on the procedure, identification of where in the oral cavity the service was performed, e.g., arch, quadrant, tooth, and/or surface, is necessary. Failure to identify the location of a procedure when it is required, may result in a claim being rejected.

Renaissance accepts arch and quadrant numerical designations of 01 through 40, left and right designations, and other areas of the oral cavity as shown below.

Area of Oral Cavity Codes									
Maxillary Arch	Mandibular Arch	Upper Right Quadrant	Upper Left Quadrant	Lower Left Quadrant	Lower Right Quadrant	Left	Right	Entire Oral Cavity	Other Area of Oral Cavity
Code									
01	02	10	20	30	40	L	R	00	09

Renaissance accepts the ADA's universal/national tooth designation system, which designates tooth numbers one through 32 for the permanent dentition, and tooth letters A through T for the primary dentition. The ADA system designates supernumerary teeth by the numbers 51 through 82. The tooth designations are shown below.

	Upper Right Quadrant								**Upper Left Quadrant**							
Permanent Tooth Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Permanent Supernumerary Tooth Number	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Permanent Tooth Number	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Permanent Supernumerary Tooth Number	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67
	Lower Right Quadrant								Lower Left Quadrant							

	Upper Right Quadrant					Upper Left Quadrant				
Primary Tooth Number	A	B	C	D	E	F	G	H	I	J
Primary Supernumerary Tooth Number	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS
Primary Tooth Number	T	S	R	Q	P	O	N	M	L	K
Primary Supernumerary Tooth Number	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS
	Lower Right Quadrant					**Lower Left Quadrant**				

Renaissance recommends keeping an updated version of the CDT code for reference. The procedure code list changes each year and using an outdated code may delay claims processing.

When submitting claims to Renaissance, please avoid writing any information in the remarks section of the claim form unless there is a documentation requirement for the procedure that submitted. Since many procedures do not require manual review, placing an unnecessary remark on a claim may slow claim processing, resulting in delay. If there is a documentation requirement for a procedure that is being submitted, only attach a separate report if there is not enough space in the remarks section to provide complete information, or if there is a requirement for documentation that cannot be submitted in a remark, such a radiograph image.

Place of Service

As required, identify the place of service where the submitted procedure(s) was performed. The codes identified below should be entered on line 38 of the ADA claim form.

- 02 - Telehealth
- 03 - School
- 04 - Homeless Shelter
- 05 - Free Standing Indian Health Service
- 06 - Provider-based location
- 07 - Free Standing Tribal Center
- 08 - Provider-based location
- 09 - Correctional Facility
- 11 - Dental Office
- 12 - Patient Home
- 13 - Assisted Living Center
- 14 - Group Home
- 15 - Mobile Unit
- 19 - Off Campus Outpatient Hospital
- 21 - Inpatient Hospital
- 22 - On Campus Outpatient Hospital
- 24 - Ambulatory Surgical Center

- 50 - Federally Qualified Health Care Center
- 71 - Public Health Clinic.

How to submit a radiograph or other information with a claim?

Renaissance accepts electronic attachments through National Electronic Attachments (NEA). The attachment must be sent with an electronic claim filed either through DOT or an electronic clearinghouse. If the provider receives a request for additional information from Renaissance, submit an electronic attachment through NEA with the applicable claim number. A new claim does not need to be submitted as long as the NEA is submitted with the original claim number. For best results, submitting the information request will speed up the processing.

For more information visit VYNE Dental at http://www.nea-fast.com. Information on additional clearinghouses can be found at {Insert URL}

Paper claims should not be stapled to any attachments, and only include attachments required to process the claim. Including unnecessary attachments may delay the claim processing.

When hard copy radiographs must be included with a dental claim, remember these tips for more efficient processing:

- Send duplicates only; do not send originals.
- Use the patient's legal name on all claims and related radiographs (do not use a nickname). Also, be sure to label each radiographic image with the date it was exposed, left and right, and/or the tooth and/or teeth exposed. These requirements are important for electronic attachments as well.
- Renaissance will not return radiographs unless submitted with a self-addressed, stamped envelope large enough for all the radiographs to fit. Multiple radiographs for different members require a stamped, self-addressed envelope for each patient.
- Do not attach radiographs to the back of the claim. These can be easily missed.
- Avoid double-sided paper radiographs, as this can delay claim processing.

How to submit claims?

Submitting claims electronically can reduce processing time and is more cost-efficient. Claims may be submitted electronically through a clearinghouse or through the Dental Office Toolkit™ (DOT). To access DOT, visit https://www.rendentalofficetoolkit.com. If unable to submit claims electronically, paper claims may be mailed to:

Renaissance
ATTN: CoverKids Claims
P.O. Box 2720
Farmington Hills, MI 48333-2720
Please call the customer service team at 866-864-2526 for member eligibility, benefits information and claims inquiries.

What About Dental Practices with More Than One Dentist?

It is important to notify Renaissance when an associate, partner or temporary dentist is hired. The claims

processing system will be updated to associate the treating dentist to the billing entity or corporation so that claims are processed appropriately. There may be instances where the practice owner may be participating with Renaissance, but the associate is not participating. Since reimbursement rates differ for participating (in-network) providers versus nonparticipating (out-of-network) providers, this can cause confusion for both the practice-billing administrator and the patient. Claims can be processed and paid differently for nonparticipating providers, ultimately affecting the patient's financial responsibility.

Recent versions of the ADA claim form provide clearly identifiable areas to report the billing entity and treating provider information. It is very important that dental offices report accurate treating provider information on the claim form.

Make sure to also provide the appropriate NPI number on the claim form:

- Type 1 NPI – Individual NPI – for health care providers, such as dentists.
- Type 2 NPI – Organizational NPI – for use by incorporated businesses, such as group practices, incorporated individuals and clinics.

Is There a Deadline for Submitting a Claim?

Yes. Dentists participating in the Renaissance Tennessee CoverKids Network must submit claims for services within 120 calendar days after the service is provided. If Renaissance denies a service(s) on a claim due to late submission, participating dentists are prohibited from billing members for the amount that Renaissance would have paid, provided that the patient advised the dentist of Renaissance coverage at the time of treatment.

What to do if Asked for More information After Submitting a Claim?

- Log in to DOT to view claims history for all submitted claims and PAs, and view the activity log for claim payment information, direct deposits, denied claims, and information requests. Register and log in to DOT at https://www.rendentalofficetoolkit.com.

Section 15

Reimbursement

Reimbursement for Services Provided to a CoverKids Member

- How is reimbursement determined for services provided to CoverKids members?
  - Reimbursement to dentists participating in the Renaissance CoverKids Network is based on the current applicable Renaissance CoverKids fee schedule. Eligible members can receive treatment from any dentist participating in the Renaissance CoverKids Network. The participating dentists cannot balance bill the member for any difference between regular fees and the amount in the current applicable CoverKids fee schedule.
  - All covered services for eligible members are reimbursed at 100 percent of the dentist's submitted fee or the amount in the Renaissance CoverKids fee schedule, whichever is less. Unless noted in the fee schedule, all of Renaissance's standard time limitations and policies apply to the covered services.
  - Copayments – Copayments for outpatient dental services are assessed for each category, even if delivered by the same provider, on the same date of service, and at the same location. When multiple services within one category are performed, only one copayment can be assessed within that category per date of service.

Dental Benefits	Group One Child	Group Two Child	American Indian/Alaskan Native (AI/AN) Child
Preventive • Fluoride treatments - Fluoride varnish 1 year of age or older up to age 18 - 2 per calendar year • Dental sealants - For permanent molars, 1 per lifetime per tooth • Cleanings - 2 cleanings per calendar year • Silver Diamine Fluoride (SDF) four applications per tooth per lifetime	No copayment	No copayment	No copayment
Diagnostic • Oral exams - 2 oral exams per calendar year • Radiographs - Bitewings 2 years of age and older 1 set per calendar year • Full mouth radiographs 1 set every three calendar years	No copayment	No copayment	No copayment

Dental Benefits	Group One Child	Group Two Child	**American Indian/Alaskan Native (AI/AN) Child**
Emergency Services Example - Minor procedure to get patient out of pain	$15 copayment	$5 copayment	No copayment
Restorative Services • Filling • Crowns	$15 copayment	$5 copayment	No copayment
Extractions	$15 copayment	$5 copayment	No copayment
Anesthesia - Provided only when medically indicated	$15 copayment	$5 copayment	No copayment
Other Dental Services	$15 copayment	$5 copayment	No copayment
Orthodontic Services	$15 copayment	$5 copayment	No copayment
Deductibles	None	None	None

- How to read Renaissance's Explanation of Benefits (EOB) statement? Renaissance provides notification of favorable and adverse utilization management decisions to practitioners through electronic or hard copy explanation of benefits statements in compliance with federal and state requirements, client requirements, and applicable accreditation standards. For all adverse UM decisions where Renaissance disapproves benefit payment for a dental service or procedure based on a professional determination that a dental procedure is not medically necessary or is clinically inappropriate, explanation of benefit denial notifications will include:
    - Identification of dental services or procedures that were submitted for benefit payment which were either approved or disapproved.
    - A message that explains the clinical basis for the adverse UM decision that is specific to the member's dental condition, is written in language that a layperson can understand and that provides the member and practitioner with enough information to file an appeal if so desired.
    - A reference to the specific clinical criteria that was used to make the adverse UM decision that includes the name and source of the criteria.
    - Notification that the criteria used to make the adverse UM decision is available at no charge upon request.
- Can claim payment be received through direct deposit?
    - Yes. If enrolled in direct deposit, Renaissance sends claim payments electronically to the designated bank account and issues an explanation of payment in either paper or electronic format. Payments are often in a dentist's bank account in as little as 48 hours after claim submission. Direct deposit is a free service only available to participating dentists.

- If the provider wants to enroll in National EFT, log in to DOT and follow the direct deposit link. If the provider is not currently a DOT user, complete a short registration to set up the account. Direct deposit account activation will typically take seven days from registration.

- What happens if a CoverKids patient has other dental insurance?
  - Federal regulations require that if a CoverKids member has another source of coverage, such as private dental insurance, the other source of coverage must pay claims under its policy before CoverKids can pay. As a dentist participating in the Renaissance CoverKids Network, be alert to the possibility that a CoverKids member may have other dental insurance. If that is the case, claims must be submitted and payment received from the primary payer before submitting secondary payer claims to Renaissance. When submitting these secondary claims to Renaissance, make sure that a copy of the primary payer EOB statement showing the primary payment is included.

    Renaissance pays the difference between the amounts paid by the patient's other dental carrier and the maximum allowed amount. Renaissance will not make any payment if the amount received from the patient's other dental carrier is equal to or greater than the maximum allowed amount. In that case, Renaissance may not pay anything after the patient's other dental carrier pays, and the provider may not bill or collect from the CoverKids patient.

- What if a CoverKids patient has a prior authorization from a previous carrier?

  If the member previously received Medicaid dental benefits from another Medicaid dental plan, Renaissance will honor a new member's previous care authorizations for **90 days** per the Transition of Care policy. The member should call customer service at 866-864-2526 (TTY users dial 711) and reference the Transition of Care policy for additional assistance.

Reimbursement for Services Not Covered by the CoverKids Programs

- Can payment be received if a service is performed that is not on the Renaissance CoverKids fee schedule? Yes, but the process below must be followed, otherwise the patient must not be billed:
  - If a procedure does not appear on Renaissance's CoverKids fee schedule or exceeds an age or frequency limitation, it is not a covered benefit under the program. Payment for non-covered services is the responsibility of the member or responsible party.
  - However, the fee must be discussed with CoverKids members or responsible parties in advance, and treatment should only be rendered if they sign a private-pay agreement where the patient agrees, in writing, to pay for non-covered (or alternate) procedures. Participating dentists can use any form for the private-pay agreement, as long as it includes the fees associated with the non-covered service, the responsible person's signature and date. Keep the signed private-pay agreement in the patient's file and be ready to share a copy of it with Renaissance if requested. Download a private pay form from Renaissance at. tenncare.renaissancebenefits.com
  - The patient's and/or responsible party's approval to proceed with treatment via the private-pay agreement should be included in the patient record. Due to federal Medicaid requirements, covered services that are denied by Renaissance (for example, a procedure that exceeds a frequency limitation or is deemed to be not medically necessary) **cannot** be charged to a Medicaid patient or responsible party unless the person has agreed to pay for the service.

Overpayment Recovery

If Renaissance makes an overpayment on a claim, a participating dentist has two options for reimbursement:

1. Voluntary Reimbursement - Within sixty (60) days of the dentist discovering that that a claim has been overpaid, the provider can document the amount and reason for the overpayment on the claim payment statement and mail it with a check for the exact amount of the overpayment to:

Renaissance
ATTN: Accounting
P.O. Box 30416
Lansing ,MI 48909-7916

2. Refunding by Auto Deduction - If Renaissance makes an overpayment to a participating dentist and the dentist does not promptly send an explanation and refund back to Renaissance, the overpayment is generally recovered by automatic deduction in one of the following ways:
    a. Deduction from new payments - The amount of the overpayment is deducted from checks as issued to that dentist until the full amount is recovered. Adjustment explanation and tracking information is included on the EOB
    b. Transferring a previous payment - When an EOB is received that includes an auto deduction, look up that patient's account to confirm the date and amount of Renaissance's overpayment. Add the amount of the overpayment recovery back into the patient's account so that the two transactions (overpayment and recovery) total $0.
    c. Identifying the right process for the office - If the office is not familiar with the overpayment process, Renaissance recommends contacting an accountant and/or dental practice software vendor for instructions. The auto deduction can be recorded as a negative payment or an adjustment, depending on the accounting system. When this step is complete, bookkeeping records indicate that the office received a payment that has not been applied to a specific account.

       The EOB lists the claims and amounts that Renaissance paid with the auto deduction. Since payment was not received for the claims, the method of crediting the patient account(s) must balance with the method used for the auto deduction. This method depends on the accounting system.

Section 16

Utilization Management (UM)

Relevant Information Pertaining to the Utilization Management Activities Provided by Renaissance

UM Definition

The Renaissance utilization management (UM) program encompasses the activities involved in the governance of dental utilization review (UR) to ensure the appropriate and efficient evaluation of claims while promoting high-quality care. In this context, utilization review refers to the activities of licensed dentist peer reviewers who assess the medical necessity or clinical appropriateness of a dental service or procedure. UM decisions may be favorable or adverse.

Oversight of Utilization Management Program and Staff

The UM Program is maintained under the management of the Dental Director in collaboration with the TennCare Chief Dental Officer. The Dental Director is fully involved in the implementation, supervision, oversight, and evaluation of the UM Program including, but not limited to, utilization review activities.

The requirements of the UM Plan are enforced on a day-to-day basis by the Utilization Management Director. The UM Director oversees and manages all aspects of utilization review by Renaissance's licensed dentist peer reviewers, including the appropriate application of clinical criteria, use of relevant clinical documentation, and the assignment of appropriate professionals.

Renaissance's panel of licensed dentist peer reviewers includes general dentists and specialists who only adjudicate claims for services for which they have the appropriate experience or training. They may also advise or assist other UM staff as required.

Unlicensed dental claim review staff do not have authority to deny coverage based on an adverse medical necessity or clinical appropriateness determination. However, if appropriately trained and supervised, they may approve dental services through the application of explicit, pre-established UM decision criteria that do not require clinical judgment.

Renaissance does not offer financial or other forms of compensation to encourage peer reviewers to render adverse UR determinations.

Scope of the Utilization Management Program

As defined in the UM Plan and as governed by the UM Committee, the scope of UM activities includes the review of services requiring prior authorization, prepayment post-service (retrospective) dental claims, reconsiderations, and appeals of adverse utilization review determinations.

Utilization Review includes assessment of dental services to determine if they are:

- Medically necessary and/or clinically appropriate
- Consistent with the applicable generally accepted standards of dental practice (clinical criteria)
- Not provided primarily for the convenience of the member or dental practitioner

Factors considered in the claim review process include, but may not be limited to:

- Guidelines and criteria of the TennCare Dental Plan
- Applicable clinical criteria based on the generally accepted standards of dentistry
- Individual needs and circumstances of the patient
- The local delivery system

UM determinations are made on a case-by-case basis and documented in Renaissance's claim processing system for future reference. Members and practitioners are informed of the UM decisions through an online explanation of benefits (EOB).

Purpose

The primary function of the UM Program is to ensure that CoverKids members have access to dental care that is medically necessary, clinically appropriate, of acceptable quality, consistent with the diagnosis and required level of care, and performed within generally accepted standards of dental practice while providing members and practitioners with clear information on adverse medical necessity or clinical appropriateness determinations and the options should they disagree, including patient appeal rights and the availability of communication services for questions related to the UM process and provider peer-to-peer calls when a negative UM determination has been made.

Clinical Criteria

It is Renaissance's policy to develop and adopt objective and evidence-based written clinical criteria to be applied as guidelines by professional peer reviewers in the adjudication process. To remain consistent with current clinical evidence, these criteria are reviewed and updated as necessary, which occurs at a minimum on an annual basis.

The provision of dental advice and the clinical treatment of members is the sole responsibility of the dentist involved, and the Renaissance criteria are not intended to restrict a dentist from carrying out that responsibility. It is recognized that there may be atypical situations where a patient's clinical condition and specific needs do not coincide with traditional treatment modalities. In those cases, documentation of unusual circumstances can be submitted for a case-by-case review to determine if an exception is warranted.

Availability of Clinical Criteria

Clinical criteria are made available to practitioners through an open-access Renaissance website found at Renaissance - Clinical Criteria

General Policies and Guidelines

Dentists participating in the Renaissance CoverKids network are responsible for:

- Providing Renaissance Medicaid members with the same quality of clinical and non-clinical services provided to members who are not in the program, including referrals to appropriate specialists (within the Renaissance Medicaid network) when needed
- The development of an appropriate treatment plan consistent with the exam and diagnostic evidence
- Obtaining appropriate consent from the Member or appropriate parent or guardian prior to the provision of services
- Obtaining the appropriate authorization where necessary prior to the provision of services
- Submitting the required materials in support of pre-payment, post-service claims

Additional Policies and Guidelines

- Benefit payment for procedures determined not to be medically necessary or not meeting generally accepted standards of dental practice are not collectable from a patient by a participating dentist
- Dentists should not only consider the clinical condition of the teeth/oral structures involved, but the likely prognosis and chance of success before providing dental services (e.g., restorative services on teeth with poor periodontal support). Benefits for services on teeth with a poor prognosis are not collectable from the patient from a participating provider
- Procedures determined to have been performed solely for cosmetic change are not benefits of CoverKids and may be charged to a patient only if a private-pay agreement is obtained
- Charges made for unbundled procedures are not collectable from a patient by a participating dentist
- Unless extraordinary circumstances are validated, applicable time, frequency, and other limitations on benefit payment for specific services are established by the client dental plan contract

Quality Assurance

If there is evidence of a provider departure from the generally accepted standards of care or appropriate claims submission protocol, the Renaissance response is based on the degree of deviation. Verification of a minor deficiency may result in a Renaissance service contact to identify and mitigate the root cause of the problem, whereas, if there is evidence of a serious departure from applicable law, regulations and/or accepted standards of practice, which could result in harm to a patient, the case may be referred to the appropriate authorities of government agency. **Renaissance shall monitor the quality of services delivered and initiate corrective action where necessary to improve quality of care, in accordance with that level of dental care which is recognized as generally acceptable dental principles and/or the standards established by TennCare.**

Section 17

Fraud, Waste, and Abuse

What is Fraud, Waste, and Abuse?

Government-funded health care programs include an important element of fraud, waste, and abuse (FWA) prevention. The cooperation of dentists participating in the Renaissance CoverKids Tennessee network is a critical component in FWA prevention and reporting. The involvement of the provider and staff is a key factor in making sure that health care resources are appropriately directed to those who need the services.

- **Fraud** is the act of intentional misrepresentation of information for financial gain.
    - Example: Submitting false claims for dental services (e.g., filing claims for services that were not provided or for more complicated services than those that were provided).
- **Waste** is the act of extravagant, careless, or needless expenditure of health care benefits or services that result from deficient practices or decisions.
    - Example: Overutilization of services or misuse of resources.
- **Abuse**, in the context of this program, is the act of providing products or services that are inconsistent with accepted practices or that are clearly not reasonable or necessary.
    - Example: Billing for a non-covered service.

What is Renaissance Required to do?

Renaissance maintains a program integrity plan for continuous monitoring of potential FWA activity. Renaissance monitors and audits the activities of its dentists, members, employees, and vendors. Dentist activities that may be monitored and audited include, but are not limited to, both contract and regulatory compliance requirements. Renaissance may periodically request the completion of a questionnaire, submission of documentation, and/or attestation to applicable policy, procedure, and/or compliance requirements.

Renaissance may also perform in-office or desk audits, which may include the inspection of the facilities, systems, books, procedures, and/or records related to services provided. Disciplinary actions could result from these monitoring activities including, but not limited to, payment recoupment, education, corrective action plans, and/or contract termination. A corrective action plan is the written plan agreed upon between Renaissance and a participating dentist to correct any identified problem or meet acceptable levels of performance measures.

Examples of Fraud and/or Abuse include but are not limited to:

- Billing for a service not performed.
- Keeping overpayments.
- Billing for a non-covered service as a covered service.
- Misrepresenting dates of service, diagnosis, or procedures performed.
- Misrepresenting the location of a service.
- Misrepresenting the provider of a dental service.
- Billing twice for the same service.
- Billing for inappropriate or unnecessary services.
- Reporting a higher level of dental service than was actually performed.

- Falsifying patient names or other personally identifiable information to obtain payment for services.
- Deliberately failing to report the existence of additional dental benefits coverage and billing two or more carriers for the full amount.
- Taking kickbacks or bribes.
- Lying about education degrees and licenses.
- Misrepresenting oneself as another person in order to obtain dental benefits.

What to do with Suspected Fraud, Waste, or Abuse?

Renaissance has an FWA plan that complies with state and federal law. Renaissance is committed to identifying, investigating, sanctioning and prosecuting suspected FWA. If the provider suspects that a person who receives benefits, or that a dentist (or other health care provider) has committed FWA, the provider has the right and responsibility as a participating dentist to report it. All reports will remain confidential. Report any member dentist or other health care provider suspected of FWA directly to Renaissance by:

- Calling Renaissance anti-fraud hotline at 1-800-971-4139
- Completing and submitting the Fraud or Abuse Complaint Form which can be found at tenncare.renaissancebenefits.com
- Calling the TennCare Fraud Hotline at 1-833-687-9611
- Calling the Member Fraud Hotline at 1-800-433-3982

To report fraud, waste, or abuse, please provide a detailed account of the incident or service(s) by gathering as much information as possible.

When reporting about a health care provider, include the:

- Name, address, and phone number of the provider.
- Name and address of the facility (office, hospital, nursing home, home health agency, etc.).
- Government program identification number of the provider and facility (if available).
- Type of provider (physician, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened

When reporting about someone who receives benefits, include:

- The person’s name
- The person’s date of birth, Social Security number or case number (if available)
- The city where the person lives
- Specific details about the fraud, waste or abuse

Annual Required Fraud, Waste, and Abuse Prevention Training

Dentists participating in the CoverKids network are required to annually complete a training module on FWA prevention and detection, which is required by U.S. Centers for Medicare and Medicaid Services regulations. This module is combined with a training module on cultural competency. Once the training modules are completed, dentists need to confirm completion of the training by downloading and filling out a cultural competency and FWA training acknowledgment form. The training modules and form can be accessed through Renaissance's online annual provider training web page at: tenncare.renaissancebenefits.com.

Anti-Fraud Laws

In accordance with the federal Deficit Reduction Act (DRA), entities like Renaissance that receive or make payments totaling at least $5 million annually must comply with the Employee Education about False Claims Recovery requirements of the DRA. This means that, as a contractor doing business with Renaissance, Dental Practices and staff have the same obligation to report any actual or suspected violation of Medicaid funds either by fraud, waste, or abuse.

Dental Practices must have written policies that inform and educate staff, contractors, and agents about the following:

- The federal False Claims Act and state laws related to submitting false claims.
- How to detect and prevent FWA in the office.
- Employee protection rights as a whistleblower, that is, someone who reports instances of FWA to the government.

Pursuant to the federal False Claims Act (31 USC §§ 3729-3733), civil penalties and damages may be brought against anyone who:

- Knowingly submits, or causes another to submit, a false or fraudulent claim for payment.
- Knowingly makes, or causes to be made, a false statement or record in connection with a claim for payment.
- Knowingly retains an overpayment.

The False Claims Act defines "knowingly" to mean that a person has actual knowledge of information, acts in deliberate ignorance of the truth or falsity of the information, or acts in a reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The federal Fraud Civil Remedies Act (31 USC § 3802-3811) provides administrative remedies for false claims and false statements in connection with claims designated to federal agencies, including the U.S. Department of Health and Human Services.

Furthermore, it is unlawful to knowingly:

- Make, or cause to be made, a false or misleading statement or representation for use in obtaining reimbursement from the CoverKids program.
- Alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods or services for which a claim was submitted, or for which reimbursement was received from the CoverKids program.
- Solicit, offer, or receive any remuneration, other than any authorized cost-sharing expenses including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the CoverKids program.

Additional details about these laws, and Renaissance's policies and procedures for complying with the same,

can be found in Renaissance's anti-fraud laws policy, which are available upon request or online at: tenncare.renaissancebenefits.com

Compliance with Policies and Procedures

Renaissance requires participating providers to comply with all state and federal laws relating to CoverKids providers, as well as the Renaissance policies and procedures distributed and made available for reference. These policies and procedures include, but are not limited to, the following:

- Anti-fraud laws policy.
- Renaissance's code of conduct.
- Renaissance's program integrity plan.
- Other relevant Renaissance policies and procedures.

Participating providers agree to provide, upon request, immediate access to records, books and other documents as necessary for audits to Renaissance, the U.S. Department of Health and Human Services, the Tennessee Department of Medicaid and other state and/or federal governmental agencies with appropriate jurisdiction in connection with any activity involving the prevention, detection or reporting of fraud, waste, abuse and/or overpayments.

Section 18

Glossary – Key Terms and Definitions

This glossary includes definitions of terms found within this guide that are commonly used within dental benefit plans and publicly funded dental programs. Knowing what these terms mean will help to better understand the Medicaid programs administered by Renaissance.

Adverse benefit determination - A decision made by Renaissance to deny, reduce, terminate, refuse to provide, or refuse to pay dental benefits for which an individual filed a claim. An adverse benefit determination may be issued based on an adverse benefit decision, an adverse utilization management (UM) decision, or other reason(s). An adverse benefit determination affecting TennCare Dental Program Services or benefits (as defined in 42 C.F.R. § 438.400) shall mean, but it is not limited to, a delay, denial, reduction, suspension, or termination of TennCare Dental Program dental benefits, as well as any other act or omission of the TennCare Dental Program which impairs the quality, timeliness, or availability of such benefits. **See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01**

Appeal - A request to change an adverse benefit determination issued by Renaissance on an adjudicated claim. A member or authorized member representative, such as a provider, may file an appeal if they do not agree with a coverage or payment decision made. The appeal process shall be governed by Federal law at 42 C.F.R. § 438.100 et seq. TennCare Dental Program rules, regulations and any and all applicable court orders and consent decrees. **See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01**

An appeal can be filed if Renaissance:

- Denies a request for:
    - A dental service
    - A dental appliance, device, or prosthetic
- Reduces, limits, or denies coverage of:
    - A dental service
    - A dental appliance, device, or prosthetic
- Stop providing or paying for all or part of:
    - A dental service
    - A dental appliance, device, or prosthetic
- Does not provide timely dental administrative services

Benefits – Shall mean the health care package of services developed by the Bureau of TennCare Dental Programs and which define the covered services available to the TennCare Dental Program members. The Agreement focuses on Dental benefits although benefits provided by the Member's MCO are sometimes mentioned. **See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01**

Children's Health Insurance Program (CHIP) – A program funded by states and the federal government that provides health coverage to eligible children through both Medicaid and separate CHIP programs. Children eligible for CHIP are in families with incomes too high to qualify for Medicaid but too low to afford private coverage.

Claim - A request for payment under a dental benefit plan; a statement listing services rendered with the dates of services and itemization of costs. The completed request serves as the basis for payment of benefits.

Co-payment - An amount that a person covered under a dental plan is required to pay as the member's share of the cost for a dental service or supply.

Covered service(s) – The unique dental services and procedures reimbursable under plan or policy, as described in the contract between a dental plan sponsor and a dental plan administrator, which are subject to defined limitations (e.g., frequency and age limitations). **See also TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01**

CoverKids – See TennCare Medicaidhttps://www.tn.gov/tenncare

Date of Service (DOS) - The date that a service or services are rendered to a member.

Denial - An adverse benefit decision (exclusions and limitations) or adverse utilization management (UM) decision made by Renaissance not to provide benefit coverage for a dental service or procedure for which an individual submitted a claim.

Dental Office Toolkit™ (DOT) - Renaissance's free, HIPAA-compliant online portal that allows providers to sign in and confirm eligibility, check the status of claims, and more. This can be accessed at https://www.rendentalofficetoolkit.com.

Dental Practice - Includes one or more dentists who have a contractual agreement with Renaissance to participate in the Renaissance Tennessee CoverKids Network.

Diagnosis - A process carried out by a practitioner to identify a patient's dysfunction (e.g., disease, disorder, condition) toward which the diagnosing provider, or another provider, directs treatment.

Eligibility - To be eligible for CoverKids, one must be a resident of the state of Tennessee, a U.S. national, citizen, permanent resident, or legal alien, and in need of health care insurance assistance, whose financial situation would be characterized as low income or very low income.

Emergency Dental Care - Unscheduled dental services necessary to treat a condition in the mouth or face that occurs suddenly and requires immediate care in the dental office or emergency room, such as uncontrolled bleeding, severe spreading infection, severe debilitating pain, or severe traumatic injury to the mouth or face. **See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01**

Explanation of Benefits (EOB) - A notice sent detailing benefit coverage provided by the dental plan for dental services and procedures rendered. An EOB communicating an adverse benefit determination may also be referred to as a denial notice or denial notification.

Fee schedule - A listing of fees to pay providers for services rendered. As a participating provider, payment in full is the lesser of the applicable Renaissance CoverKids Network fee schedule or the fee submitted for covered services rendered.

Generally accepted standards of dental practice - Refers to rules or requirements for clinical practice that are commonly accepted as correct, i.e., they are regarded by the dental profession as generally accepted principles of patient management that establish norms for the reasonable and prudent dental health care practitioner. Standards of practice must be based on credible scientific evidence published in peer-reviewed medical or dental literature generally recognized by the relevant professional community, considering professional organization recommendations, expert opinions of health care providers practicing in the relevant clinical areas, and any other relevant factors.

Grievance - An expression of dissatisfaction from or on behalf of a member or dental service provider about any action taken by Renaissance or a dental service provider other than an adverse benefit determination. Grievances may include, but are not limited to, expressions of dissatisfaction about the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a dental service provider or employee, or failure to respect the members' rights, regardless of whether remedial action is requested. A

grievance is not used regarding a treatment decision or service that is not covered or denied (see “Appeal”). "Grievance" is synonymous with "complaint". The federal regulations have different requirements depending on whether the issue-at-hand involves (1) the enrollee's dispute of a DBM-proposed "adverse benefit determination" (appeal/request for State fair hearing) or (2) enrollee's expression of dissatisfaction with some aspect of the TennCare program, such as poor customer service from the provider's office (grievance/request to document enrollee's expression of dissatisfaction with the DBM, and attendant documentation by DBM of how the enrollee's grievance was handled by the internal DBM grievance process).

Medicaid - The federal medical assistance program that is described in Title XIX of the Social Security Act. Medicaid is administered at the state level and is income or resource-based.

Medical Necessity - Medically Necessary - Is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term “medically necessary,” as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare members. Implementation of the term “medically necessary” is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No member shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of “medically necessary” items or services, as defined either in the statute or in the TennCare Medical Necessity rule chapter at 1200-13-16.

To be medically necessary, a medical item or service must satisfy each of the following criteria: (a) It must be recommended by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member; (b) It must be required in order to diagnose or treat a member’s medical condition; (c) It must be safe and effective; (d) It must not be experimental or investigational; and (e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the member’s medical condition.

Determination of medical necessity is based on specific criteria and:

- Relate to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition.
- Are consistent with currently accepted standards of good dental practice, including defined criteria.
- Are the most cost-efficient service that can be provided without sacrificing effectiveness or access to care.
- Are not primarily for the convenience of the patient, family, or dental service provider.

Member - A person in a Medicaid dental plan administered by Renaissance. Also referred to as a patient. Member shall mean an individual eligible for and enrolled in the TennCare Program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the US Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act. **See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01**

National Provider Identifier (NPI) – A 10-digit number required by law for health care providers and organizations. There are two types:

- Type 1: Individual NPI – for health care providers, such as dentists.
- Type 2: Organizational NPI – for use by incorporated businesses, such as group practices, incorporated individuals and clinics.

National Committee for Quality Assurance (NCQA) - An independent 501c3 nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based

standards, measures, programs, and accreditation.

National Plan and Provider Enumeration System (NPPES): The National Plan and Provider Enumeration System assigns unique identifiers to healthcare providers and organizations to ensure efficient and accurate data exchange within the U.S. healthcare system.

Network - All participating providers who have a contract with Renaissance for the delivery of dental services to members who are enrolled in a dental plan administered by Renaissance. Participation in Renaissance's CoverKids Network is necessary to render services to members.

Participation Agreement - The document that defines the contractual rights and obligations between a provider and Renaissance for participation in the Renaissance network(s).

Participating Dentist - A dentist who has an agreement with Renaissance to participate in a Renaissance network.

Policies and Procedures (Operational) - A formal documented process adopted by the organization that describes the course of actions the organization will follow and the methods that will be carried out to achieve the policy objectives.

Post-Service Claim - Post-service claims arise when a member receives a dental service or procedure before filing the claim. Post-service claims may require a benefit decision (post-service benefit claim) or a Utilization Management (UM) decision (post-service UM claim). May also be referred to as a post-service request.

Post-Service Claim Appeal - An appeal of an adverse benefit determination that was issued on a post-service claim.

Pre-Payment Review (PPR) – A review of a claim and appropriate clinical documentation prior to reimbursement for service and therefore requiring the submission of supporting documentation when the claim is submitted.

Prior authorization (PA) - An assessment of a preservice claim to determine whether a proposed dental service or procedure is medically necessary or clinically appropriate for a particular patient. When prior authorization is required by a member's dental plan, post-service benefit payment for a service or procedure is conditioned on preservice prior authorization approval, as well as coverage by the member's dental plan. May also be referred to as a *prior approval* or *prior certification*.

Procedure (Clinical) - A planned process rendered by a practitioner or an individual working under the supervision of a practitioner that has the objective of contributing to a desired health effect through evaluation, prevention, or treatment of an oral or maxillofacial injury, illness, condition, or disease.

Processing Policies - Renaissance's policies and guidelines used in the adjudication of, prior authorizations and in-for-payment claims.

Protected Health Information (PHI) - Individually identifiable health information that is transmitted or maintained in any form or medium (electronic, oral, or paper) by a covered entity or its business associates, excluding certain educational and employment records.

Service (Clinical) - Any activity provided by a practitioner, or an individual working under the supervision of a practitioner, that relates to the evaluation, prevention, or treatment of an oral or maxillofacial injury, illness, condition, or disease.

Specialist - Refers to practitioners who limit their practice to specific services, including endodontics (root

canal treatment), pediatric dentistry (dentistry for children), periodontics (gum treatment), prosthodontics (bridges and dentures), and oral surgery.

Submitted Amount - The amount billed for a specific dental service or procedure.

Treatment - The provision of dental items or services based on the recommendation of a treating health care provider practicing within the scope of a dental license.

Urgent Preservice Claim - A preservice claim where the application of the standard time periods for making a nonurgent benefit decision or nonurgent UM decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, and/or subject the member to severe pain.

Urgent Care - Unscheduled dental services necessary to treat a sudden or ongoing problem in the mouth or face that is not severe enough to require immediate care in the emergency room or dental office but should be treated within a couple of days, such as minor to moderate dental pain, minor localized swelling, or a broken or lost tooth. Urgent dental care procedures are provided to control pain, treat infections, and provide treatment to prevent a visit to the emergency room or a dental problem from causing permanent damage to a patient's oral health, such as tooth loss.

Utilization Management (UM), UM Decision, and UM Notification - A system of policies and procedures for evaluating and determining medical necessity, clinical appropriateness and coverage for dental care services and procedures, as well as providing needed assistance to practitioners or members, in cooperation with other parties, to ensure the appropriate and efficient allocation of dental health care resources. Once the decision is made to provide benefit coverage for a dental service or procedure submitted on a claim, an electronic or written notice of the UM decision is sent to Renaissance members and practitioners in the form of an explanation of benefits statement. The UM decision may be favorable in providing benefit coverage to a member, or adverse in not providing benefit coverage. An adverse UM decision notification may be referred to as a notice of adverse benefit determination (NABD) or denial notice.

Utilization Review (UR) - Review by a licensed dentist peer reviewer performed to assess the medical necessity or clinical appropriateness of a dental service or procedure for the purpose make a utilization management decision to determine benefit coverage.

Section 19

Forms

Renaissance

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – **OR** – ☐ Request for Predetermination/Preauthorization

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, ZIP Code

PRIMARY SUBSCRIBER INFORMATION

4. Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

5. Date of Birth (MM/DD/CCYY) | 6. Gender | 7. Subscriber Identifier (ID#)

8. Plan/Group Number | 9. Employer Name

PATIENT INFORMATION

10. Relationship to Primary Subscriber (Check applicable box)
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

11. Student Status
☐ FTS ☐ PTS

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender | 15. Patient ID/Account # (Assigned by Dentist)

CARRIER NAME AND ADDRESS:

2. Renaissance
P.O. Box 1596
Indianapolis, IN 46206-1596
Payer ID TNC02

OTHER COVERAGE

16. Other Dental or Medical Coverage? ☐ No (Skip 17-23) ☐ Yes (Complete 16-23)

17. Subscriber Name (Last, First, Middle Initial, Suffix)

18. Date of Birth (MM/DD/CCYY) | 19. Gender | 20. Subscriber Identifier (ID#)

21. Plan/Group Number | 22. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

23. Other Carrier Name, Address, City, State, ZIP Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	30. Description	31. Fee
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

MISSING TEETH INFORMATION

33. (Place an 'X' on each missing tooth)

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

31a. Other Fee(s)

32. Total Fee

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature | Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature | Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99)
Radiograph(s) | Oral image(s) | Model(s)

40. Date Last SRP ____/____/____

41. Is Treatment for Orthodontics?
☐ No (Skip 42-43) ☐ Yes (Complete 42-43)

42. Date Appliance Placed (MM/DD/CCYY)

43. Months of Treatment Remaining

44. Replacement of Prostheses?
☐ No ☐ Yes (Complete 45)

45. Date Prior Placement (MM/DD/CCYY)

46. Treatment Resulting from (Check applicable box)
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

47. Date of Accident (MM/DD/CCYY)

48. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

49. Name, Address, City, State, ZIP Code

50. Corporate Entity NPI (Type 2) | 51. License Number | 52. TIN

53. Phone Number ( ) - | 53a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) | Date

55. Individual NPI (Type 1)
Locum Tenens Treating Dentist?

56. License Number

57. Address, City, State, ZIP Code

57a. Provider Specialty Code

58. Phone Number ( ) -

59. Treating Provider Specialty

Renaissance Claim Form 8/25

Renaissance.

Notice of non-covered services consent form

Your dental plan does not cover all services. Some services you or your health care provider feel are needed may not be covered. Renaissance will not pay for non-covered services. If you do choose to have one of the services, your health care provider can bill you.

Before signing this form:

- Read this notice and instructions to make an informed choice.
- Ask your health care provider any questions that you may have.
- **This form must be presented and signed prior to the services being rendered on the date treatment is performed.**

Provider: Print this form; keep one copy in member file, give one copy to member.

Member information

MEMBER LAST NAME	FIRST NAME	MI	MEMBER ID #	DATE OF BIRTH

Non-covered service/item-description (and code, if available)	
Reason(s) service/item is not covered by Medicaid	
Alternate covered service(s)/item(s)	
Cost of non-covered service/item	
Terms of payment	

Member signature—Read the statement below, check the box if you understand and agree, sign and date.

I want the non-covered service/item listed above. I understand that:

- The service or item is not covered by Medicaid and no payment will be made by Renaissance
- I will have to pay for the service listed above and all fees associated will be my responsibility
- A different service or item may be covered by Medicaid and I do not want that service or item
- The provider may have asked for authorization and the authorization was denied

SIGNATURE—MEMBER OR LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/RESPONSIBLE PARTY	DATE	LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/ RESPONSIBLE PARTY NAME (Please print)

Provider signature—**Providers:** As a participating provider in the Renaissance network who is treating a Medicaid member, I understand and acknowledge, in accordance with the terms of my contract, I am only permitted to bill Renaissance Medicaid members for non-covered services when members have agreed in writing, prior to the time services are rendered, to assume full financial responsibility for the non-covered services. I confirm and attest I have reviewed the dental services with the undersigned member or parent/guardian and that such services are not covered by Renaissance and have not been denied by on the basis of lack of medical necessity or my failure to comply with the terms and conditions of my contract or any applicable Renaissance policies. I attest I have offered the non-covered services, in good faith, to the undersigned member or parent/guardian based on my assessment of the undersigned member's needs and I have discussed the relevant health care services that Renaissance does cover that can safely and effectively treat the undersigned member's health condition.

PROVIDER NAME	NPI/UMPI	PROVIDER SIGNATURE	DATE

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Appendix A

Orthodontics

The following documentation is required to be submitted (see the Malocclusion Severity Assessment (MSA) form "Evaluation Form Instructions"). Any prior authorization request submitted without complete documentation will be disapproved due to the missing information. Note: All images and radiographs must be labeled with the patient's name, date of birth, and the date of exposure. The list of required clinical documentation required to properly adjudicate the claim may include:

- The completed MSA form (see below).
- A narrative of the handicapping malocclusion including any other supporting dental/medical information.
- The proposed treatment plan.
- Appropriate radiographs which may include:
    - Panoramic and other relevant intraoral images.
    - Traced lateral cephalometric image with the patient in centric occlusion and associated measurements.
    - Maxillary and mandibular occlusal images.
- Appropriate photographs including:
    - Extraoral facial frontal, left and right lateral views.
    - Intraoral views with the patient in centric occlusion showing anterior, left and right occlusal relationships.
    - Images of any soft tissue damage associated with the malocclusion.
    - Photographic images of articulated maxillary and mandibular models or three- dimensional scans of the same.

Requests from Renaissance for any additional information required for a proper evaluation of medical necessity.

If the case is approved, the provider will receive a prior authorization confirming approval. This authorization includes one Comprehensive treatment of the adolescent dentition and up top 23 periodic orthodontic treatment visits. Orthodontic retention, D8680, must be billed separately after completion of the case.

Providers may bill for one periodic treatment visit, D8670, per calendar month aligned with the delivery of services. The 23 months of adjustment are included under the procedure code D8080.

Any periodic treatment not performed will not be reimbursed. TennCare members must not be charged for missed appointment or broken brackets.

If the case is denied, the provider will receive an EOB indicating the denial. The member will also receive written notification of the denial. To receive reimbursement for records review in denied cases, the provider must submit a claim using D8660

The date of the service should reflect the date the treatment plan, radiograph, photographs and diagnostic models were completed by the provider.

Orthodontics

Malocclusion Severity Assessment

Summary of Instructions

Score: 2 points for each maxillary anterior tooth affected. 1 point for each mandibular incisor and all posterior teeth affected.

1. Missing teeth. Count the teeth; remaining roots of teeth are scored as a missing tooth.
2. Crowding. Score the points when there is not sufficient space to align a tooth without moving other teeth in the same arch.
3. Rotation. Score the points when one or both proximal surfaces are seen in anterior teeth, or all or part of the buccal or lingual surface in posterior teeth are turned to a proximal surface of an adjacent tooth. The space needed for tooth alignment is sufficient in rotated teeth for their proper alignment.
4. Spacing. Score teeth, not spacing. Score the points when:
5. Open spacing. One or both interproximal tooth surfaces and adjacent papilla are visible in an anterior tooth; both interproximal surfaces and papilla are visible in a posterior tooth.
6. Closed spacing. Space is not sufficient to permit eruption of a tooth that is partially eruption.
7. Overjet. Score the points when the mandibular incisors occlude on or over the maxillary mucosa in back of the maxillary incisors, and the mandibular incisor crowns show labial axial inclination.
8. Overbite. Score the points when the maxillary incisors occlude on or opposite labial gingival mucosa of the mandibular incisor teeth.
9. Cross-bite. Score the points when the maxillary incisors occlude lingual to mandibular incisors, and the posterior teeth occlude entirely out of occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.
10. Open-bite. Score the points when the teeth occlude above the opposing incisal edges and above the opposing occlusal surfaces of posterior teeth.
11. Mesiodistal deviations. Relate mandibular to opposing maxillary teeth by full cusp for molars; buccal cusps of premolars and canines occlude mesial or distal to accepted normal interdental area of maxillary premolars.

Instructions for using the "Malocclusion Severity Assessment Record"

Introduction

This record (not an examination) is intended to assess the severity of the malocclusion according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health and function. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment. Assessments can be made from casts or directly in the mouth. An additional assessment record form is provided for direct mouth assessment of mandibular function, facial asymmetry, and lower lip position.

Intra-Arch Deviations

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Malocclusion Severity Assessment Record." The scoring can be entered later.

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

      and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment.
      A tooth scored as rotated is not scored also as crowded.
   d. Spacing
   a. Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papilla of a tooth. Score the number of teeth affected (not the spaces).
   b. Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

A. Inter-Arch Deviations

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

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

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

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

c. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.
d. Open-bite refers to vertical interarch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion. Edge-to-edge occlusion is not assessed as open-bite.

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

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

Malocclusion Severity Assessment

Patient Name _____

ID# _____ Provider Name _____

INTRA-ARCH DEVIATION

Score Teeth Affected Only		Missing	Crowded	Rotated	Spacing Open	Spacing Closed	No.	Point Value	Score
Maxilla	Ant							X2	
	Post							X1	
Mandible	Ant							X1	
	Post							X1	
								Total Score	

Ant = Anterior teeth (4 incisors); Post = Posterior teeth = (Include canine, premolars and first molar). No. = number of teeth affected

INTER-ARCH DEVIATION

Anterior Segment

Score Maxillary Teeth Affected Only Except Overbite*	Overjet	Overbite	Crossbite	Openbite	No.	P.V.	Score
						X2	
						Total Score	

*Score maxillary or mandibular incisors. No. = number of teeth affected; P.V. = point value 2.

Posterior Segment

Score Teeth Affected Only	Related Mandibular to Maxillary Teeth				Score Affected Maxillary Teeth Only				No.	P.V.	Score
	Distal		Mesial		Crossbite		Openbite				
	Right	Left	Right	Left	Right	Left	Right	Left			
Canine											
1st Premolar											
2nd Premolar											
1st Molar											
										Total Score	
										Grand Total	

No. = number; P.V. = point value;

Orthodontic Continuation of Care

This benefit is available once in a lifetime and does not have a maximum dollar amount. Providers must submit the following form with any orthodontic service prior authorization requests for continued orthodontic services.

This form is located on the DOT at https://www.rendentalofficetoolkit.com

Renaissance Orthodontic Services Continuation of Care Form		
For the continuation of TennCare Children's State orthodontic benefits, Renaissance requires documentation of the previous carrier's determination of medical necessity, any current or previous provider supplied services, the related dates and dollar amounts involved.		
Patient Information		
Name (First/Last):	DOB:	SS or ID#:
Address:	City, State, Zip:	Area Code and Phone #:
Group Name:	Plan Type:	Other Information:
Provider Information		
Dentist Name:	Provider NPI #:	Office Location ID #:
Address:	City, State, Zip:	Area Code and Phone #:
Previous Dental Benefits Administrator Who Approved the Initial Orthodontic Services:		
Banding Date:	Reimbursement Rate Previously Approved:	
Amount Paid to Date for Services Prior to Renaissance:		$
Amount Owed for Dates of Service Prior to Renaissance:		$
Amount Expected for Future Orthodontic Services:		$
Number of Orthodontic Appointments/Adjustments Remaining:		
Previous Carrier/Administrator Required Information		
Existing TennCare Children's Managed Care Organization or State FFS Program Member: A copy of the original orthodontic medical necessity approval.		
Existing private pay or commercial insurance transfer: In addition to copies of the patient treatment records highlighting the status of treatment, copies of the original diagnostic clinical documentation including photographs, radiographs and scans of the orthodontic models.		

Provider Signature:	Date:

This form is located on the DOT at https://www.rendentalofficetoolkit.com

TennCare Dental Orthodontic Readiness Necessity Form

This form is required to be submitted with documentation as outlined (Orthodontic Treatment Criteria) of the TennCare Provider Office Reference Manual to determine if the patient qualifies for orthodontic treatment in the TennCare program. Failure to complete this form in its entirety may result in a denied request.

As a condition for coverage, orthodontic treatment must be proved medically necessary. Medical Necessity can be established upon:

- The substantiated presence of one of the three medical conditions listed below or a DentaQuest-scored Malocclusion Severity Assessment (MSA) result of 28 or higher. (Important note: An MSA score is never used to deny orthodontic treatment.)

Patient Information		
Name (First & Last):	Date of Birth:	SS or ID#:
Address:	City, State, Zip:	Area Code & Phone Number:
Referring DDS or Pediatric Dentist:	Address:	City and State:

1. **Tissue laceration from a deep impinging overbite.**
   - ☐ YES Along with this form, please submit intraoral photographs or study casts, which document the laceration.
   - ☐ NO

2. A **nutritional deficiency** has been diagnosed by a licensed physician, and the substantiated nutritional deficiency cannot be corrected without orthodontic treatment.
   - ☐ YES Along with this form, please submit supporting documentation from the physician who diagnosed or attempted to treat patient's nutritional deficiency.
   - ☐ NO
   - ☐ DON'T KNOW

3. **Speech pathology** has been diagnosed by a licensed and certified Provider, and the substantiated speech pathology cannot be corrected without orthodontic treatment.
   - ☐ YES Along with this form, please submit supporting documentation from the patient's speech pathologist.
   - ☐ NO
   - ☐ DON'T KNOW

I certify, by my signature, that all responses on this form are true and I agree with the following statements:

1. I have consulted with the referring general dentist or pediatric dentist and the patient has completed all restorative treatment necessary to begin orthodontic treatment.
2. I have personally examined the patient and the patient's oral hygiene and periodontal condition are within acceptable limits for orthodontic treatment.
3. I agree to submit my complete orthodontic record and treatment notes on the patient within 3 days of a request made by DentaQuest or TennCare, if denials of authorization by DentaQuest results in an appeal or anytime such records are requested by DentaQuest or TennCare.

Orthodontist's signature _____

Orthodontist's name _____

Street Address _____

City_____**State** _____**Date** _____

OrthoCAD Submission Form

Date:_____

Patient Information		
Name (First & Last)	Date of Birth:	SS or ID#
Address:	City, State, Zip	Area code & Phone number:
Group Name:	Plan Type:	

Provider Information		
Dentist Name:	Provider NPI #	Location ID #
Address:	City, State, Zip	Area code & Phone number:

Treatment Requested

Code:	Description of request:

Appendix B

Sedation and General Anesthesia

When submitting for covered services related to parenteral sedation or general anesthesia, the provider, in addition to the supporting clinical documentation (radiographs, patient treatment records, treatment plan, medical referrals/records), must complete the following attestation form in support of the medical necessity for the services. To complete submission, please refer to the following checklist.

Checklist for Sedation/General Anesthesia Authorization	
Written narrative detailing type of anesthesia to be used	☐
Clinical narrative of medical necessity	☐
Recent radiographs (unless unable to obtain)	☐
Definitive diagnosis and detailed treatment plan	☐
Referring dentist reports if applicable	☐
ASA physical status classification	☐
Completed Hospital Readiness Form (if applicable)	☐

This form is located on the DOT at https://www.rendentalofficetoolkit.com

TennCare Inpatient and Outpatient Hospital Readiness Pre-Admission Form

This form is required to be submitted with documentation as outlined in Section 10, Clinical Criteria for Adjunct General Services

Patient Name: _____
Patient ID: _____
Patient Address: _____
_____

Date: _____

a. **I certify that I have examined this patient**
   A.Yes☐ NoDate of Exam _____

b. **There is pathology or injury requiring extensive dental treatment (restorative or surgical)**
   A.Yes☐ No

c. **I certify that I have attempted to treat this patient in my office**
   A.Yes☐ NoDate _____

d. **If a general dentist, I have attempted to refer this patient to a dental specialist (oral surgeon or pediatric dentist)**
   A.Yes☐ No

If no, why was a referral not made?

_____
_____

e. **I have attempted to manage the member with Silver Diamine Fluoride in the office (general and pediatric dentists)**
   A.Yes☐ No

f. **I have offered Silver Diamine Fluoride treatment to the member in the office as an alternative to treatment under general anesthesia in a medical facility (general and pediatric dentists)**
   A.Yes☐ No

g. If answer to "E" or "F" is no, please explain why SDF has not been used (general and pediatric dentists

_____
_____
_____

h. Were radiographs taken to determine diagnosis?

A.Yes☐ No

i. I have submitted all the documentation required for prior authorization as described in the TennCare Office Reference Manual

A.Yes☐ No

j. If answer to "H" or "I" is no, please explain why the documentation is not being submitted:

_____
_____
_____

Renaissance reserves the right to request a second opinion for any inpatient/ outpatient hospital or ambulatory surgery center request.

I Certify That the Above Information Is Correct

Name of Provider: _____
Provider Signature: _____
Date: _____

Submit to

Renaissance – TennCare
Attn: Pre-Authorizations
P.O. Box 2720
Farmington Hills, MI 48333-2720

Appendix C

Revision History

Version:	Date:	Reason for Revisions:	Completed By:
1.0	Policies and Procedures: 11.26.2024 Published:	New document	Renaissance

Appendix D

Notice of Nondiscrimination

Notice of Nondiscrimination

Protections

Discrimination is against the law. TennCare obeys federal and state civil rights laws. We don't discriminate on the basis of race, color, national origin including limited English proficiency and primary language, age, disability, or sex. TennCare doesn't exclude people or treat them less favorably (differently) because of race, color, national origin, age, disability, or sex.

Help You Can Get

Disability Related Help

TennCare provides people with disabilities reasonable modifications. Reasonable modifications are reasonable requests for changes to a rule, policy, practice, or service to help a person with a disability related need. TennCare has free auxiliary aids and services to communicate effectively with you. Auxiliary aids and services are types of help like:

- Qualified sign language interpreters and
- Written information in large print, audio, accessible electronic formats, letter reading, Braille, or other formats.

Language Help

TennCare offers free language help to people whose primary language is not English like:

- Qualified interpreters and
- Translations - Information written in other languages.

Who to Contact

TennCare Connect

Do you need help like applying or renewing your TennCare, need auxiliary aids and services, or language help to talk with TennCare? Call TennCare Connect for free at 855-259-0701.

TennCare's Office of Civil Rights Compliance

- Reasonable Modifications
  If you need reasonable modifications, contact TennCare's Office of Civil Rights Compliance ("OCRC").
- Grievance/Complaint
  If you believe that TennCare failed to provide these services, or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a

grievance/complaint with TennCare's OCRC by email at HCFA.fairtreatment@tn.gov, mail at 310 Great Circle Road Floor 3W, Nashville, TN 37243, OCRC's website at https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html, or calling 615-507-6474 (TRS 711). If you need help filing a grievance call TennCare Connect for free at 855-259-0701.

More Information

You can find forms, policies and more information about civil rights and help like for food or other things on OCRC's website: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.