The HDS Procedure Code Guidelines (PCG) provides a framework of rules and policies for benefit determination. Please note that specific group contract provisions, limitations, and exclusions take precedence over these guidelines. Certain contractual items (e.g. time limits, frequency of procedure, age limits, etc.) can vary among groups, therefore they have not all been listed.

For instructions on using HDS Online and DenTel to obtain group benefit information and limits and/or patient's eligibility verification for specific benefits, please contact HDS Professional Relations.

A. General Guidelines

Where stated**,** general guidelines precede the category of the procedure and are related to each procedure code listed in the category. Terms of the group contracts may vary. Group contracts will take precedence over the HDS Procedure Code Guidelines.

B. PCG Submission Requirements

A "submission requirement" is additional information that is required in order to make a benefit determination**.** The columns for these requirements are: "Valid Tooth/Quad/Arch/Surface" and "Submission Requirements". The following details the expectation for the items listed in these columns:

1. **Valid Tooth/Quad/Arch/Surface** column: Specifies the tooth number, quadrant, arch or surface applicable to the procedure. When a range of teeth or multiple teeth are indicated for one procedure, include all applicable tooth numbers in a narrative or tooth chart.

2. **Submission Requirements** column: Attached information that is required to process the claim. A procedure submitted without the required attachment is not billable to the patient and is not payable by HDS. When mailing attachments for electronically submitted claims, indicate the claim number and send to the attention of: "Electronic Claims". If attachments are not received within 5 days of the electronic claim submission, services are not billable to the patient. The following defines each type of" submission requirement":

    a. **X-ray Images:** X-ray image submissions must be of diagnostic quality, free of positional errors, radiographic artifacts, and should have adequate image contrast and resolution.

    When reviewing the submission requirements in this Procedure Code Guideline manual, a pre-operative x-ray image is always required unless otherwise noted. Post-operative X-ray images are required for certain procedures and are specifically noted under Submission Requirements.

        1) Original X-ray images are considered part of the patient's clinical record and should be retained by the dentist. HDS assumes that duplicate copies of X-ray images are submitted for claims processing purposes.

        2) X-ray image submissions should be mounted, dated and identified with the patient's name, tooth number/area, dentist's name and address. Duplicated X-ray images must be labeled as "left" and "right." When submitting a manual claim, secure the X-ray image to the claim form.

        3) When scanning X-ray film images using HDS Online, the original X-ray film must be placed with the raised dot faced down on the image scanner. Incorrectly scanned X-ray images will delay review and payment of the submitted claim.

        4) When submitting claims with X-ray image attachments, dental offices should keep the original X-ray for their records and submit copies of X-ray images along with the claim to HDS. Original X-ray images will not be returned unless the following are provided to HDS:

i. The X-ray image must be labeled, "**Return X-ray**."
ii. A self-addressed, stamped envelope must accompany **each claim with an X-ray image** requesting to be returned. Multiple X-ray image claims with only one envelope will **NOT** be returned. An X-ray image labeled "Return X-ray" with no envelope provided will be discarded.

5) Intraoral photographic images are not accepted in lieu of X-ray images, however they can be submitted to augment X-ray images and demonstrate areas not clearly depicted on an X-ray image.

b. **Narrative**: The corresponding guidelines may state the criteria to include in the narrative. When narrative criteria are not specified in the guidelines, please include the following:

1) Diagnosis
Example: Acute periapical abscess #30 with fluctuant swelling on buccal

2) Determination of Treatment (Brief description of the procedure performed)
Example: I & D of acute periapical abscess

3) Procedure or Treatment Performed (Steps of surgical procedure, to include location and instrument used)
Example: Incision on buccal of #30 with #15 scalpel, drain placed and secured with one 3-0 black silk suture.

c. **Periodontal Chart**: The periodontal chart is expected to indicate:

- Patient's name
- Date of periodontal probing examination
- 6-point pocket depth measurements on all teeth
- Areas of clinical attachment loss
- Probing sites that exhibit bleeding

For benefit purposes, a current periodontal charting (recorded **less than 6 months prior to the date of service**) must be submitted.

d. **Operative Report**: The operative report should indicate diagnosis, operation, site of procedure and instrument(s) used. For surgical procedures, an operative report may be submitted in lieu of a narrative.

e. **Pathology Report**: The report from the pathology laboratory where the specimen was submitted.

f. **Other Carrier Medical Statement**: Certain surgical procedures may be a benefit of the patient's medical plan. If the patient has medical coverage, an "other carrier medical statement" of payment indicating the "primary payment" is required. If the medical carrier is an HMO, the other carrier medical statement is not required. Instead, note the name of the HMO in the comment section of the claim.

g. **Other Carrier Statement of Benefits:** The report from a non-HDS dental insurance carrier that summarizes how reimbursement was determined. If HDS is secondary, services are not billable to the patient until the amount of the primary carrier's benefit is received.

h. **Tooth Chart**: The tooth chart must be current, dated and include the patient's name. Missing teeth should
be indicated on the tooth chart. Tooth charting on manual claim forms is accepted as well as missing teeth numbers entered in the claim narrative on both manual and electronically

submitted claims.

i. **Laboratory Invoice**: A detailed invoice from the dental laboratory listing services and charges. A dental laboratory prescription does not meet the laboratory invoice submission requirement.

C. Reduced Attachment Program (RAP)

RAP was developed to streamline the claims submission process and reduce the volume of submitted attachments (i.e. x-rays or narratives) for HDS participating dentists.

The HDS Procedure Code Guidelines provide a base level of submission requirements for dental procedure codes. With RAP, HDS may waive these requirements for certain select procedure codes.

For electronic claims, the HDS computer system uses a sampling algorithm based on a dentist's historical practice patterns and the disposition of previously adjudicated claims. It is normal for claims submitted via the HDS website or through an electronic dental practice management system to be approved without an attachment. However, HDS may still periodically require attachments.

For hardcopy claims, dental offices must comply with all submission requirements. However, based on historical claim adjudication history, HDS may waive submission requirements for specific dentists, clinical procedures, and time periods.

D. Additional Information

HDS may request additional information (e.g. X-ray images, clinical photographs, clinical notes, periodontal chart, narrative, itemized dental laboratory invoice, pathology reports, study models, materials, chair time, diagrams, etc.) to clarify a specific service.

E. By Report

"By Report" procedure codes require the review of documentation before the allowed benefit can be determined. Submitted documentation should include the following where applicable:

- Clinical diagnosis
- Narrative (description of service, materials used, tooth numbers, surfaces, quadrants or area of mouth, chair time)
- Itemized dental laboratory invoice
- Pathology reports
- X-ray images
- Any other supporting documentation

F. Definitions

The following are definitions of frequently used HDS terms:

1. **Alternate Benefit** – In cases where alternate methods of treatment exist, benefits are provided for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of the patient's coverage. The dentist and the patient should decide on the course of treatment. If the treatment rendered is other than the one benefited, the HDS approved fee will be the submitted charge.

2. **Covered Benefit** – Any procedure for which HDS has established a Maximum Plan Allowance

3. **Coordination of Benefits (COB) –** Occurs when a patient/subscriber has dental coverage under HDS and another non-HDS carrier.

4. **Deny** – When a procedure is denied, it is not payable by HDS but it is collectable from the patient up to the approved amount. If the fee is not payable because of a deductible, annual maximum, waiting period or frequency limitation, the dentist may bill up to the Maximum Plan Allowance. When a procedure is not a covered benefit and is denied, the dentist may bill up to the submitted fee.

5. **Not billable to the patient (NBP)**– When the fee for a procedure is not billable to the patient, it is not payable by HDS and is not collectable from the patient.

6. **Dual Coverage** – Occurs when a patient/subscriber is covered under two or more HDS dental plans.

7. **In Conjunction with** – "In conjunction with" means as part of another procedure or course of treatment including, but not limited to, being rendered on the same day.

8. **Maximum Plan Allowance** – The maximum eligible amount for payment to a Member Dentist for a Covered Benefit. The Maximum Plan Allowance is determined by HDS as to each Covered Benefit.

9. **Shaded fields** – Fields shaded in gray indicate procedures that may be benefited as an alternate benefit. In some cases a procedure may be a regular benefit for some groups and an alternate benefit for others. Specific group benefits can be obtained on HDS Online or HDS Fax Back.

10. **Same Dentist** – The definition of "same dentist" includes providers that generally practice with the same payee.

G. Abbreviations

1. **Tooth numbers**
   - Primary teeth: A - T
   - Permanent teeth: 1 - 32
   - Supernumerary teeth:
     - Add 50 to the permanent tooth number (e.g.: #14 will be #64)
     - Add 'S' to primary tooth number (e.g.: C will be CS)

2. **Quadrants**
   - Upper Left: UL
   - Upper Right: UR
   - Lower Left: LL
   - Lower Right: LR

3. **Arches**
   - Upper Arch: UA
   - Lower Arch: LA

4. **Tooth Surface**
   - D - distal
   - F - facial (labial or buccal)
   - I - incisal
   - L - lingual
   - M - mesial
   - O - occlusal

H. HDS Policy for Cosmetic and Other Patient-Elected Services

Services elected by the patient for cosmetic procedures or for restoring/altering vertical dimension (VDO) are not covered benefits. The dentist must explain that the services will be denied.

1. The dental office should submit a preauthorization for these services with a narrative stating that the patient has elected the services for cosmetic reasons or for altering VDO. Both the patient and the dental office will then receive a report indicating if the services are covered by HDS or processed as non-benefits.

2. For services that are not benefited by HDS, the dental office, prior to rendering the service, should obtain the patient's written consent on a form that clearly discloses to the patient the extra financial charge that will be incurred.

3. If a preauthorization is not submitted, the dental office should submit a claim with an accompanying narrative that states "services elected by patient for cosmetic reasons".

4. The patient's Explanation of Benefits and the dentist's Remittance Advice will indicate the patient's responsibility for the cost of the service.

HDS reserves the right to review these services for compliance reasons. If it is deemed that services were performed due to dental necessity, the HDS plan benefit will take precedence over cosmetic reasons.

I. Informed Consent

Informed consent is more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and dentist that results in the patient authorization or agreement to undergo a specific dental treatment. A dentist must provide the patient the information that a reasonable patient needs in order to make an informed and intelligent decision regarding a proposed treatment. It should include the significant risks, benefits, and alternatives to the proposed treatment along with the option of no treatment. In general, a dentist must obtain informed consent from the patient prior to all surgeries, invasive treatments and treatments that have a risk of serious complications (whether due to the particulars of the patient, the nature of the treatment, or otherwise).

1. **A Dentist Must Disclose the Following to Obtain Informed Consent**

   - The condition being treated
   - The nature and character of the proposed treatment or procedure
   - The anticipated results of the proposed treatment
   - The recognized possible alternative forms of treatment for the condition, including no treatment
   - The recognized serious possible risks, complications, and anticipated benefits involved in the proposed treatment and in possible alternative treatments

2. **Method and Timing of Disclosures**

   - Disclosures can be made orally, in writing, or by use of brochures or other materials, but must be in a manner that the patient can be reasonably expected to understand with an opportunity for the patient to ask questions.
   - A signed consent form, by itself, does not suffice to show a proper informed consent. Rather, the process used must be effective in obtaining a true informed consent. It is the dentist's duty, not the patient's duty, to ensure that there is informed consent.
   - It is highly recommended that the dentist also inform the patient of the proposed services that are covered by the patient's insurance and which are not, to avoid misunderstanding and payment disputes after the services are performed.

J. Administration

1. **Timely submission of claims** – Claims must be received for HDS Commercial plans with all required documents no later than 12 months from the date of service. If the claim is received after 12 months from the date of service, the dentist by contract cannot charge the patient a copayment and/or amounts HDS does not pay. A denial exception can be made after 12 months past the date of service only when the patient fails to communicate his/her coverage to the dentist. Note: claim submission deadlines may vary among Delta Dental Plans; please contact the specific Delta Dental Plan for more information.

   Some Government programs (e.g., Medicare Advantage) may have a 180 day claim submission deadline for Medicare network providers. Claims received after 180 days will not be billable to the patient.

2. **Appeals –**HDS must receive the appeal within one year from the date of the action, omission, or decision being contested. If the appeal concerns a benefit coverage or payment dispute, HDS must receive the appeal within one year from the date of the explanation of benefits (EOB) in which HDS first informed the enrollee of the denial or limitation of a claim for benefits. Requests that do not comply with the requirements of the appeals process will not be recognized or treated as an appeal by HDS. All information in support of the treatment should be included with the request. If no new information is provided, no further appeals will be considered.

   Some Government programs (e.g., Medicare Advantage) may have a 120 calendar day appeal filing deadline or may specify a period from the day that the provider receives the remittance advice.

3. **Eligibility Guarantee –** HDS offers an eligibility guarantee as part of our commitment to provide a high level of service to our participating dentists and to guarantee payment of covered services. Inaccuracies in eligibility may occur when HDS is not notified in a timely manner that a patient's status has changed. In these cases, the eligibility guarantee will ensure payment of covered services if the following conditions are met:

   - Eligibility verification must be performed on the date of service with documentation either from HDS Online or DenTel. Calls to Customer Service are not applicable for the Eligibility Guarantee.
   - If, on the date of service, eligibility was verified for more than one HDS plan, but at the time the claim processed:
     - Two or more coverages are active- Claim will process under the active coverages.
     - Only one coverage is active - Claim will process under the active coverage only.
     - No coverage is active - Claim will process under the former primary plan only.
   - Eligibility Guarantee does not apply when Other Carrier plan coverage exists on the date of service.
   - Only eligibility is subject to this guarantee. Product maximums, frequencies and other processing criteria will be subject to HDS claims adjudication.
   - Group contracts may have specific provisions that govern claims submission timelines and/or payment restrictions upon termination. In these special situations, the Eligibility Guarantee may not apply.

4. **Preauthorization –** Provided upon request and recommended for major services and treatment plans, the preauthorization gives an estimated preauthorized benefit amount of how much a proposed treatment plan will be covered under a patient's benefit plan and what the patient's out-of-pocket cost will be. A preauthorization reserves the HDS payment amount against the patient's plan maximum for up to one year from the processing date. Actual benefits are subject to plan benefits, plan maximum, fee schedules and eligibility status on the date of service.

5. **Continuation Policy –** HDS requires restorations and other qualified multi-stage services to be submitted using the insertion or completion date. If the conditions listed below are met, HDS will benefit the service even though the patient no longer has coverage.

    - Preparation was completed prior to the patient's termination date.
    - Restoration insertion or service completion date is within 30 days of patient's termination date.
    - Patient has no current coverage with another HDS plan or other carrier during the 30 days after termination.
    - Orthodontic procedures do not qualify for the continuation policy.

6. **Group Contract Provisions –** HDS may negotiate special time limitations or benefit coverages with individual employer groups. Those special provisions override the Procedure Code Guidelines and will be noted in the group's benefit description. When determining plan benefits, HDS considers previous restorative, endodontic, periodontic, prosthodontic, oral surgery and orthodontic services performed within the applicable time limitations, including prior services performed under a different group contract.

7. **Treatment limitations –** If an HDS Plan limits the number of times a particular benefit (e.g. oral prophylaxis) is available annually, that limit will apply even if an Eligible Person is covered by two or more HDS dental plans. The Eligible Person is not entitled to that Benefit more frequently than permitted by the most generous HDS Plan.

8. **Medicaid and Medicare** –Specific sections throughout these Guidelines refer to Government Program benefits for "Supplemental Medicaid" and "Medicare".

    The "Supplemental Medicaid" plan is for adult Medicaid recipients who are also covered under the HDS Supplemental Medicaid Plan through a Managed Care Organization (MCO). If you treat a patient covered under this plan and have not joined the HDS Supplemental Medicaid provider network, services for the patient will be denied. **NOTE: This is not the State of Hawaii's Med-QUEST program** administered by HDS (i.e. HDS Medicaid) which covers children and emergent dental services only for adults.

    The "Medicare" plan is for eligible recipients who are covered under the HDS Medicare Advantage Plan through a Medicare Advantage Organization (MAO). If you treat a patient covered under this plan and have not joined the HDS Medicare Advantage provider network, services for the patient will be denied.

9. **Autorecovery/Overpayment** –When HDS makes an overpayment to a participating dentist, and the dentist does not promptly send an explanation and refund back to HDS, the overpayment is generally recovered by automatic deduction (autodeduction).

K. Office Reviews and Fraud and Abuse

HDS periodically conducts office reviews of participating dentists as a contractual obligation to employer groups and to ensure that the participating dentists are in compliance with HDS Member Dentist contract documents. These reviews are conducted to verify that services were rendered as billed to HDS, ensure HDS patients were charged appropriately and to provide opportunities to discuss proper claims submission procedures. A dentist may be selected at random for an office review or if there is a pattern of unusual claims submission, a history of patient complaints to HDS or unusually high utilization when compared to his/her peers. Examples of fraudulent activities are listed below:

- Misrepresentation of services
- Billing for services not rendered

- Falsifying dates of service
- Failing to disclose coordination of benefits
- Waiving patient copayments
- Altering records for the purpose of enhancing billing
- Unbundling of claims
- Unlicensed personnel performing clinical services
- Upcoding of services

L. The Remittance Advice Report

HDS provides a weekly Remittance Advice report (RA) that is available on HDS Online. Below are the definitions of the most pertinent items:

1. **Approved Amount –** Your total reimbursement per procedure is limited to the Approved Amount.

   - For covered benefits, your Approved Amount will be the lower of your Submitted Amount, or the HDS Maximum Plan Allowance for the respective procedure code.
   - For most Alternate Benefits, you may charge the HDS patient up to your Submitted Amount. Accordingly, for most Alternate Benefits, the Approved Amount is equal to your Submitted Amount.
   - For all non-covered benefits, the Approved Amount is equal to your Submitted Amount.

2. **Allowed Amount –** The HDS co-payment percentage is applied to the Allowed Amount to determine the benefit. Most of the time, the Allowed Amount will be equal to the Approved Amount. There are three occasions when the Allowed Amount is not the same as the Approved Amount:

   - Non-covered procedures are submitted
   - An Alternate Benefit is involved
   - A Deductible applies

   For more information regarding these exceptions, please contact the HDS Customer Service department.

3. **Patient Portion –** HDS determines the patient portion by calculating the Approved Amount less the HDS payment and any Other Carrier payment.

4. **Deductibles –** When a patient's plan includes a Deductible, the Allowed Amount is reduced by the Deductible amount. The benefit percentage is then applied to this Allowed Amount to determine the HDS payment and patient share amounts.

   Deductible example using a Covered Benefit:

   - Approved Amount = Covered Benefit Maximum Plan Allowance = $100
   - Benefit Percentage = 80%
   - Deductible = $25
     1) Subtract the Deductible from the Maximum Plan Allowance to arrive at the Allowed Amount for benefit calculations.
        - [$100 MPA] — [$25 Deductible] = $75 Allowed Amount

     2) Determine the HDS Payment by multiplying the Allowed Amount by the Benefit Percentage for the respective procedure.
        - [$75 Allowed Amount] x [80% Benefit Percentage] = $60 HDS Payment

3) Calculate the Patient Share by subtracting the HDS Payment from the Approved Amount.
   - [$100 Approved Amount] — [$60 HDS Payment] = $40 Patient Share

5. **Explanation Codes –** Sometimes the terms Denied or Not Billable to the Patient will appear in the explanation. For clarification, when a service is Denied, HDS will not pay for the procedure and the patient is fully responsible for the Approved Amount. If a procedure is not billable to the patient, HDS will not pay for the procedure and the office is not permitted to collect any amount from the patient for that procedure.