Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna℠

Dental Office Guide

www.aetnadental.com

Call our Dentist Contracting Hotline if you need assistance with your contract or this guide.
1-800-776-0537

Call the National Dentist Line to obtain eligibility or answers to claims questions.
1-800-451-7715

Preferred Provider Organization (PPO)
Participating Dental Network (PDN)
Aetna Voluntary Dental Plan
Exclusive Provider Plan (EPP)
Vital Savings by Aetna℠
Aetna Dental Access®
Aetna Dental® Administrators

23.05.803.1B (9/12) Revised 10/15/2024

Aetna Dental
Preferred Dental Organization
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Dental Office Guide

The purpose of this *Dental Office Guide* is to provide you with an explanation of certain plan administrative procedures, plan provisions and your role as a participating dentist. Note that certain procedures may vary, depending on individual state regulatory requirements. Aetna recognizes the vital role the dental office plays in delivering a successful dental plan. We appreciate your participation and look forward to a long and mutually beneficial relationship. Please read this *Dental Office Guide* carefully. Your participating dentist agreement requires you to comply with Aetna policies and procedures, including those contained in this manual.

Note: The relationship between Aetna and participating dentists is that of an independent contractor. None of the provisions of this *Dental Office Guide* are intended to create, or to be construed as creating, any agency, partnership, joint venture and/or employee-employer relationships. All member care and related decisions are the sole responsibility of the dentist. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Aetna reserves the right to add, delete or change the policies and procedures described in this *Dental Office Guide* at any time.

We hope this information helps you in working with us and providing care to our members.

Important note as you review this guide: In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN).

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Quick facts

National Dentist Line
1-800-451-7715

Call us if you have a question about:

- Claims
- Member eligibility
- Fee schedule

The Aetna Voice Advantage® telephone self-service system is available 24 hours a day, 7 days a week, without a wait.

Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Dentist Contracting Hotline
1-800-776-0537

This is a dedicated Dentist Contracting Hotline.

Representatives are always available Monday through Friday, 8 a.m. to 5 p.m. (ET):

This phone number is dedicated to your use. Please do not give your patients the Dentist Contracting Hotline number; this causes unnecessary delays in answering your question(s).

NOTE: See **page 8** for instructions on calling for **eligibility information**.

California Language Assistance Program

Use our free interpretation service

You must use our Language Assistance Program (LAP) when providing care to non-English-speaking Aetna members in your office. There is no charge to your office for this interpretation service. The LAP applies to Aetna participating dentists in California only.

The toll-free telephone number to reach an interpreter is **1-800-525-3148**. This number bypasses our Dental Service Center and connects directly to qualified interpreters.

Our California members can also request interpretation services from our LAP. Members can contact our LAP to ask general questions, to file a grievance or to obtain a grievance form by calling the Member Services phone number.

Health plans and insurers were required to establish a Language Assistance Program under CA SB 853, which was passed in 2003. These regulations also require us to inform contracted dentists about certain aspects of our program.

How to contact state regulators

If you have questions about this state program, you may contact the following numbers:

- For traditional (PPO) plans, call the CA Department of Insurance Hotline at **1-800-927-4357**.
- For DMO plans, call the CA Department of Managed Health Care Help Center at **1-888-466-2219 (TDD: 1-877-688-9891).**

Plan design

PPO/PDN plan features

Plan members **do not all have the same coverage**. Plan design and dental coverage can vary among plan sponsors, and services that are covered by some plans may not be covered by others.

However, the fundamental features of Aetna Dental PPO/PDN plans are similar to traditional fee-for-service indemnity plans and include member and family deductibles, coinsurance rates that may vary by type of procedure (for example, diagnostic procedures versus restorative versus prosthetic), contractual limitations and exclusions, and annual and lifetime limitations or maximums. Some plans also include "alternate benefit provisions."

Plan design features may also include incentives that encourage members to use participating dentists. These incentives may include lower deductibles, lower levels of coinsurance, lower out-of-pocket costs and higher plan maximums when receiving care from participating dentists. Eligible PPO/PDN members are responsible for the cost of services that are not covered.

We encourage you to take advantage of applicable pretreatment estimate procedures and predetermine the member's benefits (as described later in this guide). This step helps eliminate most misunderstandings regarding coverage and assists members in budgeting for the out-of-pocket expenses that will be paid directly to you.

Services that are commonly not covered in Aetna's PPO/PDN plans include:

- Services not medically necessary or not customarily performed for an existing condition
- Services that are covered in whole or in part under any other dental or medical plan or another plan of group benefits
- Treatment performed by anyone other than a licensed dentist or licensed dental hygienist who is supervised by a dentist
- Services or supplies considered cosmetic in nature (including facings on molar crowns and pontics)
- Replacement of lost, missing or stolen appliances
- Services or supplies for orthodontic treatment, except when specifically provided in the plan
- Services/appliances/supplies for the purpose of splinting, altering vertical dimension, restoring occlusion, or correcting attrition, abrasion, or erosion
- Services for which frequency limitations apply (for example, prophylaxis, bitewing radiographs, examinations, replacement of crowns and prosthetics)
- Services to replace teeth missing and not replaced prior to the effective date of the plan, including congenitally missing teeth, as well as those removed by a dentist

EPP plan features

The EPP uses the same fee schedule and claims submission processes as the Aetna PPO/PDN. Members with ID cards that say "EPP" should be billed in accordance with the PPO/PDN fee schedule.

Vital Savings by Aetna® features

Aetna offers a dental discount program called Vital Savings by Aetna. This program enables participants to receive care in your office at the same rate as the rates listed on your negotiated PPO fee schedule.

It is important to note that this is not an insurance plan. Participants pay you 100 percent of your negotiated rate at the time of service. There are no claims to submit or forms to fill out. No benefits are payable through this program, and Aetna will not compensate you for services rendered. To verify a participant's eligibility, you can call Aetna at the number listed on the participant's ID card and access Aetna Voice Advantage (our 24-hour self-service telephone systems) or talk with a Member Services representative. We recommend that your office verify member eligibility with each office visit.

Aetna Dental Access®

The Aetna Dental Access network supports discount dental programs, such as Vital Savings by Aetna®, the Aetna ValuePass℠ card and other discount programs offered through external relationships.

Key facts:

- Anytime you see the "Aetna Dental Access" logo on a card and/or certificate, charge participants the same rate as your negotiated PPO rate.
- Programs supported by this network are not insurance, and your office will not have any claims to submit.
- Participants only need to show their card and/or certificate when they visit your office, receive dental care and pay the full, negotiated rate at the time of service.
- Call the phone number on the patient's card with any questions.
- Visit **www.aetnadental.com** for more information

Aetna DentalFund® features

In most instances, an annual dental fund account is set up for the member. The benefit is coupled with a base dental PPO or indemnity plan that usually includes a deductible. The plan may include a variety of coinsurance options. The dental fund, annual plan maximum, deductible amounts and coinsurance options depend on the employer's preference.

Aetna DentalFund members receive ID cards that list "ADF" along with the Dental PPO logo. ID cards for members with an integrated medical and dental Aetna HealthFund product will show "AHF" along with the medical plan and Dental PPO logos.

In addition to member ID cards, your office can easily verify eligibility and benefits information for Aetna DentalFund members by contacting us directly through our Aetna Voice Advantage self-service telephone system, using the number noted on the member's ID Card.

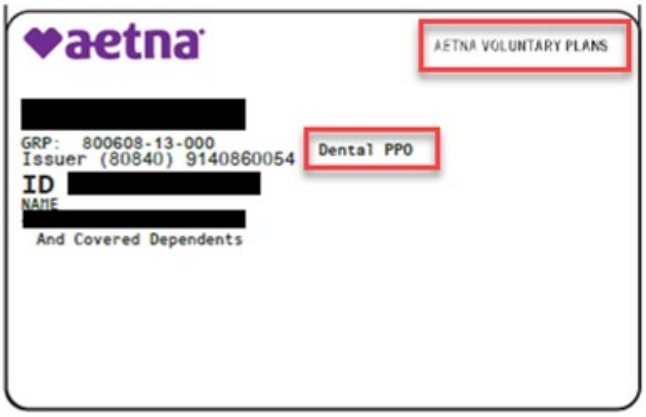
As the member incurs covered expenses paid for by the dental fund, the member's deductible and fund balance are simultaneously reduced. Coverage for preventive care is usually not subject to an annual deductible or deducted from the dental fund.

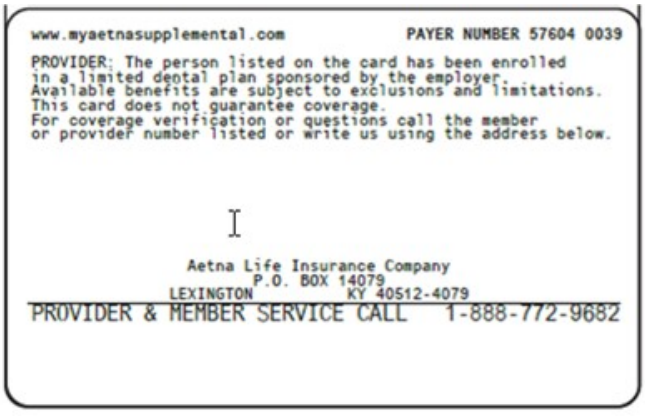
Claims should be submitted to Aetna as they are for our other PPO plans. For Aetna DentalFund plans, your participating PPO office generally should not collect anything from the member at the time of their visit. The Explanation of Benefits will specify if there is any amount for which the member will need to be billed.

Aetna Voluntary Dental Plan

This Plan is administered by Aetna Voluntary.

- Call Aetna Voluntary at 888-772-9682 to verify patient eligibility
- Submit claims to: Aetna Voluntary, PO Box 14079, Lexington, KY 40512
- Look for Aetna Voluntary Plans (upper right corner) and "Dental PPO" on the ID Card (middle of the card)





· This is a PPO dental plan and is supported by the Aetna Dental PPO Network.

· Compensation will be based on your PPO fee schedule.

· Deductible, coinsurance, annual maximums may apply.

· An Explanation of Benefits (EOB) will be issued to help you determine what to collect from the patient.

Aetna Dental® Administrators

- Through a variety of external relationships with insurance carriers and third-party administrators (TPAs), the Aetna Dental Administrators program provides dentists with increased opportunities for building their patient base.
- Although these relationships may vary, they all provide plan members with access to dental care from participating dentists in accordance with the contracted PPO fee schedule.
- For these PPO plans, Aetna handles claims pricing, provides network services and management, and works to resolve network contract issues.
- Contracted carriers and TPAs must agree to meet Aetna claims payment and other key standards.

Contact information/additional resources:

- Call the number on the member's ID card with eligibility questions.
- Call the Dentist Contracting Hotline at **1-800-776-0537** with general questions.
- Send claims to the address on the back of the ID card.
- Visit **www.aetnadental.com** for a list of current plans that the Aetna Dental Administrators network supports.
- ***Dental Office Guide:*** In general, most information about PPO plans in this ***Dental Office Guide*** applies to the Aetna Dental Administrators program. We have noted any significant differences in the applicable sections of the guide.

Plan administration

Fee schedules

As a participating dentist, you have agreed to accept an Aetna maximum fee as payment in full for any service rendered to eligible employees and dependents.

Compensation Schedules are calculated for specific three-digit zip code areas. **If you practice in multiple locations, you can have a different Compensation Schedule for each of your locations.**

The **Compensation Schedule** reflects the most common dental services that **may be covered** under the member's plan of benefits. Inclusion of a service on the Compensation Schedule is not a guarantee that the service is covered under the member's plan. **The member must be informed in advance and agree in writing when a non-covered service is provided.** You should always confirm coverage prior to providing the service.

Aetna will pay for covered dental services in accordance with the **maximum fees** listed in the relevant **Compensation Schedule,** less any applicable deductibles or member coinsurance amounts. Depending on the service(s) rendered, payment(s) can come from Aetna and/or the member. If your usual fee for a service is less than the maximum fee, the usual fee becomes the maximum fee that can be used to determine the patient copay.

- **For covered services,** the charge to the member may not exceed the maximum fee on the Compensation Schedule. You may not bill the member the balance between your usual fee and the maximum fee listed on your Compensation Schedule.
- **For non-covered services,** except where prohibited by state law, you may not charge an Aetna Dental PPO member more than the maximum fee, as specified on your fee schedule. If your state prohibits mandatory discounts on non-covered services, you may voluntarily agree to offer this discount.

No lab fees may be charged to the patient. Brand-name crown materials (for example, Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. Your office is not permitted to bill the member for brand-name materials.

Orthodontics

Ceramic, clear, and lingual fixed brackets and clear, removable orthodontic aligners are considered a cosmetic upgrade; however, the plan will consider benefits based on the contract fee for a conventional comprehensive orthodontic treatment plan.
If the member elects and agrees in writing to a cosmetic upgrade to ceramic, clear, or lingual fixed brackets or to clear, removable orthodontic aligners (e.g. Invisalign), the member is responsible for his/her normal copayment for the comprehensive orthodontic treatment plan, plus the difference between your usual fees for conventional orthodontic fixed brackets and the ceramic, clear, or lingual fixed brackets or clear, removable orthodontic aligners.
To avoid misunderstandings, we recommend you not bill the member for out-of-pocket payments until you have received a Claim Detail Statement. You may also take advantage of the pretreatment estimate of benefits process.

Please note:
If you exclusively perform ceramic, clear, or lingual fixed brackets or clear, removable orthodontic aligners, you cannot charge an upgrade to the member.

Clear, removable orthodontic aligners (e.g. Invisalign)
The starting date of service for clear, removable orthodontic aligners is the date the first aligner is delivered.
01/28/2020 thru 05/17/2021 – If the starting date of service is during this time period, an upgrade may not be charged for clear, removable orthodontic aligners. Effective 05/18/2021 - The Plan reversed this guideline. An upgrade is allowed if the starting date of service is on or after 05/18/2021, contingent upon the patient financial informed consent guidelines outlined above.

For services not listed on the Compensation Schedule, Aetna will determine coverage and calculate maximum fees in a manner consistent with the formula used to develop the applicable Compensation Schedule. (This includes changes or revisions in the Current Dental Terminology published by the American Dental Association subsequent to issuance of the Compensation Schedule.) If your usual fee for a service is less than the maximum fee, the usual fee becomes the maximum fee that can be used for the patient copay. You should call the Dentist Contracting Hotline at **1-800-776-0537** to obtain a fee for any unlisted service.

Dental services covered under an Aetna medical plan

In certain situations, a member of an Aetna medical plan for which you do not serve as a participating dentist may receive services from you that are covered by both his/her medical plan and his/her Aetna Dental PPO/PDN plan. In that event, Aetna may apply the Aetna Dental PPO/PDN compensation terms of your participation agreement to some or all of the covered services you provide to that member.

There may also be situations where a member of an Aetna managed dental plan for which you do not serve as a participating dentist may receive services from you. In that event, we may apply the Aetna Dental PPO/PDN compensation terms to your participation agreement for some or all of the covered services you provide to the managed dental plan member.

Alternate benefit provisions

Some Aetna plan sponsors have elected to include alternate benefit provisions (ABP) in their PPO/PDN dental plans. ABP limitations and exclusions take effect when the member's dental condition or dental problems can be treated by a less expensive, professionally acceptable service.

Alternate benefit provisions limit plan benefits to services and supplies that are customarily used for treatment and deemed by the dental profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice.

After an alternate benefit is allowed in lieu of the proposed procedure, the member may still elect to proceed with the more costly service. However, expenses for care beyond the ABP limitation remain the member's responsibility. **Written consent, signed by both the dentist and the member, should be obtained prior to rendering treatment.**

In those cases, you may still bill the member for the services performed, but only up to the maximum fee shown on your Compensation Schedule. For example, if a fixed bridge is placed and Aetna allows an alternate benefit for a removable partial denture, you may balance bill the member the difference, but only up to the maximum fee for the fixed bridge as listed on your Compensation Schedule. **We strongly recommend that a pretreatment estimate be requested for any course of treatment where clarification of coverage would be helpful.**

Specialist referrals

Participating Aetna Dental PPO/PDN dentists are responsible for evaluating the member's dental care needs, including the need for specialty care. When a specialty service is required, the proposed treatment and reason for referral should be discussed with the member.

We strongly recommend that you refer your patients to a participating specialist whenever one is available. If the member is referred to a nonparticipating dentist, he/she will usually incur higher costs.

If the member asks for a referral to a nonparticipating specialist, please inform the member that he/she will not receive the benefit of the negotiated fees and, in many instances, may receive reduced benefits. **EPP members must use participating PPO/PDN/ EPP specialists, or the services will not be covered.**

You can access Aetna's participating dentist listing, DocFind®, at **www.aetna.com**. DocFind is a web-based application designed to put information about participating dentists at your fingertips.

Verification of eligibility

The member must be eligible on the date treatment is provided in order to qualify for benefits under the plan.

Aetna Dental PPO/PDN/EPP members have been instructed to identify themselves as participants when they call your office or arrive for an appointment. To avoid misunderstandings, we recommend confirming member eligibility prior to the scheduled appointment. You can do this via:

- **The Internet:** Online, real-time eligibility information can be obtained through **www.aetnadental.com**. Once registered, your office will be able to submit preauthorization requests and query for member eligibility and detailed benefits information.
- **The automated telephone response self-service:** The Aetna Voice Advantage telephone self-service system is also available to dental offices. The system is available 24 hours a day, 7 days a week, without a wait. The number is on the member's ID card.

More information can also be obtained by calling the National Dentist Line at **1-800-451-7715**.

Note that even if you have received a pretreatment estimate for a member's care, it is still recommended that you verify eligibility at the time of treatment. **Benefits are only payable if the member is covered under the plan at the time services are rendered.**

For Aetna Dental Administrators members, please call the telephone number on the member's ID card to verify eligibility

Dental claim submission

Aetna requires that participating dentists submit all claims on behalf of PPO/PDN/EPP members. Claims should only be submitted for completed services (for example, after insertion of a crown, bridge or denture prosthetic, or the final fill of a root canal).

Submitting a claim for an Aetna Dental PPO/PDN/EPP member is no different than submitting a claim for a member covered by one of our traditional fee-for-service indemnity plans. Your dental office may:

- Submit electronically
- Use a standard "ADA-approved" dental claim form

The individual dentist rendering treatment must be clearly identified on the claim form. The service address and dentist's tax ID number must also be included.

The claim form should include and clearly identify the following:

- Patient's name and address
- Insured's name, address, and Aetna member ID or Social Security number
- Insured's employer
- Patient's date of birth
- Procedure code(s) (CDT), description of service(s) and date(s)
- Tooth number(s), quadrant(s) and surface(s), where appropriate
- Your **usual and customary fee(s)** for each service
- Any additional coverage under another dental plan

The box indicating "Statement of Actual Services" should be checked. Note that we will accept "signature on file" notations for both the employee and the patient.

Claims-related questions should be referred to Aetna Member Services. The phone number is listed on the member's ID card.

Claims should be submitted to the address listed on the member's ID card (or as noted below) no later than 90 days after the date of service.

Aetna Dental
PO Box 14094
Lexington, KY 40512-4094

For Aetna Dental Administrators members, mail your claims to the address listed on the member's ID card, or call the telephone number on the member's ID card for additional information.

Electronic claims submission

We encourage you to submit your claims electronically. Claims submitted electronically are generally processed more quickly and, because manual handling is virtually eliminated, subject to very few errors. Information regarding electronic submissions can be obtained by calling the National Dentist Line at **1-800-451-7715**.

For more information, visit **www.aetnadental.com** or see the Electronic Solutions section later in this guide.

Assignment of benefits

Members are encouraged (but not required) to assign benefits to the dentist, which facilitates payment for covered services directly to you. Permission for assignment of benefits can be obtained either on a claim-by-claim basis or through a signature on file. **If the patient wishes to assign benefits, you must accept the assignment.**

Explanation of Benefits (dentist version)

Your office will receive an Explanation of Benefits (EOB) statement after a claim has been processed. The EOB statement may provide detailed claims payment information on multiple members and claims.

The EOB statement includes:

- The office that processed the claim
- A Member Services phone number that can be used for questions
- The identity of the individual receiving care
- A claim identification number that can be used to identify the specific claim
- The service(s) received by the member
- Service dates
- The submitted or billed charge, which is the dentist's **usual and customary fee** for each service
- Any adjustments made, based on the **network negotiated amount for each service** and the relevant Compensation Schedule
- Non-covered and/or not payable amounts (services not covered under the member's plan are explained in the "Remarks" section of the EOB statement)

- Pending amounts for services rendered without adequate information to calculate payment (additional information required and what, if anything, the member or dentist needs to do is explained in "Remarks")
- Any amount applied to the member's deductible and coinsurance
- The amount payable by the plan and the total patient responsibility amount
- The total payment included on the EOB statement

Billing the member

You may not bill the member more than the maximum fee listed on the Compensation Schedule. If your usual fee for a service is less than the maximum fee, the usual fee becomes the maximum fee that can be used for the patient copay.

- **For covered services,** the charge to the member may not exceed the maximum fee on the Compensation Schedule. You may not bill the member the balance between your usual fee and the maximum fee listed on your Compensation Schedule. This applies whether or not the benefit maximum has been met, except where prohibited by state law.

No lab fees may be charged to the patient. Brand-name crown materials (for example, Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand-name materials.

- **For non-covered services,** except where prohibited by state law, you may not charge an Aetna Dental PPO member more than the maximum fee, as specified on your fee schedule. If your state prohibits mandatory discounts on non-covered services, you may voluntarily agree to offer this discount.

Providers may bill Aetna Dental PPO/PDN/EPP members for the coinsurance or deductible amounts due, but **cannot** bill the difference between the Aetna Dental PPO/PDN/EPP maximum fees and their usual and customary fee for any service, except as noted above.

To avoid misunderstandings, we recommend you not bill the member for out-of-pocket payments until you have received a Explanation of Benefits statement. We also recommend you take advantage of the pretreatment estimate of benefits process.

We strongly suggest that any financial arrangements between the dentist and the member be in writing and signed by both the member and the dentist prior to services being rendered.

Coordination of Benefits

When members are covered under more than one group dental plan, the Coordination of Benefits or Maintenance of Benefits provision may affect the amount of benefits paid when the Aetna plan is the secondary plan. Coverage under all plans is taken into account.

Your dental office should ask members if they, or any other family members, have coverage under another dental plan. This information should be clearly noted on the claim form.

Please note that the Coordination of Benefits or Maintenance of Benefits provision and general rules (for example, the "birthday rule") that designate the order in which multiple carriers are to pay benefits may vary by state law or individual plan.

Regardless of the amount you collect from all plans, you are not permitted to balance bill the member for amounts in excess of the difference between the maximum fee in the Compensation Schedule and the total of the amounts paid by all plans. Information will be provided on Explanation of Benefits statements.

Pretreatment estimates and predetermination of benefits

We recommend that a pretreatment estimate be requested for any course of treatment where clarification of coverage is important to you and the patient. This is especially recommended for treatment plans involving multiple crowns/inlays, prosthodontics and periodontal surgery. This may help avoid misunderstandings concerning available benefits and enable you and the member to make financial arrangements prior to treatment being rendered.

Pretreatment estimates may be submitted on standard claims forms and should include:

- Patient's name and address
- Insured's name, address and Aetna member ID number
- Insured's employer
- Patient's date of birth
- Procedure code(s) (CDT) and description of service(s)
- Tooth number(s) and surface(s), where appropriate
- Your **usual and customary fee(s)** for each service

The box indicating "Pretreatment Estimate" should be checked. Note that we will accept "signature on file" for both the employee/insured and the patient.

Aetna will send **both** you and the member a pretreatment estimate of benefits for the proposed treatment plan, including:

- The office that processed the pretreatment estimate
- A Member Services phone number that can be used for questions
- The identity of the patient
- A claim identification number that can be used to identify the specific pretreatment estimate
- The service(s) to be received by the member
- The submitted or billed charge, which is the dentist's **usual and customary fee** for each service
- Any adjustments made, based on the **maximum fee for each service** and the relevant Compensation Schedule
- Non-covered amounts (services not covered under the member's plan are explained in the "Remarks" section)
- Pending amounts for services to be rendered without adequate information to calculate payment (the additional information required is explained in "Remarks")
- Any amount that will be applied to the member's deductible
- The amount estimated as payable by the plan and by the patient

The estimate of benefits does not guarantee payment, as benefits are only payable if the member is covered under the plan when services are rendered. It is still recommended that you verify the member's eligibility at the time of treatment.

Dental claim review: required radiographs and documentation

Certain procedures and treatments, submitted either on claims or pretreatment estimates, are referred to our in-house professional staff – dental consultants – for compliance with treatment guidelines and professional standards for appropriateness.

Our dental consultants rely on the same records, radiographs and other supporting data you use to reach your diagnosis. Claim Documentation Guidelines are available on **www.aetnadental.com** or by calling our National Dentist Line at **1-800-451-7715**.

Note that claims or pretreatment estimates submitted without required records, radiographs and/or relevant documentation will be delayed. Do not send your original radiographs; **please send copies**. Label all copies with the patient's name, dentist's name and the dates the radiographs were taken. You should identify left and right views on each radiograph.

Updating your information

Accurate and reliable information regarding you and your practice is essential to reimbursing you correctly and quickly for your services, and listing your name, address, telephone numbers and specialty in our directory of participating dentists.

Please inform us at **1-800-451-7715**, our toll-free National Dentist Line, of any changes or errors in your:

- Name
- Office address(es) or new/additional locations
- Tax ID number
- National Provider Identifier (NPI)
- Phone number(s)
- Billing address(es)
- New associates who join your practice
- Participating dentists who leave your practice and are no longer at your location

Grievance and appeal process

Aetna has policies and procedures in place to address member and provider complaints. The scope of this program includes time frames and processes for the acknowledgment, evaluation, monitoring and resolution of complaints. (It should be noted that the handling of complaints may be subject to federal and state legislative requirements.)

Note: In order for the grievance and appeal process to function effectively, it is imperative that the dentist cooperates fully by submitting all requested information (for example, records, X-rays, etc.) in a timely manner. Lack of complete documentation can have an impact on the ability to meet state-mandated deadlines and can also adversely affect the final decision. You are required to comply fully with the grievance and appeal process. Non-compliance with policies and procedures may result in termination of network participation.

All complaints are documented and are routed to the appropriate area responsible for resolution. Complaints will be resolved and communicated in a timely manner depending on the urgency of the situation and requirements of specific state laws.

Electronic solutions

Visit www.aetnadental.com for more information on the available electronic solutions.

Have you been searching for an easier way to communicate with Aetna?

Using your computer, you can:

- Submit claims
- Send attachments
- Check eligibility
- Review the status of your claims
- Do much more

What are the advantages of using electronic solutions?

Submitting claims electronically can help you:

- Cut down on administrative work — telephone calls, faxes and paperwork
- Improve efficiency
- Experience fewer claims returned due to missing or incorrect information
- Receive faster reimbursement

Frequently asked questions about submitting electronic claims

Q. What is the correct payer ID for Aetna claims?

A. Use 60054 for Aetna claims.

Q. Can all claims be submitted electronically?

A. Yes. All claims can be submitted electronically.

Q. Can electronic claims be resubmitted electronically?

A. Yes, claims can be resubmitted electronically. This is especially beneficial if a claim is rejected through the vendor for missing or invalid information. Electronic claims reports identify these rejects, which can be corrected and resubmitted electronically. Duplicate claims logic is in place to reject exact duplicates of claims submitted electronically.

Q. Can old claims be submitted electronically?

A. Claims that are past timely filing limitations, often referred to as "old claims," can be submitted electronically. Timely filing limits will be enforced appropriately during claims processing.

Q. If the dentist is having a problem with electronic claims rejecting, who do they call?

A. Call the contact number on the claims status report from the EDI vendor.

Q. Are primary payer Explanations of Benefits (EOBs) always required when Aetna is the secondary payer?

A. While Aetna does not always require the actual statement of payment or rejection from the primary carrier, we may sometimes need the actual document. Please provide the primary carrier's payment amount in the "Remarks" field, and if we require the actual document, we will request it.

Q. What types of attachments are required for dental electronic claims?

A. Claim attachments are not always necessary. We encourage you to review our Claim Documentation Guidelines to determine which attachments, if any, are required. Or, submit claims without attachments. We will request any attachments if needed. Claim Documentation Guidelines are available on **www.aetnadental.com**, or by calling our National Dentist Line at **1-800-451-7715**.

Q. Can I send attachments electronically?

A. You can send attachments to us electronically through the attachment vendor, National Electronic Attachment (NEA). This vendor allows you to transmit X-rays, periodontal charts, intraoral pictures, etc. via the Internet for insurance carriers to view in support of electronic claims. For more information, visit **www.aetnadental.com**, or contact the vendor directly at **1-800-782-5150**.

Q. Can claim transactions be submitted without a CDT procedure code?

A. No, a valid CDT procedure code must be reflected, and the code must support the tooth in question, if applicable. Claims submitted with missing or invalid procedure codes will be rejected.

Q. Who should I contact if I have additional questions about electronic claims?

A. To assist you in determining whom to contact with questions on your electronic claims, please use the following as a guide:

- If your claim is rejected at the vendor or clearinghouse level, contact your vendor.
- If your claim is rejected at the carrier/payer level, contact your vendor.
- If you have questions regarding claim handling (payment or denial), please call the National Dentist Line at **1-800-451-7715**.

Aetna Dental has a website to provide you with tools and educational resources to help increase your efficiency while saving time and money. For additional frequently asked questions, visit **www.aetnadental.com**.

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

What is ERA?

- ERA is an electronic communication containing claims payment information that can be easily viewed or printed.
- It is intended to replace your paper Explanation of Benefits (EOB) statement. Paper statements will be stopped after ERA enrollment.
- Since it is available online, the ERA gives you access to the information it contains sooner than with a mailed paper EOB.

What is EFT?

- When you sign up for EFT, your funds will be electronically deposited into the bank account of your choice.
- You can access your money faster — no waiting for your check to come in the mail and making trips to the bank.
- EFT eliminates the threat of lost or stolen checks.
- We have a secure process in place to perform this function. Dentists enrolling for EFT go through a 10-day test period with the financial institution where the account is held.
- Once an error-free test is performed, your EFT enrollment will become effective.

How do I enroll in ERA and/or EFT?

1. After determining which vendor best suits your needs, complete the enrollment form (please ensure you complete it in its entirety). As a security measure, we require two different signatures. You can find the form on **www.aetnadental.com**.
2. Mail or fax as directed on the enrollment form.
3. As part of your submission, include a voided check, or for a savings account, a preprinted deposit slip. ***Note this only applies for EFT enrollment***.

Register for **www.aetnadental.com**

By registering online, you can get instant access to the secure features of **aetnadental.com**. This will allow you to submit claims electronically, check the status of a claim or perform real-time eligibility inquiries.

Information about www.aetnadental.com

Visit www.aetnadental.com for these benefits:

Electronic services via a secure website

- Submit claims for multiple payers
- Perform real-time eligibility inquiries
- Make claims status inquiries
- View Electronic Remittance Advice

Additional secure features

- Access downcoding and bundling policies
- Submit or change name, address, phone number, e-mail and NPI online
- View dental office guides
- Read our *Dental Dialog* newsletter

Information about joining the network

- Learn about Aetna's other dental networks
- Request an application to join the other networks

Claim resources

- Get help with electronic transactions
- Check Claim Documentation Guidelines
- Access electronic claims processing information
- Learn about electronic attachments
- Register for Electronic Remittance Advice (ERA)/Electronic Funds Transfer (EFT)
- Download a claim form

Educational resources

- Receive continuing education credits available with access to free continuing education courses
- Use the Practice Management Coach
- Read the latest dental news and research

Other helpful tools

- **DocFind provider directory** — An online application designed to put information about participating providers at your fingertips. Visit DocFind for details about provider type, specialty, languages spoken, hospital affiliation, etc.
- **Aetna Voice Advantage system** — Our state-of-the-art interactive voice response technology makes it easy to do business with us through personalized call routing and self-service options for simple and common inquiries.
- **Information on Aetna policies**

And more...

We are continually adding online resources and tools to help you do business with us.

EOB statements online

Get your daily list of predeterminations and claims Explanation of Benefits (EOB) statements online through the secure section of **www.aetnadental.com**.

The easy-to-use, searchable format allows you to:

- Search for dental predeterminations.
- Search for any claim EOB.
- Produce an EOB statement for completed claims or predeterminations.

And, if you choose, you never have to receive paper predeterminations or EOBs again.

Aetna EDI Connect℠ (www.aetnaedi.com)

This is an electronic solution for the technically savvy — a free, direct-connect, web-based option for submitting your electronic transactions to Aetna. Best of all, with Aetna EDI Connect, there's no third party involved and no website data entry required.

Use this website to send and receive X12-formatted files directly between you and Aetna using one of several protocols. If you are knowledgeable of X12-formatted data and HIPAA requirements, you may find this website to be appropriate for your business needs.

Be up and running with Aetna EDI Connect in as little as 24 to 48 hours!

Steps:

1. Read the Aetna EDI Connect Companion Guide available on **www.aetnaedi.com**. This document will help you determine if Aetna EDI Connect is the right choice for your office.
2. Register. To register, go to **www.aetnaedi.com**, select "Request an Account" and complete the screen. You will receive a confirmation e-mail.
3. Log in within 72 hours to change your password.
4. After you have logged in, you are ready to begin submitting test files.
5. Once you successfully submit your test files, you can request to move into "live" production.

Send your claims attachments electronically to Aetna

Attachments can be submitted to Aetna electronically. Claim attachments are not always necessary. We encourage you to review our Claim Documentation Guidelines to determine which attachments, if any, are required.

To streamline submitting claims with attachments to Aetna, you can send attachments electronically through the attachment vendor, National Electronic Attachment (NEA). This vendor allows you to transmit X-rays, periodontal charts, intraoral pictures, etc. via the Internet for us to view in support of electronic claims. For additional information, visit **www.aetnadental.com** or contact the vendor directly at **1-800-782-5150**.

Aetna Voice Advantage®

Aetna Voice Advantage, Aetna's voice-recognition self-service technology, allows your dental office to:

- Check on several patients in a single call to a single number. (Toll-free numbers can be found on member's ID card.)
- Check coverage and benefits at the ADA code level. Choose to hear the information or have it faxed.
- Check the status of a claim(s). Choose to hear the information or have it faxed.
- Obtain a claims mailing address.
- Speak with a Member Services professional if needed.

Other Aetna Voice Advantage features:

24-hour service	Automated member and dentist services are available day and night (24x7).
Natural speech	A single automated voice uses friendly, conversational language, rather than robotic tones and instructions.
Voice recognition	Just speak naturally, and you'll discover how conversational the call will be.
Voice to touch	Allows you the flexibility to switch from speaking to using the keypad.

National Provider Identifier: the one number you need for all payers

The HIPAA-regulated National Provider Identifier (NPI) number makes conducting electronic transactions with multiple payers easier.

Your NPI is the only number you need to supply to your payers on electronic claims, certifications and approvals. It replaces the many different provider numbers (Medicare and Medicaid numbers, and other payer proprietary numbers) you may have used for these transactions. (Your tax payer ID number [TIN] is an IRS requirement and is not replaced by the NPI.) The 10-digit NPI number is yours for life and does not convey information about you, such as your type of practice or your location.

Apply for your NPI now

We encourage all dentists to apply for an NPI, if you haven't obtained one already. If you transmit dental health information by way of standard electronic transactions, as defined by HIPAA, you are required to obtain an NPI. This is true even if you use a billing agency to prepare transactions.

You can apply for an NPI by:

- Going to **https://nppes.cms.hhs.gov**
- Completing a paper application that you can download from this address
- Calling **1-800-465-3203** to request a copy

Share it with Aetna:

Share your NPI as soon as possible and before you use it in transactions with us by:

- Updating your personal information on **www.aetnadental.com** (site registration required)
- Calling our National Dentist Line at **1-800-451-7715**
- Faxing your NPI to us at **860-754-1602**

Use it in electronic transactions with Aetna

We can accept and use your NPI if it is included in a real-time transaction but only if it has been previously entered into our database. Otherwise, the transaction will reject. The NPI number must be used in all HIPAA standard electronic transactions.

For more information

- Visit **www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/**
- Call the National Provider Identifier call center at **1-800-465-3203**.

Resources available for you on W9 forms

Information on how to complete a W9 form, the IRS Matching Program and backup withholding can be found on the IRS website at **www.irs.ustreas.gov**.

Quality management

An important Aetna objective is the promotion of appropriate, affordable and timely dental care by participating dental providers to all plan members. As a result, Aetna has implemented a nationwide Dental Quality Management Program (QM Program). This QM Program is supported by various systems that tabulate, sort and analyze data collected on prospective and existing participating provider offices. Certain key components of the QM Program are summarized below.

Because the success of the QM Program depends upon the full cooperation of participating providers, network dentists are contractually required to participate in and comply with all requirements of Aetna's QM Program, policies and procedures, whether or not they are specifically included in this Dental Office Guide. Aetna works closely with participating providers on tools that help measure dental care delivery effectiveness. We encourage you to contact us with any questions.

Aetna's credentialing process has two major elements:

Initial certification and credentialing

Initial verification — Initial verification is performed on a prospective level prior to accepting a dentist into the network. Primary source verification is performed to verify or identity the following:

- Current dental licensure and expiration date
- DEA certification eligibility/licensure
- Appropriate certifications
- Highest educational level
- Current professional liability insurance
- Malpractice and disciplinary history
- Medicaid/Medicare sanctions
- Negative past professional histories

In addition, a participating dentist who renders general anesthesia and/or intravenous sedation must have a current and valid state certification or permit, if applicable.

Periodic re-evaluation of credentials

Ongoing verification – All existing dentists will be recredentialed every three years (or more frequently if required by state law). Primary source verification is completed to ensure current licensure and to obtain an update on past professional history.

Aetna is responsible for ensuring that all dentists participating in our dental plans are credentialed and recredentialed. **To that end, it is the participating dentist's responsibility to notify his/her regional network support office when the dental office adds or terminates dentist associates. The participating dentist is also responsible for notifying Aetna of any adverse action with respect to any of the credentialing and recredentialing elements noted above. Failure to do so may result in the termination of your participation agreement.**

Member satisfaction surveys

Member satisfaction surveys assist in rating patient perception of the Aetna network. The feedback is based upon experiences of members who have had dental treatment rendered in participating dentists' offices. The surveys address key patient issues, such as level of satisfaction with the program, access to care, utilization, perceptions of care received and interaction with your office staff. The surveys may be random or targeted to specific covered patients, certain plan sponsors or specific offices, or administered in a variety of combinations.

Member satisfaction is measured and monitored on an ongoing basis. Patient surveys are distributed on a periodic basis to a sample of members. We compile and analyze satisfaction data at the plan and network levels, and share results with customers and brokers/consultants.

Utilization review

Aetna employs various tools to analyze care provided to members of certain dental plans. The analysis includes treatment patterns emerging from a specific office, as well as comparing treatment patterns among peer network offices. A critical source for utilization analysis is the reporting of the treatment provided by the participating dentist. This information is received directly from your office by means of submission of claim forms. Treatment data from these forms is collected and sorted to facilitate the development of treatment pattern models and comparative benchmarks for commonly performed dental services. Reports are generated that provide a "snapshot" of the type of services delivered and the level of patient utilization. This aids in determining the impact of Aetna dental plans in a specific office. Alternative methods of reporting treatment provided to plan members must be approved by Aetna.

Members are periodically contacted to verify the services performed, to confirm the presentation of alternate treatment options, and to verify collection of appropriate and correct copayments. In addition to satisfying our oversight requirements, these periodic calls allow us to assess the need of any additional training in your office.

Clinical policies and guidelines

Aetna's professional staff uses periodically updated clinical criteria and guidelines for review of coverage, medical necessity and appropriateness of treatment.

Explicit clinical policies, supported by documented technology assessments, guide utilization management (UM) and clinical decision making. The goal of these assessments is to evaluate significant new advances for availability to members as soon as appropriate, and to prevent unproven, ineffective and potentially harmful technologies from receiving coverage.

Policies are based on established and accepted professional "best practices." The chief dental officer directs reviews of the dental literature and seeks input from Aetna's professional staff, outside dental experts, the academic community and network dentists.

Dental review guidelines/rules are in place to identify and refer specific procedures and treatment plans to our professional staff, which reviews the case for compliance with treatment protocols and clinical policies.

Patient records

A complete patient record should be maintained for each member, documenting the member's dental and medical history. Records should be legible, readily accessible, understandable, complete and in compliance with standards for confidentiality and dental/medical record-keeping practices.

Members' dental records should include reports from referred-to and/or referring dentists and records of emergency care received. General information, including name, address, date of birth, sex, marital status, telephone number, member ID number, other insurance information (for example, coordination of benefits information), individual responsible for payment and emergency contact name/telephone number should be compiled and maintained.

A medical history should be completed at the initial visit and updated at each visit. The medical history, which should be signed and dated by both the member/guardian and clinician, should be comprehensive and include, without limitation, questions about allergies, medications, cardiovascular problems, other pertinent medical conditions and disease history, and such other information as Aetna may require from time to time. The member should be asked whether he/she is presently under the care of a physician, and medical alerts and drug allergies pertinent to the member's care should be conspicuously noted in the member's record in compliance with HIPAA privacy rules.

Examinations should include the following:

- Head and neck/soft tissue evaluation
- Dentition/periodontal evaluation
- Arch relationship and growth/development evaluation
- Appropriate radiographs
- Diagnoses

Each patient's record should include a complete treatment plan detailing proposed treatments and alternatives. Any financial arrangements and informed consent forms should be included or cross-referenced to the treatment plan. Specialty treatment recommendations and follow-up should be documented. Progress notes must provide a clear and complete record of the member's treatment and be signed by the clinician.

All patient records are considered confidential and should not be released to anyone without proper authorization. Please note that the enrollment forms signed by all Aetna Dental plan members contain an authorization to allow you to release necessary records to Aetna Dental, including independent dental consultants sent to your office by Aetna. In addition, the "Patient Authorization" block on all claim forms contains an authorization to release necessary records to Aetna Dental and to provide access to patient charts in order to perform reviews necessary to carry out our responsibilities under the Dental QM Program.

In addition to these authorizations, the provisions of your Participating Dentist Agreement require that such records be made available to Aetna Dental. No information obtained by Aetna Dental in the course of such reviews may be released to any other party without the express written authorization of the patient. All Aetna Dental employees, as well as the independent dentists who perform the facility/chart review, are trained in the maintenance of confidential information.

Access to care

An essential part of QM is the promotion of timely and appropriate dental care. Appropriate access to care can vary by the type of dental care needed. The following appointment availability standards are monitored via the QM Program:

I. **Emergency care — patient must be seen immediately (or referred to ER, as appropriate)**
Emergency care is defined as those dental services needed to relieve pain or prevent worsening of a condition when that would be caused by delay. Coverage for emergency care is subject to state law.

II. **Urgent care — must be provided same day or within 24 hours**
This care should apply to conditions involving swelling, bleeding, fever or infection.

III. **Routine care — within 5 weeks (Primary Care within 10 days and Specialist within 15 days in Connecticut)**
Most routine care should be appointed within five weeks of request, provided the patient can schedule the next available appointment.

IV. **Hygiene appointments — within 8 weeks**
Hygiene appointments must be scheduled within 8 weeks of the request, provided the patient can schedule the next available appointment. (It is recognized that requests for special times, such as after work hours or on weekends, may take longer to schedule for routine care and hygiene appointments.)

Access to care is monitored by our regional Provider Relations staff. Periodically, a written inquiry or phone call may be generated by an Aetna service representative to obtain information concerning your next available appointment. Member complaints regarding appointment availability are documented and investigated.

Note: Participating dentists are also required to comply with applicable state-specific requirements regarding appointment availability.

Billing practices

Aetna is committed to preventing health care fraud and inappropriate patient charges. Participating dentists must adhere to industry billing standards and avoid all forms of fraudulent billing.

Termination of participating dentist

A participating dentist may be terminated from the network for any misrepresentation(s) made on his/her application or failure to disclose any required information. Other causes for termination include, but are not limited to: fraud, failure to comply with the terms of the Participating Dentist Agreement or those outlined in this Dental Office Guide or any other supplementary material provided in writing by Aetna, failure to follow referral guidelines for specialty services, failure to meet participation criteria, failure to comply with grievance/complaint resolutions, etc.

Informed consent

Aetna expects all participating dentists to understand and comply with applicable legal requirements, as well as to adhere to the established standards of the dental community in which they practice, regarding informed consent from their patients. In general, it is the participating dentist's duty to give patients adequate information and be reasonably sure the patient has understood it before proceeding to treat the patient. Informed consent documents should be written and signed prior to treatment being performed. This information helps members take active roles in making decisions about their dental health.

Disclosure of information

Dentists must complete and sign an application form, including responses to a series of confidential questions, in order to be credentialed and accepted for participation.

The information you provide must be complete and accurate as of the date of the application. You must update your information when changes occur. Updates should be submitted within 30 days or in accordance with your participating agreement. Failure to submit timely updates could result in your termination from the network.

Dentists are responsible for confirming the completeness and accuracy of information submitted by their staff; material omissions or inaccuracies in an application may not be excused on the grounds that the application was completed by someone other than the applicant dentist.

Claim Documentation Guidelines

We encourage you to review our Claim Documentation Guidelines, which are available on our website, **www.aetnadental.com**.

Conditions for participation and Participation Criteria

The Dentist Participation Criteria lists a variety of requirements that the participating dentist must meet. These requirements include standards such as your office's physical attributes, practice coverage, patient access, office procedures, office records and insurance, and professional competence and qualifications. These criteria are used in our credentialing and recredentialing process and are attached to our current Dentist Agreements. A copy of the criteria is included below for your reference.

Primary Dentist Participation Criteria

I. BUSINESS CRITERIA

A. Applicability

1. These criteria shall apply to each applicant for participation and each Primary Dentist participating in Company Plans and shall be enforced at the sole discretion of Company.[1]
2. Each applicant for participation as a Primary Dentist must satisfactorily document evidence meeting the criteria listed herein for at least six (6) months prior to application, unless applicant has entered clinical practice or completed a residency or a fellowship program within the past six (6) months.
3. Each participating Primary Dentist must continue to meet the following criteria for the duration of participation in the Company Plans.
4. Unless specifically permitted otherwise by Company, in its sole discretion, if Primary Dentist is part of a group practice, all dentists in the group must meet Company's Participation Criteria and must agree to participate in all Company Plans in which Primary Dentist participates. If all dentists in the group do not meet Company's criteria, the group cannot participate.
5. Each Primary Dentist must execute a Provider Agreement (with a footer dated 05/97 or later) or an alternative acceptable to Company, under which Primary Dentist agrees to provide services to Members of all health products, plans or programs issued, administered, or serviced by Company or one of its affiliates and specified in the Agreement.
6. Each applicant must fully complete the participation application form, and each applicant and participating Primary Dentist shall periodically supply to Company all requested information, including, but not limited to, the confidential information forms.

B. Office Standards

Each Primary Dentist's office must:

1. Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.
2. Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
3. Be readily accessible to all patients, including but not limited to its entrance, parking and bathroom facilities.
4. Be clean, presentable, and have a professional appearance.
5. Provide clean, properly equipped patient toilet and hand washing facilities.
6. Have a waiting room able to accommodate at least four (4) patients.
7. Have treatment rooms which are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.
8. Have a no-smoking policy.

[1] Company refers to Aetna Health Management, LLC. and/or its affiliates.

9. Have at least one (1) staff person (in addition to Primary Dentist) on duty during normal office hours.
10. Provide evidence that Primary Dentist has a copy of current licenses for all dental hygienists and other non-dentist dental professionals practicing in the office, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).
11. Keep on file and make available to Company any state required practice protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in office.
12. Complete a Location Form identifying the address(es) and physical location(s) of office(s).
13. Have appropriate, safe x-ray equipment. Radiation protection devices, including, without limitation, lead aprons, should be available at all times and used according to professionally recognized guidelines (e.g., Food and Drug Administration). All equipment in Primary Dentist's office must comply with and maintain such certifications as may be required by federal, state and local laws and regulations (including, but not limited to, laws and regulations regarding maintenance and calibration of equipment).
14. Use appropriate sterilization procedures for instruments; use gloves and disposable needles; and maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state and local laws and regulations, including but not limited to, those mandated by OSHA, and as advocated by the American Dental Association ("ADA") and the component state and local societies.
15. Comply with all applicable federal, state and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.
16. Use an appointment book (or an electronic equivalent acceptable to Company) for scheduling of dental appointments. Appointments should be made in a manner which will prevent undue patient waiting time and in compliance with the access criteria in D. below.
17. Have evidence of a functional recall system in place for notifying Members of the need to schedule dental appointments.
18. Have documented emergency procedures, including procedures addressing treatment and transportation plans to provide for the safety of Members.

C. Coverage

1. Twenty-four (24) hours-a-day coverage for Members must be arranged with another Company Participating Primary Dentist except as provided in Section C.3 below.
2. The covering dentist's office must be located within 45 minutes of the Primary Dentist's office.
3. A Primary Dentist must submit for prior approval by Company any coverage arrangements made with a nonparticipating primary dentist. Approval of coverage by a nonparticipating primary dentist is subject to Company's sole discretion, and such approval must be in writing. If Primary Dentist receives approval from Company for coverage by a nonparticipating primary dentist, Primary Dentist shall require such nonparticipating primary dentist to comply with applicable terms of the Agreement. Primary Dentist shall make suitable arrangements regarding the amount and manner in which such covering nonparticipating primary dentist shall be compensated, provided, however, that Primary Dentist shall ensure that (except with respect to Reduced Fee Services) the covering dentist will not under any circumstances bill Members (except for applicable Copayments, Coinsurance and Deductibles) for any Covered Services.

D. Access

1. Each Primary Dentist's office must have, at a minimum, twenty (20) hours of regularly scheduled office hours for the treatment of patients (whether Members or other patients) over at least three (3) days per week.
2. Each Primary Dentist or his or her covering primary dentist must respond to a Member within thirty (30) minutes after notification of an urgent call.
3. Each Primary Dentist must schedule appointments with Members within the following time frames (except as more speedily required by applicable law):
   - Emergency care: must be seen immediately (or referred to ER, as appropriate)
   - Urgent complaint: same day or within twenty-four (24) hours
   - Routine care: within five (5) weeks (eight (8) weeks in TX)
   - Routine hygiene: within eight (8) weeks (six (6) weeks in AZ and four (4) months in TX) (Ten (10) days in Connecticut)
4. Each Primary Dentist office must have adequate plans for managing an increase in patient load.
5. Each Primary Dentist must have a reliable system, twenty-four (24) hours-a-day, seven (7) days-a-week, for reaching a Primary Dentist in an emergency. A recorded message or answering service which refers Members to emergency rooms is not acceptable.

E. Patient Load

1. Each Primary Dentist practice must agree to and be able to demonstrate the capability to accept a minimum of two hundred and fifty (250) Members of capitated Plans, to the extent Primary Dentist participates in capitated Plans, unless otherwise approved in writing by Company. If Primary Dentist participates in Company's dental preferred provider organization (PPO or PDN) plan(s), Primary Dentist may not close his/her practice to members of those plans.
2. Each Primary Dentist must designate by age, according to Company guidelines, those Members for whom Primary Dentist will provide care.
3. Any use of a dental hygienist or other non-dentist dental professional by a Primary Dentist must comply with Company's then current policies and all applicable legal requirements regarding practice of such dental professionals.

F. Office Records

1. A Primary Dentist must demonstrate, at the time of application and thereafter as requested by Company, that his/her dental records are legible, reproducible and otherwise meet Company's standards for confidentiality, and dental/medical record keeping practices, and that clinical documentation demonstrates comprehensive care. Members' dental records shall include reports from referred and/or referring providers, records of emergency care received, a complete medical history of the Member which is updated periodically and includes, without limitation, any allergies, medications, cardiovascular problems, high blood pressure and/or diabetes of Member, and such other information as Company may require from time to time.
2. Each Member encounter must be documented in writing and signed or initialed by the Primary Dentist or as required by state law.

G. Professional Liability Insurance

1. During the entire term of this Agreement, Primary Dentist shall maintain insurance or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by primary dentist's in the state or region in which the Primary Dentist operates. Primary Dentist's insurance shall cover the acts and omissions of Primary Dentist, as well as Primary Dentist's agents and employees. Certificates of insurance or other documentation as appropriate to show evidence of such coverage shall be delivered to Company upon request. Primary Dentist must notify Company at least thirty (30) days in advance of the cancellation, limitation or material change of said policies.

H. Philosophy

1. A Primary Dentist must be supportive of the philosophy and concept of managed care and Company. A Primary Dentist shall not differentiate or discriminate in the treatment of, or in the access to treatment of, patients on the basis of their status as Members, or other grounds identified in the Agreement.
2. Each Primary Dentist shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.
3. Primary Dentist's obligations under the Agreement not to disclose Proprietary Information do not apply to any disclosures to a patient determined by Primary Dentist to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate Primary Dentist's legal or ethical obligations.
4. Primary Dentist is encouraged to discuss Company's provider reimbursement methodology with Primary Dentist's patients who are Members, subject only to Primary Dentist's general contractual and ethical obligations not to make false or misleading statements. Accordingly, Proprietary Information does not include descriptions of the reimbursement methodology under which Primary Dentist is reimbursed, although such Proprietary Information does include the specific rates paid by Company due to their competitively sensitive nature.

II. PROFESSIONAL CRITERIA

A. Licensure

1. A Primary Dentist must have a valid, unencumbered license to practice dentistry in his/her state of practice, or in the case of a Primary Dentist with an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that encumbered license does not raise concern about possible future substandard professional performance, competence, or conduct.
2. A Primary Dentist must be eligible for or possess an unrestricted DEA certification, and, where applicable, a state-mandated controlled drug certification, unless otherwise approved in writing by Company.
3. A Primary Dentist who renders general anesthesia and/or intravenous sedation services must have a current and valid state certification or permit, if available in the applicable state.

B. Education

1. A Primary Dentist must be a graduate of a school of dentistry which is accredited by the Commission on Dental Accreditation (of the ADA) or be a graduate of a non-accredited school of dentistry and have completed a pre-licensure advanced education program at an ADA accredited school of dentistry.

C. Continuing Education

1. A Primary Dentist shall meet the continuing education requirements required by state law. An applicant for participation in Company must demonstrate that he/she has met such continuing education requirements for the three (3) years immediately prior to submitting his/her application for participation. If an applicant has been in practice less than three (3) years, or has had a hiatus in practice, the applicant need only demonstrate that he/she has met such continuing education requirements during the period of his/her practice.

III. PROFESSIONAL COMPETENCE AND CONDUCT CRITERIA

A. General

1. Primary Dentist must be of sound moral character and must not have been indicted, arrested for or charged with, or convicted (i.e., finding of guilt by a judge or jury, a plea of guilty or nolo contendere, participation in a first offender program or any other such program which may be available as an alternative to proceeding with prosecution, whether or not the record has been closed or expunged) of any felony or criminal charge related to moral turpitude or the practice of dentistry.
2. Primary Dentist must not have engaged in any unprofessional conduct, unacceptable business practices or any other act or omission which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

B. Professional Liability Claims History

1. Primary Dentist must not have a history of professional liability claims, including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

C. History of Involuntary Termination or Restriction

1. Primary Dentist must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, or reduction or restriction of duties or privileges, or of a contract to provide health care services, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

D. Notification of Adverse Actions or Limitations

1. Primary Dentist shall provide immediate notice to Company of any adverse action relating to said dentist's: (i) hospital staff privileges (if applicable); (ii) DEA or state narcotics numbers; (iii) participation in the Medicare, Medicaid, or other governmental programs; or (iv) state licensure, certification, accreditation or other authorization required by law or the Agreement, including censure. Each applicant and Primary Dentist shall inform the Company in writing of any previous adverse actions with respect to any of the above. For the purpose of this section, "adverse action" includes, but is not limited to, any of the following or their substantial equivalents (regardless of any subsequent action or expungement of the record): denial; exclusions; fine; monitoring; probation; suspension; letter of concern, guidance, censure, or reprimand; debarment; expiration without renewal; subjection to disciplinary action or other similar action or limitation; restriction; counseling; medical or psychological evaluation; loss, in whole or in part; termination or refused participation; revocation; administrative letter; non-renewal; voluntary or involuntary surrender of licensure or status to avoid, or in anticipation of, any of the adverse actions listed regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry; and

initiation of investigations, inquiries or other proceedings that could lead to any of the actions listed, regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry. Any such adverse actions may be grounds for action, including without limitation denial, termination or other sanctions imposed pursuant to Company's credentialing/quality improvement programs.

2. Primary Dentist shall provide immediate notice to Company of any condition or circumstance that impairs or limits his/her ability to perform the essential functions of a Participating Primary Dentist.
3. Primary Dentist shall provide immediate notice to Company of any condition or circumstance of which he/she is aware that may pose a direct threat to the safety of himself/herself, coworkers or patients.
4. Primary Dentist shall provide immediate notice to Company and to Members of any condition or circumstance of which he/she is aware which law or regulation requires Primary Dentist to report.

E. References

1. Each applicant for participation must supply references as specified in the application and as requested by the applicable peer review committee.
2. The applicable peer review committee shall have the right to act on any reference or information received from a Primary Dentist's colleagues or other professionals. Primary Dentist waives any and all rights to bring any legal action relating to such information or the collection or use thereof against Company, any Affiliates or related companies or any director, officer, employee or agent thereof, or any person or entity providing a reference or information at the request of the applicable peer review committee.

These criteria may be modified at the sole discretion of Company.

Please refer to the California Participation Criteria for the criteria specific to California Dental Maintenance Organization (DMO®) participating providers.

Specialist Dentist Participation Criteria

I. BUSINESS CRITERIA

A. Applicability

1. These criteria shall apply to each applicant for participation and each Specialist Dentist participating in Plans and shall be enforced at the sole discretion of Company[1].
2. Each applicant for participation as a Specialist Dentist must satisfactorily document evidence meeting the criteria listed herein for at least six (6) months prior to application, unless applicant has entered clinical practice or completed a residency or a fellowship program within the past six (6) months.
3. Each participating Specialist Dentist must continue to meet the following criteria for the duration of participation in the Company Plans.
4. Unless specifically permitted otherwise by Company in its sole discretion, if Specialist Dentist is part of a group practice, all dentists in the group must meet Company's Participation Criteria and must agree to participate in all Company Plans in which Specialist Dentist participates. If all dentists in the group do not meet Company's criteria, the group cannot participate.
5. Each Specialist Dentist must execute a Provider Agreement (with a footer dated 05/97 or later) or an alternative acceptable to Company, under which Specialist Dentist agrees to provide services to Members of all health products, plans or programs issued, administered, or serviced by Company or one of its affiliates and specified in the Agreement.

6. Each applicant must fully complete the participation application form, and each applicant and participating Specialist Dentist shall periodically supply to Company all requested information, including, but not limited to, the confidential information forms.

B. Office Standards

Each Specialist Dentist's office must:

1. Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.
2. Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
3. Be readily accessible to all patients, including but not limited to its entrance, parking and bathroom facilities.
4. Be clean, presentable, and have a professional appearance.
5. Provide clean, properly equipped patient toilet and hand washing facilities.
6. Have a waiting room able to accommodate at least four (4) patients.
7. Have treatment rooms which are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.
8. Have a no-smoking policy.
9. Have at least one (1) staff person (in addition to Specialist Dentist) on duty during normal office hours.
10. Provide evidence that Specialist Dentist has a copy of current licenses for all dental hygienists and other non-dentist dental professionals practicing in the office, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).
11. Keep on file and make available to Company any state required practice protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in office.
12. Complete a Location Form identifying the address(es) and physical location(s) of office(s).
13. Have appropriate, safe x-ray equipment. Radiation protection devices, including, without limitation, lead aprons, must be available at all times and used according to professionally recognized guidelines (e.g., Food and Drug Administration). All equipment in Specialist Dentist's office must comply with and maintain such certifications as may be required by federal, state and local laws and regulations (including, but not limited to, laws and regulations regarding maintenance and calibration of equipment).
14. Use appropriate sterilization procedures for instruments; use gloves and disposable needles; and maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state and local laws and regulations, including but not limited to, those mandated by OSHA, and as advocated by the American Dental Association ("ADA") and the component state and local societies.
15. Comply with all applicable federal, state and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.
16. Use an appointment book (or an electronic equivalent acceptable to Company) for scheduling of dental appointments. Appointments should be made in a manner which will prevent undue patient waiting time and in compliance with the access criteria in D. below.
17. Have evidence of a functional recall system in place for notifying Members of the need to schedule dental appointments.
18. Have documented emergency procedures, including procedures addressing treatment and transportation plans to provide for the safety of Members.

C. Coverage

1. When applicable to the relevant specialty, as determined by Company in its sole discretion Specialist Dentist shall ensure that twenty-four (24) hour-a-day coverage for Members is arranged with another Company Participating Specialist Dentist, except as otherwise provided in Section C.3 below.
2. The covering dentist's office must be located within sixty (60) minutes of the Specialist Dentist's office.
3. A Specialist Dentist must submit for prior approval by Company any coverage arrangements made with a nonparticipating specialist dentist. Approval of coverage by a nonparticipating specialist dentist is subject to Company's sole discretion, and such approval must be in writing. If Specialist Dentist receives approval from Company for coverage by a nonparticipating specialist dentist, Specialist Dentist shall require such nonparticipating specialist dentist to comply with applicable terms of the Agreement. Specialist Dentist shall make suitable arrangements regarding the amount and manner in which such covering nonparticipating specialist dentist shall be compensated, provided, however, that Specialist Dentist shall ensure that (except with respect to Reduced Fee Services) the covering dentist will not under any circumstances bill Members (except for applicable Copayments, Coinsurance and Deductibles) for any Covered Services.

D. Access

1. Each Specialist Dentist's office must have, at a minimum, twenty (20) hours of regularly scheduled office hours for the treatment of patients (whether Members or other patients) over at least three (3) days per week.
2. Each Specialist Dentist or his or her covering specialist dentist must respond to a Member within thirty (30) minutes after notification of an urgent call.
3. Each Specialist Dentist must schedule appointments with Members within the following time frames (except as more speedily required by applicable law):
   - Emergency care: must be seen immediately (or referred to ER, as appropriate)
   - Urgent complaint: same day or within twenty-four (24) hours
   - Routine care: within five (5) weeks (eight (8) weeks in TX) (Fifteen (15) days in Connecticut)
4. Each Specialist Dentist office must have adequate plans for managing an increase in patient load.
5. Unless deemed inapplicable to the relevant specialty by Company, in its sole discretion, each Specialist Dentist must have a reliable system, twenty-four (24) hours-a-day, seven (7) days-a-week, for reaching a Specialist Dentist in an emergency. A recorded message or answering service which refers Members to emergency rooms is not acceptable.

E. Patient Load

1. Each Specialist Dentist must designate by age, according to Company guidelines, those Members for whom Specialist Dentist will provide care. If Specialist Dentist participates in Company's dental preferred provider organization (PPO or PDN) plan(s), Specialist Dentist may not close his/her practice to members of those plans.
2. Any use of a dental hygienist or other non-dentist dental professional by a Specialist Dentist must comply with Company's then current policies and all applicable legal requirements regarding practice of such dental professionals.

F. Office Records

1. A Specialist Dentist must demonstrate, at the time of application and thereafter as requested by Company, that his/her dental records are legible, reproducible and otherwise meet Company's standards for confidentiality, and dental/medical record keeping practices, and that clinical documentation demonstrates comprehensive care. Members' dental records shall include reports from referred and/or referring providers, records of emergency care received, a complete medical history of the Member which is updated periodically and includes, without limitation, any allergies, medications, cardiovascular problems, high blood pressure and/or diabetes of Member, and such other information as Company may require from time to time.
2. Each Member encounter must be documented in writing and signed or initialed by the Specialist Dentist or as required by state law.

G. Professional Liability Insurance

1. During the entire term of this Agreement, Specialist Dentist shall maintain insurance or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by specialist dentist's in the state or region in which the Specialist Dentist operates. Specialist Dentist's insurance shall cover the acts and omissions of Specialist Dentist, as well as Specialist Dentist's agents and employees. Certificates of insurance or other documentation as appropriate to show evidence of such coverage shall be delivered to Company upon request. Specialist Dentist must notify Company at least thirty (30) days in advance of the cancellation, limitation or material change of said policies.

H. Philosophy

1. A Specialist Dentist must be supportive of the philosophy and concept of managed care and Company. A Specialist Dentist shall not differentiate or discriminate in the treatment of, or in the access to treatment of, patients on the basis of their status as Members, or other grounds identified in the Agreement.
2. Each Specialist Dentist shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.
3. Specialist Dentist's obligations under the Agreement not to disclose Proprietary Information do not apply to any disclosures to a patient determined by Specialist Dentist to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate Specialist Dentist's legal or ethical obligations.
4. Specialist Dentist is encouraged to discuss Company's provider reimbursement methodology with Specialist Dentist's patients who are Members, subject only to Specialist Dentist's general contractual and ethical obligations not to make false or misleading statements. Accordingly, Proprietary Information does not include descriptions of the reimbursement methodology under which Specialist Dentist is reimbursed, although such Proprietary Information does include the specific rates paid by Company due to their competitively sensitive nature.

II. PROFESSIONAL CRITERIA

A. Licensure

1. A Specialist Dentist must have a valid, unencumbered license to practice dentistry in his/her state of practice, or in the case of a Specialist Dentist with an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that encumbered license does not raise concern about possible future substandard professional performance, competence, or conduct.
2. A Specialist Dentist must be eligible for or possess an unrestricted DEA certification, and, where applicable, a state-mandated controlled drug certification, unless otherwise approved in writing by Company.
3. A Specialist Dentist who renders general anesthesia and/or intravenous sedation services must have a current and valid state certification or permit, if available in the applicable state.

B. Education

1. A Specialist Dentist must be a graduate of a school of dentistry which is accredited by the Commission on Dental Accreditation (of the ADA) or be a graduate of a non-accredited school of dentistry and have completed a pre-licensure advanced education program at an ADA accredited school of dentistry.
2. A Specialist Dentist is required to have successfully completed a clinical postgraduate training program in a dental subspecialty (orthodontics, periodontics, etc.) which is accredited by the Commission on Dental Accreditation of the American Dental Subspecialty Board recognized by the American Dental Association (ADA), for which the provider requests to be recognized.

C. Continuing Education

1. A Specialist Dentist shall meet the continuing education requirements required by state law. An applicant for participation in Company must demonstrate that he/she has met such continuing education requirements for the three (3) years immediately prior to submitting his/her application for participation. If an applicant has been in practice less than three (3) years, or has had a hiatus in practice, the applicant need only demonstrate that he/she has met such continuing education requirements during the period of his/her practice.

III. PROFESSIONAL COMPETENCE AND CONDUCT CRITERIA

A. General

1. Specialist Dentist must be of sound moral character and must not have been indicted, arrested for or charged with, or convicted (i.e., finding of guilt by a judge or jury, a plea of guilty or nolo contendere, participation in a first offender program or any other such program which may be available as an alternative to proceeding with prosecution, whether or not the record has been closed or expunged) of any felony or criminal charge related to moral turpitude or the practice of dentistry.
2. Specialist Dentist must not have engaged in any unprofessional conduct, unacceptable business practices or any other act or omission which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

B. Professional Liability Claims History

1. Specialist Dentist must not have a history of professional liability claims, including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

C. History of Involuntary Termination or Restriction

1. Specialist Dentist must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, or reduction or restriction of duties or privileges, or of a contract to provide health care services, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

D. Notification of Adverse Actions or Limitations

1. Specialist Dentist shall provide immediate notice to Company of any adverse action relating to said dentist's: (i) hospital staff privileges (if applicable); (ii) DEA or state narcotics numbers; (iii) participation in the Medicare, Medicaid, or other governmental programs; or (iv) state licensure, certification, accreditation or other authorization required by law or the Agreement, including censure. Each applicant and Specialist Dentist shall inform the Company in writing of any previous adverse actions with respect to any of the above. For the purpose of this section, "adverse action" includes, but is not limited to, any of the following or their substantial equivalents (regardless of any subsequent action or expungement of the record): denial; exclusions; fine; monitoring; probation; suspension; letter of concern, guidance, censure, or reprimand; debarment; expiration without renewal; subjection to disciplinary action or other similar action or limitation; restriction; counseling; medical or psychological evaluation; loss, in whole or in part; termination or refused participation; revocation; administrative letter; non-renewal; voluntary or involuntary surrender of licensure or status to avoid, or in anticipation of, any of the adverse actions listed regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry; and initiation of investigations, inquiries or other proceedings that could lead to any of the actions listed, regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry. Any such adverse actions may be grounds for action, including without limitation denial, termination or other sanctions imposed pursuant to Company's credentialing/quality improvement programs.
2. Specialist Dentist shall provide immediate notice to Company of any condition or circumstance that impairs or limits his/her ability to perform the essential functions of a Participating Specialist Dentist.
3. Specialist Dentist shall provide immediate notice to Company of any condition or circumstance of which he/she is aware that may pose a direct threat to the safety of himself/herself, coworkers or patients.
4. Specialist Dentist shall provide immediate notice to Company and to Members of any condition or circumstance of which he/she is aware which law or regulation requires Specialist Dentist to report.

E. References

1. Each applicant for participation must supply references as specified in the application and as requested by the applicable peer review committee.

   The applicable peer review committee shall have the right to act on any reference or information received from a Specialist Dentist's colleagues or other professionals. Specialist Dentist waives any and all rights to bring any legal action relating to such information or the collection or use thereof against Company, any Affiliates or related companies or any director, officer, employee or agent thereof, or any person or entity providing a reference or information at the request of the applicable peer review committee.

These criteria may be modified at the sole discretion of Company.

Please refer to the California Participation Criteria for the criteria specific to California Dental Maintenance Organization (DMO®) participating providers.

Member rights and responsibilities

Discrimination

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of race, sex, age, religion, color, disability, national origin, marital status, sexual orientation or health status (including, but not limited to, chronic communicable diseases such as AIDS or HIV-positive status).

Confidentiality policy

Aetna's provider participation agreements require that all dentists maintain patient information in a current, detailed, organized and comprehensive manner and in accordance with customary dental practice, applicable state and federal laws, and accreditation standards.

Accordingly, participating dentists must have in place appropriate policies and procedures to implement these confidentiality requirements. In addition to complying with customary medical practice, applicable state and federal laws, and accreditation standards, these policies and procedures should include, but not be limited to, protection of patient confidentiality under the following circumstances:

- The release of information at the request of the member and in response to a legal request for information.
- The use of a release form, where applicable, is suggested.
- The storage of medical records, including restricted access and maintenance of such records, in secured files.
- Transmitting medical records electronically.
- Educating employees regarding confidentiality of medical records and patient information.

Informed consent

Aetna expects all participating dentists to understand and comply with applicable legal requirements, as well as to adhere to the policies of the dental community in which they practice, regarding informed consent from their patients. In general, it is the participating dentist's duty to give patients adequate information and be reasonably sure the patient has understood it before proceeding to treat the patient. Informed consent documents should be written and signed.

Members have the following rights

Dental members have the right to:

- Get up-to-date information about the dentists who participate in the plan.
- Obtain necessary care from participating dentists, including participating specialty dentists (with referrals if required by the plan) or from any licensed dentist if the plan covers out-of-network services.
- Be told by the dentist office how to make appointments and get dental care during and after office hours.
- Be told how to get in touch with the dentist or a back-up dentist 24 hours a day, every day.
- Call 911 in a situation that might be life threatening.
- Receive a copy of their dental records for transfer to a new office.
- Be treated with respect for their privacy and dignity.
- Have their dental records kept private, except as otherwise required by law or with their approval.
- Have the dentist help make decisions about dental care.
- Refuse any proposed dental treatment.
- Discuss with the dentist their treatment plan and all dental care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that their dentist cannot be penalized for filing a complaint or appeal.
- Get up-to-date information about the services covered by their plan, for instance, what is and is not covered and any applicable limitations or exclusions.
- Get information about copayments and fees, if any, they must pay.
- Be told how to file a complaint or appeal with the plan.
- Receive a prompt reply when they ask plan questions or request information.
- Receive a copy of the plan's Member Rights and Responsibilities statement.

Members have the following responsibilities

Dental members have the responsibility to:

- Follow the directions and advice the member and dentist have agreed upon.
- Tell their dentist promptly when they have unexpected problems or symptoms.
- Tell their dentist if they do not understand the treatment received and to ask if they do not understand how to care for their condition.
- Understand that participating dentists and any other dental care providers who care for them are not employees of Aetna.
- Promptly follow Aetna's complaint and appeal procedures if they believe they need to submit a complaint or appeal.
- Give correct and complete information to dentists and any other health care providers who care for them.
- Treat dentists and their staffs with respect.
- Tell Aetna about other medical/dental coverage.
- Not be involved in dishonest activity directed to the plan or any dentist.
- Read and understand their plan benefits. Know what services are covered and what services are not covered.

The member may have additional rights and responsibilities depending upon the state law applicable to the plan.

The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification and Privacy (AS&P)

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress and signed into law in 1996. HIPAA addresses a broad range of subjects, including a set of administrative simplification provisions (HIPAA AS&P), the purpose of which is to improve the efficiency and effectiveness of the health care system by standardizing the electronic exchange of data and to protect the security and privacy of member health information.

Privacy is an important topic in today's electronic world where, with the simple touch of a key, information can be transmitted quickly to a very broad audience. Much of the public's attention is focusing on member health information because it is sensitive in nature. Is it being properly protected? Who should have access to it, and when? Under what circumstances should we and others within the health care system share it?

Aetna has brought itself into compliance with the AS&P components of HIPAA by addressing these questions and taking steps to control information disclosure by reviewing and, where necessary, making changes to the company policies that safeguard the confidentiality of our member health information.

As part of the effort to improve the day-to-day exchange of data between dentists and payers, HIPAA AS&P includes a requirement mandating the use of certain procedure codes for standard dental transactions. HIPAA-approved code sets are present in the current version of the CDT. Therefore, nonstandard codes may not be used, and Aetna will not accept claims submissions using such codes. To remain compliant, all contracted dental providers treating Aetna members must use only HIPAA-approved code sets in claims submissions involving standard dental transactions.

Network Bulletins

- 2024-10 New Current Dental Terminology (CDT®) 2025 codes
- 2023-12 CDT® D4341/D4342 Claim Submission Guidelines
- 2023-10 New Current Dental Terminology (CDT®) 2024 codes
- 2023-07 Claims administration policy change – Effective 11/01/2023 (D4355)
- 2023-04 Claims administration policy change – Effective 08/01/2023 (D2975)
- 2022-11 New Current Dental Terminology (CDT®) 2023 codes
- 2021-12 New CDT 2022 codes
- 2021-09 Claim administration policy change (D9910)
- 2020-10 New CDT 2021 codes
- 2020-05 Claim administration policy changes (D0431 & D4355)
- 2019-10 New CDT 2020 codes
- 2018-09 New CDT 2019 codes
- 2018-06 Claim administration policy changes – effective September 18, 2018
- 2017-09 New CDT 2018 codes
- 2017-04 Claim administration policy changes – effective July 17, 2017
- 2017-01 Changes to the provider appeal process
- 2016-09 New CDT 2017 codes
- 2016-01 New Aetna Leap℠ and Innovation Health Leap℠ plans
- 2015-09 New CDT 2016 codes
- 2014-10 New CDT 2015 codes
- 2013-12 Dental card suppression
- 2013-10 New CDT 2014 codes
- 2013-09 New dental benefits embedded in Aetna medical plans
  Applies to All contracted Aetna dental PPO providers
- 2013-09 New dental benefits embedded in Aetna and Innovation Health medical plans
  Applies to All contracted Aetna dental PPO providers in DC, MD, and VA

Network Bulletin

Date: October 2024

From: Anna Huck, Director, Network Management, Dental

Subject: New Current Dental Terminology (CDT®) 2025 codes

Applies to: PPO and Extend Networks

This bulletin is part of your *Dental Office Guide*.

New CDT® 2025[1] codes

The American Dental Association has issued new CDT codes starting **January 1, 2025**. We've listed them below.

Fee information for the new CDT 2025 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2025 Code[1]	Nomenclature	Contracted Fees for CDT 2025 codes are based on the following:
D2000 – D2999	**III. Restorative**	
D2956	Removal of an Indirect Restoration on a Natural Tooth	30% of negotiated fee for D9120
D6000-D6199	**VIII. Implant Services**	
D6180	Implant Maintenance Procedures When a Full Arch Fixed Hybrid Prosthesis is Not Removed, including Cleansing of Prosthesis and Abutments	25% of negotiated fee for D6080 Covered only if the plan has implant coverage.
D6193	Replacement of an Implant Screw	100% of negotiated fee for D6096 Covered only if the plan has implant coverage.

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.
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Dental policies and plans are insured and/or administered by Aetna Life Insurance Company (Aetna).

In Texas, the dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN).

CDT 2025 Code[1]	Nomenclature	Contracted Fees for CDT 2025 codes are based on the following:
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7252	Partial Extraction for Immediate Implant Placement	100% of negotiated fee for D3920 Covered only if the plan has implant coverage.
D7259	Nerve Dissection	Not Covered
D9000-D9999	**XII. Adjunctive General Services**	
D9913	Administration of Neuromodulators	Not Covered
D9914	Administration of Dermal Fillers	Not Covered
D9959	Unspecified Sleep Apnea Services Procedure, by Report	Not Covered

Network Bulletin

Date: December 2023

From: Anna Huck, Director, Network Management, Dental

Subject: CDT® D4341/D4342 Claim Submission Guidelines

Applies to: All Aetna Dental plans

This bulletin is part of your *Dental Office Guide*.

According to the American Academy of Periodontology treatment guidelines, periodontal health should be achieved in the least invasive manner, often via scaling and root planing.

Periodontal scaling and root planing (CDT code D4341/4342) is distinctly different from a dental prophylaxis (CDT code D1110) and scaling in the presence of generalized moderate or severe gingival inflammation (CDT code D4346). Key to scaling and root planing is the instrumentation and removal of deposits from the root surfaces of the tooth for patients with indicators of chronic periodontitis as described in the ADA's guide, "Claims Submission: Scaling and Root Planing."

Scaling and root planing typically takes a substantial amount of time per quadrant and routinely requires local anesthetic. The length and nature of the procedure and use of local anesthetic normally necessitates multiple appointments, with one or two quadrants being performed per appointment. For a submission of D4341, the quadrant must include at least 4 teeth with periodontitis, and a submission of D4342 is appropriate for a partial quadrant that includes 1-3 teeth with periodontitis. Periodontal maintenance visits (D4910) by definition also include site-specific scaling and root planing for any number of teeth.

Documentation to support a diagnosis of chronic periodontitis and the delivery of scaling and root planing must consist of the following:

1) Periodontal charting that records pocket depths at 6 points per tooth, bleeding on probing, gingival recession, frenum involvement, and furcation defects. With periodontitis, pocket depths are usually at least 4mm, but **we do not base benefit determinations solely on pocket depth**.
2) Full mouth radiographs or digital images that **clearly show bone loss**
3) Chart notes that show whether or not local anesthetic was administered, and details regarding the treatment performed
4) Documentation of length of appointment
   The diagnostic materials must demonstrate the following:
   - Clinical loss of periodontal attachment
   - Radiographic evidence of crestal bone loss, without which root planing cannot be performed
   - Radiographic evidence of root surface calculus

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

Claims Submission: Scaling and Root Planing (SRP)

D4341 – PERIODONTAL SCALING AND ROOT PLANING – FOUR OR MORE TEETH PER QUADRANT
D4342 – PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH PER QUADRANT

According to the American Academy of Periodontology, a patient is a periodontitis case in the context of clinical care if:

-- Interdental CAL is detectable at ≥2 non-adjacent teeth, OR

-- Buccal or oral CAL ≥3 mm with pocketing >3 mm is detectable at ≥2 teeth

And the observed CAL cannot be ascribed to non-periodontal causes such as: 1) gingival recession of traumatic origin; 2) dental caries extending in the cervical area of the tooth; 3) the presence of CAL on the distal aspect of a second molar and associated with malposition or extraction of a third molar, 4) an endodontic lesion draining through the marginal periodontium; and 5) the occurrence of a vertical root fracture.[1]

According to the ADA Evidence-Based Clinical Recommendations for patients with chronic periodontitis i.e. with the clinical indicators noted above, clinicians should consider scaling and root planing (SRP) as the initial definitive treatment.

SRP Claims

- D4341 and D4342 are not "by report" codes.
- However, in order to adjudicate the patient's benefit based on plan policies, carriers require additional information to process the claims. Dentists, especially those in-network are contractually obligated to respond to such requests. Supporting documentation that may facilitate faster claim processing include:
    - Narrative indicating periodontal disease
    - Documentation of the amount of millimeter attachment loss/ bone loss. Documentation options include:
        - Diagnostic quality radiographs showing bone loss (see inset for more information). Include images for all affected teeth that need SRP
        - Complete periodontal chart Indicating loss of attachment/bone loss, bleeding on probing, and pocket depths. Proper periodontal charting typically includes documentation on at least 6 sites around each affected tooth/ implant.
- If four (4) quadrants of SRP were completed in one visit/appointment, be sure to indicate why and submit a narrative outlining the reason (Examples of circumstances that may require treatment in multiple quadrants on the same date include but are not limited to: patient's needing IV sedation for treatment, patients with special needs, patients with transportation barriers, patients need pre-treatment antibiotics etc.).

DIAGNOSTIC QUALITY RADIOGRAPHS

Dental plans have stated that a common reason for SRP claim denials or requests for additional information are due to receiving radiographs that are not of diagnostic quality. Staff should perform a quality review before an SRP claim is submitted to a dental plan and verify that:

- ✓ Preferably bite-wings (vertical or horizontal as long as the image captures the bone height in relation to the root and any furcation involvement) or sometimes the full mouth series are submitted. **NOT** panoramic X-rays.
- ✓ Radiographs are properly mounted and labeled (e.g., left and/or right, and with the patient's name)
- ✓ Diagnostic quality depicting appropriate structures
- ✓ Submitted radiographs should be duplicates and taken immediately prior to the diagnostic treatment planning appointment.
- ✓ See Appendix 2: Examples of Good and Poor Radiographs for SRP Claims

[1] https://aap.onlinelibrary.wiley.com/doi/10.1002/JPER.18-0006

- Some plans may not benefit 4 quadrants in one visit, regardless of documentation submitted. Refer to the plan's processing policies for more details.
- Some plans may additionally request a copy of your schedule indicating allocation of chair-time necessary to complete 4 quadrants on the same day.
- Some plans may request documentation that in fact local anesthesia was used during the procedure.

Offices that submit the proper documentation will have better chances of getting these claims correctly adjudicated on the first submission.

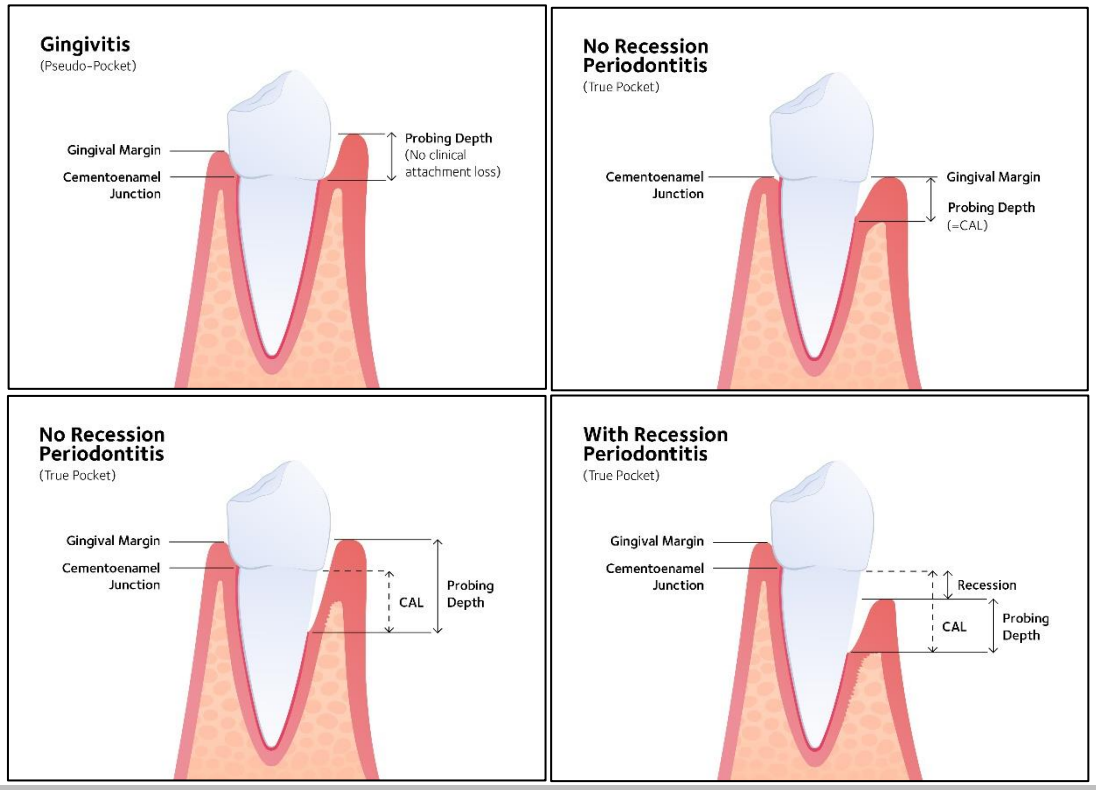
Dentists need to be involved in the claim submission quality review process as the treating dentist has an important responsibility to assure the accuracy of submitted claims. This includes completion of all accompanying clinical documentation necessary for proper claim adjudication.

Front office staff should address any concerns with the completed claim form and accompanying documentation with the treating dentist *before* submission of the claim. This includes radiographs, claim forms, periodontal charting and narrative descriptions.

Recording Attachment Loss

Probing depth or pocket depth is measured from the gingival margin, and the measurement is affected by gingival recession or inflammation. Clinical attachment loss (CAL) is measured from a fixed reference point (typically the cementoenamel junction) and is a more stable indicator of periodontal health.

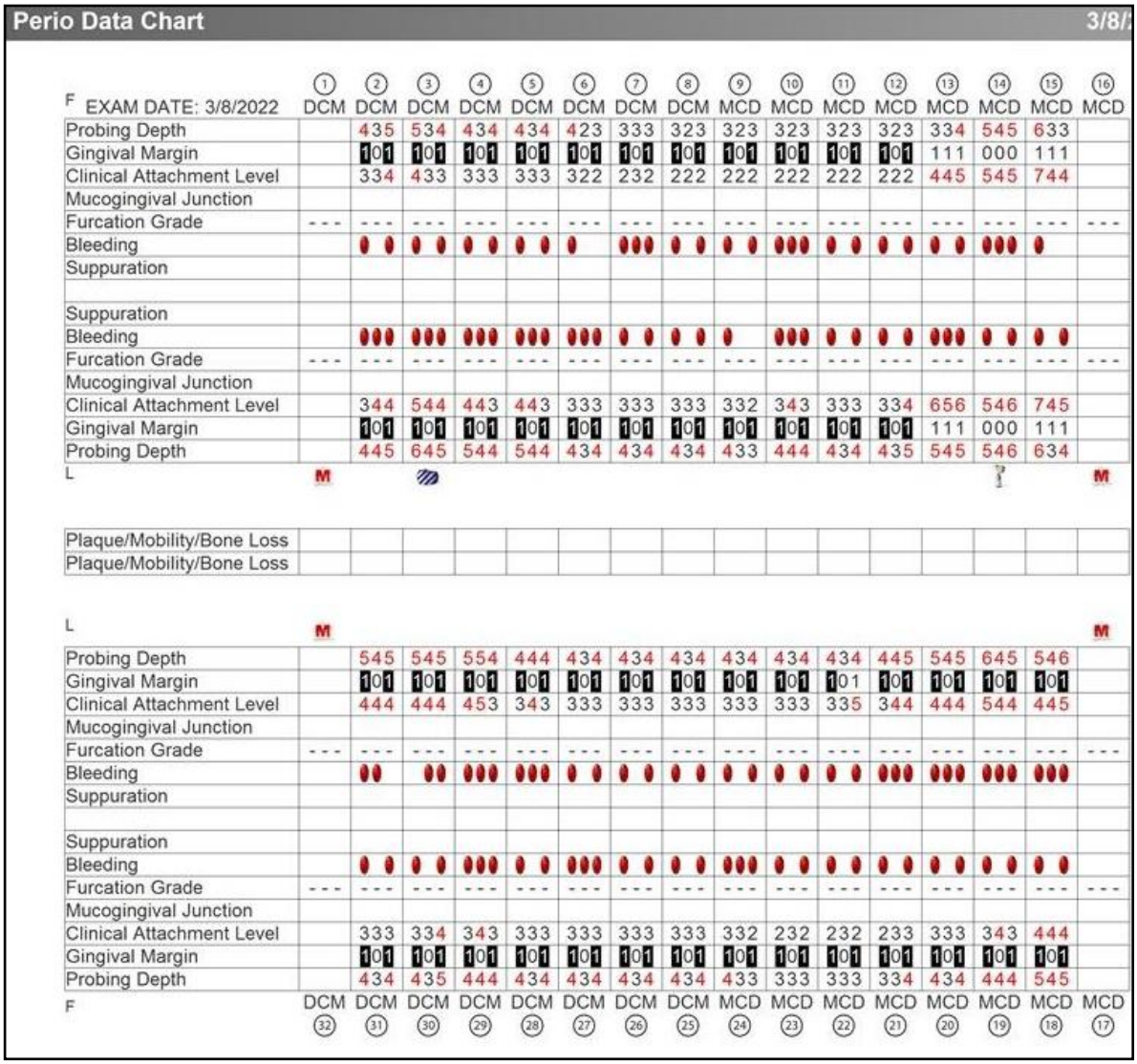
In cases without any recession, Loss of attachment (mm) = Probing Depth (mm) – mm from gingival margin to CEJ.
In cases with recession, Loss of attachment (mm) = Probing Depth (mm) + Recession (mm from CEJ to gingival margin).



Pseudo-pocketing caused by hyperplastic gingival tissue or inflamed gingival tissue can result in abnormal probing depth without concomitant bone loss/ loss of attachment. Treatment of this condition should be reported as a prophylaxis (D1110 or D1120) or scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346). More info can be found in the ADA Guide to Reporting D4346.

Sample Periodontal Chart

Dental offices that use a practice management software typically have a periodontal module that can generate a periodontal chart that can be communicated to the dental plan. A sample chart appears below. Note the different periodontal parameters included on a **complete periodontal chart**.



Perio Data Chart 3/8/

F EXAM DATE: 3/8/2022	① DCM	② DCM	③ DCM	④ DCM	⑤ DCM	⑥ DCM	⑦ DCM	⑧ DCM	⑨ MCD	⑩ MCD	⑪ MCD	⑫ MCD	⑬ MCD	⑭ MCD	⑮ MCD	⑯ MCD
Probing Depth		435	534	434	434	423	333	323	323	323	323	323	334	545	633	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	111	000	111	
Clinical Attachment Level		334	433	333	333	322	232	222	222	222	222	222	445	545	744	
Mucogingival Junction																
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Bleeding		• •	• •	• •	• •	•	•••	• •	• •	•••	• •	• •	• •	•••	•	
Suppuration																
Suppuration																
Bleeding		•••	•••	•••	•••	•••	• •	• •	•	•••	• •	• •	•••	• •	• •	
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Mucogingival Junction																
Clinical Attachment Level		344	544	443	443	333	333	333	332	343	333	334	656	546	745	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	111	000	111	
Probing Depth		445	645	544	544	434	434	434	433	444	434	435	545	546	634	
L	M															M

Plaque/Mobility/Bone Loss	
Plaque/Mobility/Bone Loss	

L	M															M
Probing Depth		545	545	554	444	434	434	434	434	434	434	445	545	645	546	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	101	101	101	
Clinical Attachment Level		444	444	453	343	333	333	333	333	333	335	344	444	544	445	
Mucogingival Junction																
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Bleeding		••	••	•••	•••	• •	• •	• •	• •	• •	• •	•••	•••	•••	•••	
Suppuration																
Suppuration																
Bleeding		• •	• •	•••	• •	•••	• •	• •	•••	• •	• •	• •	• •	• •	• •	
Furcation Grade	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Mucogingival Junction																
Clinical Attachment Level		333	334	343	333	333	333	333	332	232	232	233	333	343	444	
Gingival Margin		101	101	101	101	101	101	101	101	101	101	101	101	101	101	
Probing Depth		434	435	444	434	434	434	434	433	333	333	334	434	444	545	
F	DCM ㉜	DCM ㉛	DCM ㉚	DCM ㉙	DCM ㉘	DCM ㉗	DCM ㉖	DCM ㉕	MCD ㉔	MCD ㉓	MCD ㉒	MCD ㉑	MCD ⑳	MCD ⑲	MCD ⑱	MCD ⑰

ADA®

Why do my SRP claims get denied?

Periodontal scaling and root planing (SRP) procedures (D4341 and D4342) tend to have a higher frequency for denial and/or requests for additional information from dental plans in comparison to many other procedures. Dentists may not always understand why claims for SRP are denied when the patient has abnormal pocket depths. A claim may be paid on one patient while at other times a plan may deny the same procedure on another patient who had a similar clinical presentation.

- Different dental plans have different coverage and processing policies for SRP claims. Examples include:

  "Document at least 4mm pocket depths on the diseased teeth involved. No payment is made and the fees are not billable to the patient by a participating dentist in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss."

  "Benefits for D4341 and D4342 require root surface calculus, radiographic bone loss and bleeding upon probing. Additional information such as gingival recession, frenum involvement and furcation defects are also evaluated, but in general, documented 5-8 mm pockets determine benefits".

- Plans will typically not pay separately for SRP on the same date of service as a surgical periodontal procedure on the same teeth.
- Plans may have different coverage policies for SRP around natural teeth versus implants.
- Plans may implement frequency limitations for retreatment within a designated time frame, for example, twenty-four months from the original treatment date.
- Plans may not provide coverage for more than 2 quadrants of SRP on the same date of service unless there are extenuating circumstances and the documentation supports the need. These plans may request the amount of time it took to scale and root plane and a narrative (which includes details on use of anesthesia) in order to determine coverage and benefits.

It is essential for dentists and their teams to fully read and understand each payer's processing policies.

Payers note that if there is no radiographic evidence of bone loss, root surface calculus or adequate clinical attachment loss demonstrated by the submitted periodontal charting, the claim will typically be denied. If only certain teeth in a quadrant meet these criteria, a partial quadrant, only D4342 may be benefitted. Payers report that a common issue is that radiographs submitted with claim(s) are not properly mounted, labeled, or are not of diagnostic quality. Payers have stated that at times the charting is not legible or is incomplete.

When the claim is denied due to frequency limits, annual benefit or other plan limitations and depending on how the explanation of benefits (EOB) statement is worded, some patients may think that the dentist has provided unnecessary work. This may create unnecessary friction in the dentist-patient relationship. To help prevent this, **dental plans should make it clear to both patients and dentists that claims denials due to processing policies does not mean that the treatment was unnecessary; the denial is based on solely on plan limitations.** Dentists should advise their patients that coverage is often based on employer funding of the policy purchased rather than the clinical needs of the specific patients.

It is the ADA's position that all communications to beneficiaries from third-party payers that attempt to explain the reason(s) for a benefit reduction or denial of a dental benefits plan include the following statement, "*Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted*."

It is always appropriate to appeal the benefit decision if the dentist thinks the claim has not been properly adjudicated. A proper appeal involves sending the plan a written request to reconsider the claim with any additional information.

Guiding Values for the Treating Dentist

The American Dental Association (ADA) makes a commitment to society that member dentists will adhere to ethical standards of conduct, which have the benefit of the patient as their primary concern as noted in the Preamble of the ADA Principles of Ethics and Code of Professional Conduct (ADA Code). All member dentists voluntarily agree to abide by the ADA Code.

Specific to determining the treatment plan and procedure coding, in Section 5 of the ADA Code, the principle Veracity ("truthfulness") is one which all dentists should remain mindful of. This section specifically states that, “the dentist has a duty to communicate truthfully.”

> *This principle expresses the concept that professionals have a duty to be honest and trustworthy in their dealings with people. Under this principle, the dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity.*

For specific information about how Section 5 of ADA Code of Professional Conduct pertains to dentist’s responsibility to assure all claims submitted on their behalf are done so correctly, please refer the ADA Guide *Assuring Accuracy of Claims as a Treating Dentist*.

The Future of Artificial Intelligence (AI) and Its Role in SRP Claims Review

Dental payers complete utilization reviews on all or a portion of the claims they receive, but most notably on SRP claims. Payers use the types of required documentation covered in this guide to review submitted SRP claims, and these reviews have traditionally been carried out by the payers’ dental consultants.

Many payers are now looking towards new technology that can automate the claims review process.

The application of AI as a first pass in the screening of the large amount of documentation being requested and sent in related to SRP claims is something that is becoming more commonplace across the dental payer landscape. When used appropriately, the hope is that AI can step in and deliver immediate benefits that reduce frustration between dentists and dental carriers by ensuring claim completeness, more consistency in payers ’reviews, and an overall increase in efficiency for all parties. The ADA will continue to closely monitor the application of AI to make certain that claims are not unfairly adjudicated during its use.

Additional information on valuable educational ready-to-use resources on innovative dental insurance solutions for dentists can be found at ADA.org/dentalinsurance.

ADA®

Appendix 1: Example of Processing Policies

Payer #1:

D4341 Periodontal scaling & root planing-four or more teeth per quadrant

a. Document at least 4mm pocket depths on the diseased teeth involved. No payment is made and the fees are not billable to the patient by a participating dentist in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss.
b. Do not count teeth bounded spaces for D4210, D4341. Count only diseased teeth.
c. When there is a contractual time limitation on the frequency of benefits for scaling and root planing, and subsequent requests for scaling and root planing benefits are submitted within that contractual time limitation, benefits are DENIED. In the absence of a contractual time limitation for scaling and root planing, fees for D4341 are not billable to the patient by a participating dentist within 24 months when done by the same dentist/dental office. If treatment is done by a different dentist within 24 months, benefits are DENIED.
d. Adult prophylaxis procedures (D1110), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4341. This time limitation, like all other contractual time limitations, should be defined in the group/individual contract. Fees for the prophylaxis procedure by the same dentist/dental office are not billable to the patient by a participating dentist.
e. Benefit no more than two quadrants of scaling and root planing on the same date of service. More than two quadrants on the same date of service are not billable to the patient by the same participating dentist/dental office/DENIED-nonparticipating dentist.
f. For patients under the age of 30, clinical treatment notes, the most current (less than two years old) complete series of radiographic images, complete periodontal charting (no more 12 months old) and a copy of the appointment schedule showing the length of the appointment time are required. No payment is made for periodontal maintenance (D4910), scaling in presence of generalized moderate or severe gingival inflammation (D4346) or prophylaxis (D1110) when performed on the same day as scaling and root planning (D4341). The fee is not billable to the patient by a participating dentist.

D4342 Periodontal scaling & root planing-one to three teeth per quadrant: Scaling and root planing in the same quadrant is benefited once every 24 months unless specified by group contract. Reporting separately for periodontal root planing is not billable to the patient by a participating dentist on the same date as procedures D4240-D4241, D4249, D4260-4261, D4270-D4285.

Do not count tooth bounded spaces for D4341, D4342. In order to qualify for benefits probing depths must be 4mm or greater on 4 or more teeth. If only 1-3 teeth qualify, use partial quadrant code (D4342). If no teeth in the quadrant qualify, the Dental Consultant will DENY.

Payer #2:

When supporting documentation is requested for periodontal services, please refer to the submission guidelines as outlined in this section.

- A quadrant is defined as four or more contiguous teeth per quadrant.
- A partial quadrant is defined as one to three teeth per quadrant. For billing purposes, a sextant is not a recognized designation by the American Dental Association.
- Alveolar crestal bone loss must be evident radiographically for scaling and root planning to be covered.

When more than one periodontal service (codes D4000-D4999) is completed within the same site or quadrant on the same date of service, carrier will pay for the more extensive treatment as payment for the total service.

Benefits for all periodontal services are limited to two quadrants per date of service. If you want to request an exception to this due to a medical condition that may require your patient to receive extended treatment, please include a detailed narrative including general or intravenous anesthesia record, medical condition and length of appointment time.

Payer #3:

Benefits for D4341 and D4342 require root surface calculus, radiographic bone loss and bleeding upon probing. Additional information such as gingival recession, frenum involvement and furcation defects are also evaluated, but in general, documented 5-8 mm pockets determine benefits.

Payer #4:

Scaling and Root Planing
Scaling and Root Planing is indicated for the treatment of localized or generalized active Periodontal Disease characterized by:
Periodontal probing depths of 4-6+ mm with radiographic evidence of horizontal or vertical bone loss
Refractory or recurrent Periodontal Disease
Periodontal abscess

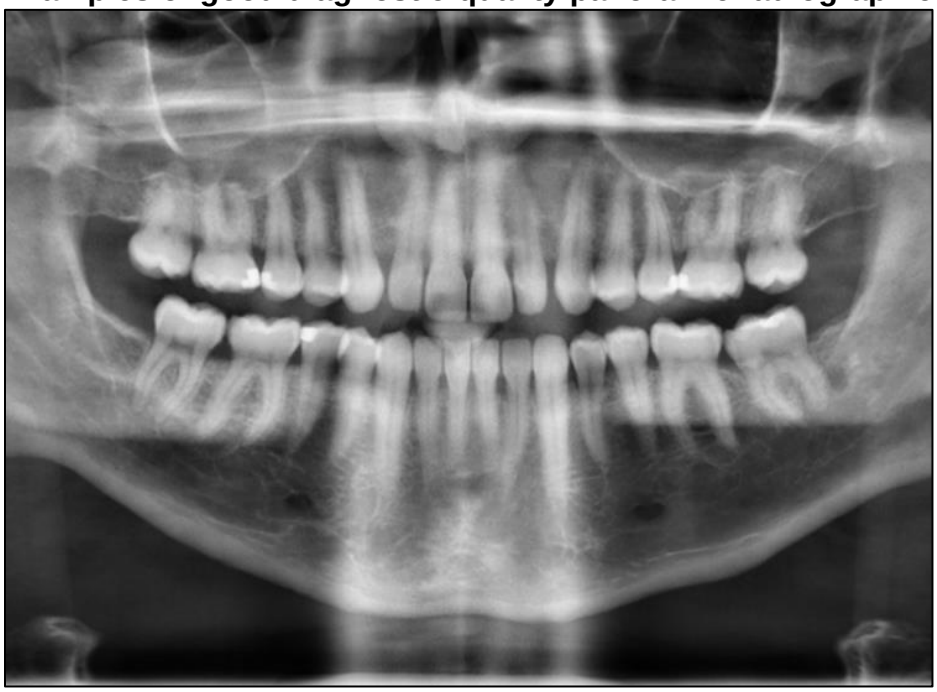
Scaling and Root Planing is not indicated for the following:
For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss
Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue)

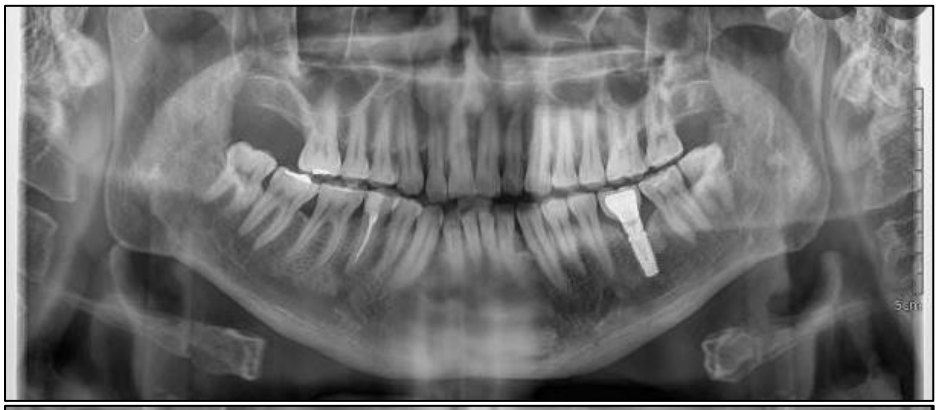
Coverage Limitations
Scaling and Root Planing is limited to 1 time per quadrant per consecutive 24 months

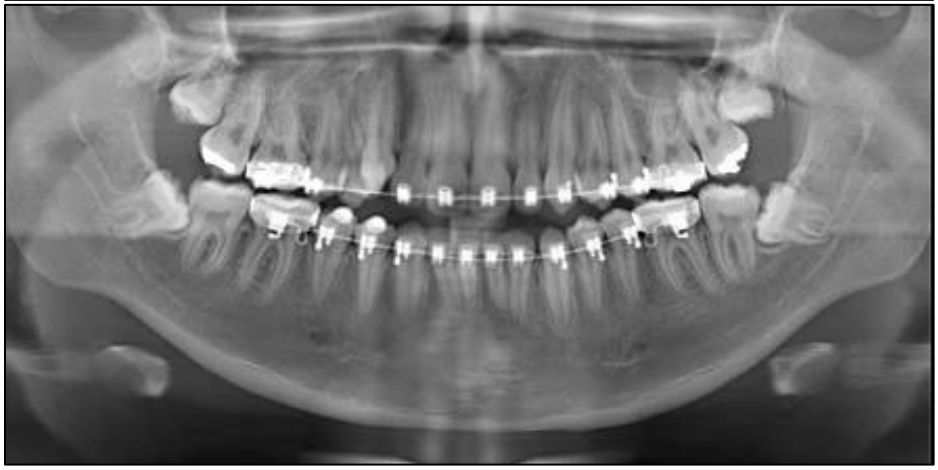
Appendix 2: Examples of Good and Poor Radiographs for SRP Claims

[Note: some of the enclosed examples are images that are zoomed-in and enlarged.]

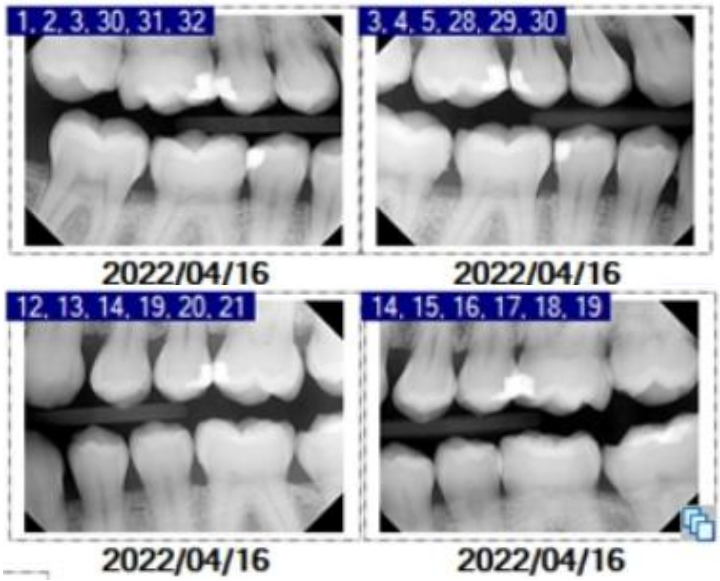
Examples of good diagnostic-quality panoramic radiographic images



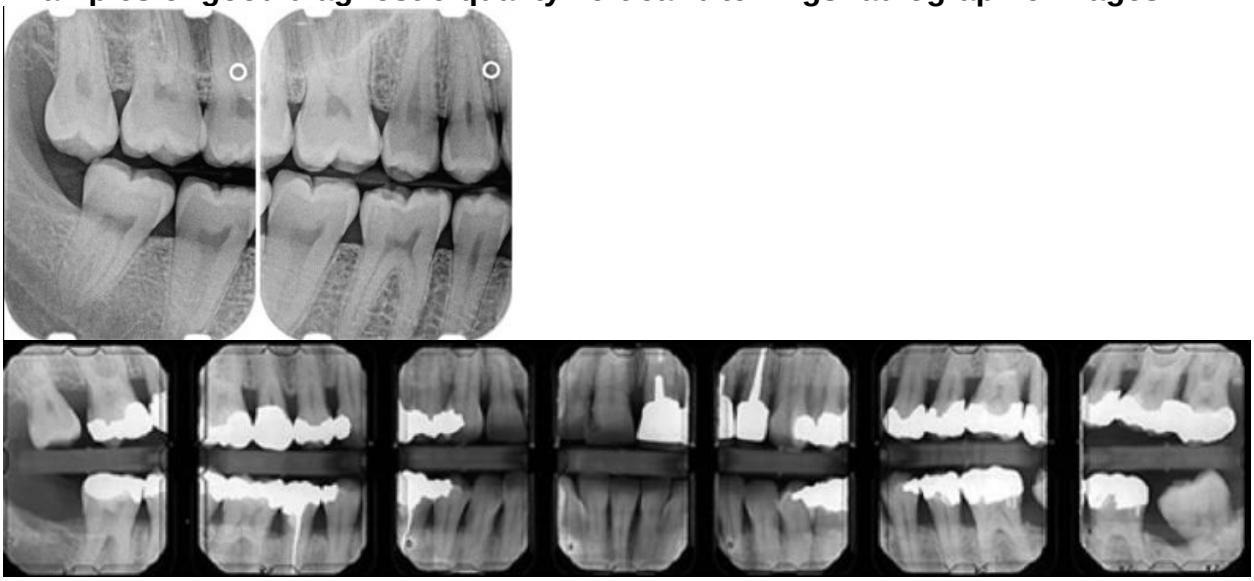




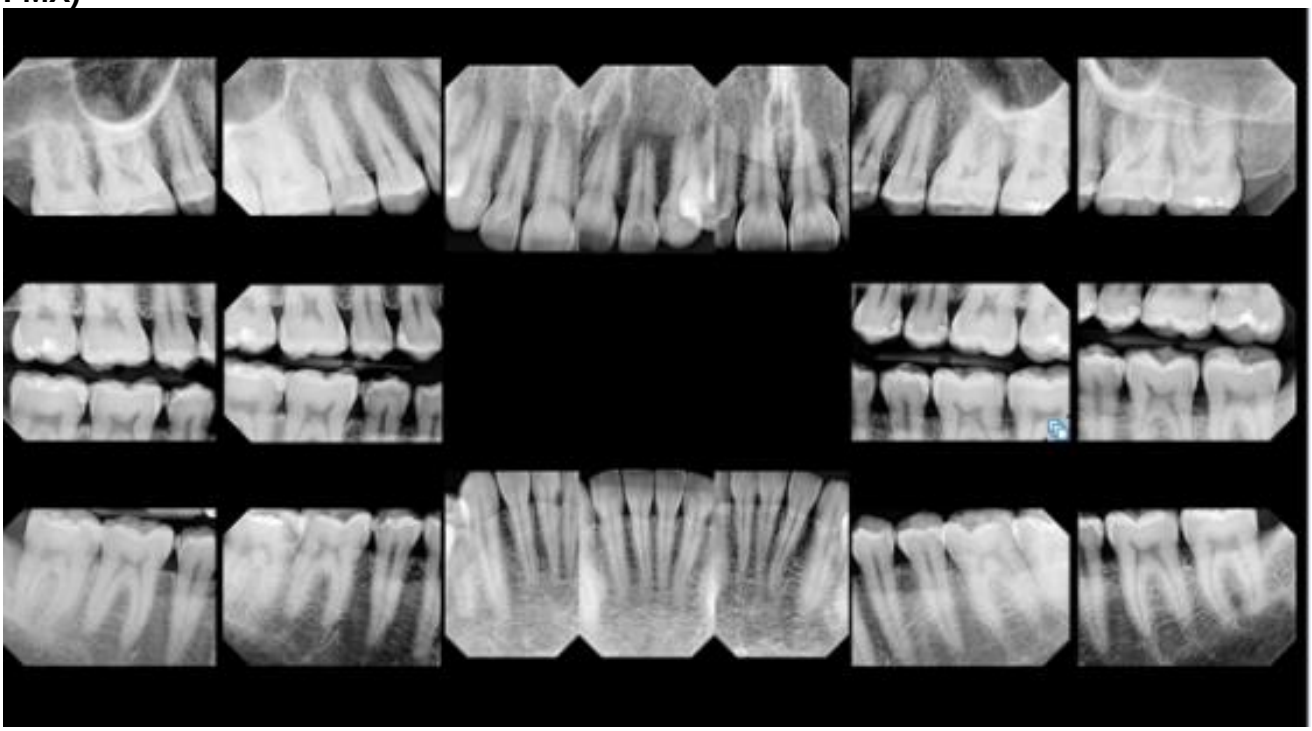
Examples of good diagnostic-quality bitewing radiographic images

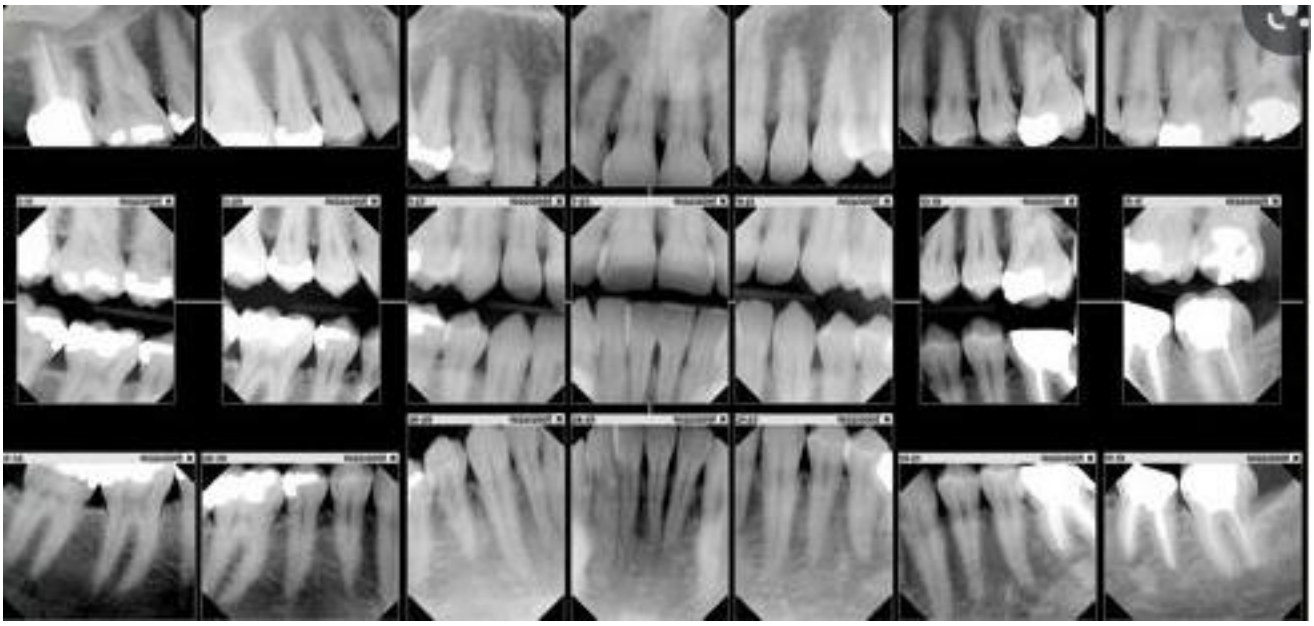


Examples of good diagnostic-quality vertical bitewings radiographic images

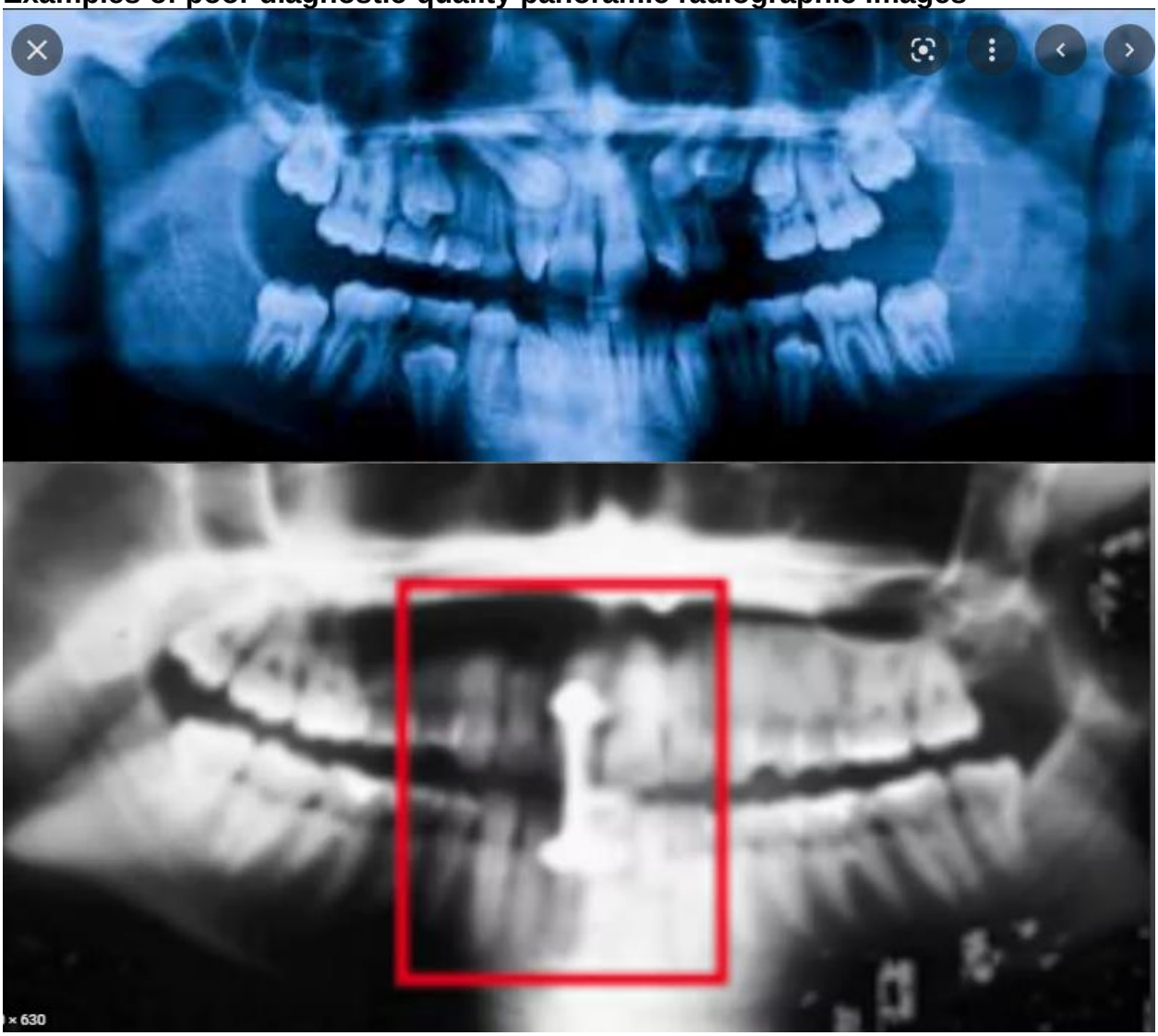


Examples of good diagnostic-quality intraoral – complete series of radiographic images (i.e., FMX)

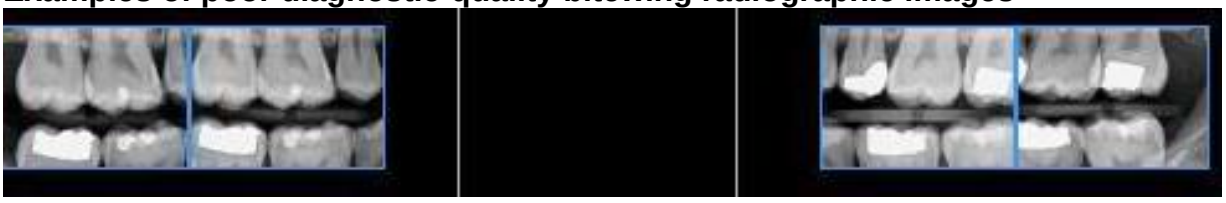


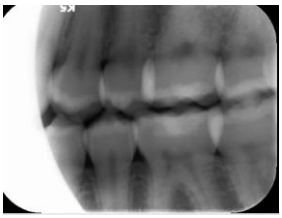


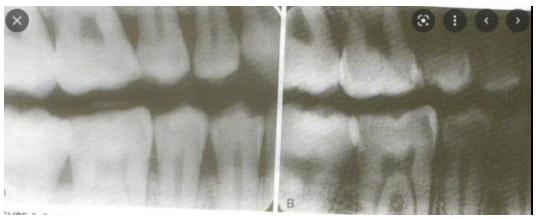
Examples of poor diagnostic-quality panoramic radiographic images



Examples of poor diagnostic-quality bitewing radiographic images







Network Bulletin

Date: October 2023

From: Anna Huck, Director, Network Management, Dental

Subject: New Current Dental Terminology (CDT®) 2024 codes

Applies to: PPO and Extend networks

This bulletin is part of your *Dental Office Guide*.

New CDT® 2024[1] codes

The American Dental Association has issued new CDT codes starting **January 1, 2024**. We've listed them below.

Fee information for the new CDT 2024 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2024 Code[1]	Nomenclature	Contracted Fees for CDT 2024 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0396	3D printing of a 3D dental surface scan	If done in conjunction with ortho, part of total case fee. Otherwise, not covered.
D1000 - D1999	**II. Preventive**	
D1301	immunization counseling	Not Covered
D2000 – D2999	**III. Restorative**	

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Dental policies and plans are insured and/or administered by Aetna Life Insurance Company (Aetna).

In Texas, the dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN).

CDT 2024 Code[1]	Nomenclature	Contracted Fees for CDT 2024 codes are based on the following:
D2976	band stabilization – per tooth	Not Covered
D2989	excavation of a tooth resulting in the determination of non-restorability	50% of negotiated fee for D2140
D2991	application of hydroxyapatite regeneration medicament – per tooth	150% of negotiated fee for D1354
D6000-D6199	**VIII. Implant Services**	
D6089	accessing and retorquing loose implant screw - per screw	40% of negotiated fee for D6096
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7284	excisional biopsy of minor salivary glands	150% of negotiated fee for D7286
D7939	indexing for osteotomy using dynamic robotic assisted or dynamic navigation	Not Covered
D9000-D9999	**XII. Adjunctive General Services**	
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance	Not Covered
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	Not Covered
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Not Covered
D9955	oral appliance therapy (OAT) titration visit	Not Covered
D9956	administration of home sleep apnea test	Not Covered
D9957	screening for sleep related breathing disorders	Not Covered

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Network Bulletin

Date: July 2023

From: Anna Huck, Lead Director, Network Management

Subject: Claims administration policy change

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following change that will take effect for all Aetna Dental plans on November 1, 2023.

D4355 – Full Mouth Debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit

- D4355 is no longer a separately eligible procedure when performed on same date of service as D0150, D0160, D0180, D1110, D1120, D4341, D4342 and D4366
- Members cannot be billed

We're here to help
If you have questions, call us at **1-800-451-7715**. You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental® plans.

MD-2173-21

Network Bulletin

Date: April 2023

From: Anna Huck, Lead Director, Network Management

Subject: Claims administration policy change

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following change that will take effect for all Aetna Dental plans on August 1, 2023.

D2975 – Coping. A thin covering of the coronal portion of a tooth, usually devoid of anatomic contour, that can be used as a definitive restoration.

Aetna considers D2975 inclusive to the primary restorative or prosthetic service. Members cannot be billed.

We're here to help
If you have questions, call us at **1-800-451-7715**. You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental® plans.

MD-2173-21

Network Bulletin

Date: November 2022

From: Anna Huck, Director, Network Management, Dental

Subject: New Current Dental Terminology (CDT®) 2023 codes

Applies to: PPO and Extend networks

This bulletin is part of your *Dental Office Guide*.

New CDT 2023[1] codes

The American Dental Association has issued new CDT codes starting **January 1, 2023**. We've listed them below.

Fee information for the new CDT 2023 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2023 Code[1]	Nomenclature	Contracted Fees for CDT 2023 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	100% of negotiated fee for D0210
D0373	intraoral tomosynthesis – bitewing radiographic image	100% of negotiated fee for D0270
D0374	intraoral tomosynthesis – periapical radiographic image	100% of negotiated fee for D0220
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	100% of negotiated fee for D0709
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	100% of negotiated fee for D0708

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Dental policies and plans are insured and/or administered by Aetna Life Insurance Company (Aetna).

In Texas, the dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN).

CDT 2023 Code[1]	Nomenclature	Contracted Fees for CDT 2023 codes are based on the following:
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	100% of negotiated fee for D0707
D0801	3D dental surface scan – direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered
D0802	3D dental surface scan – indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered
D0803	3D facial surface scan – direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered
D0804	3D facial surface scan – indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered
D1000 - D1999	**II. Preventive**	
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	Not Covered
D1709	Moderna Covid-19 vaccine administration – third dose	Not Covered
D1710	Moderna Covid-19 vaccine administration – third dose	Not Covered
D1711	Moderna Covid-19 vaccine administration – booster dose	Not Covered
D1712	Janssen Covid-19 vaccine administration - booster dose	Not Covered
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	Not Covered
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	Not Covered
D1781	vaccine administration – human papillomavirus – Dose 1	Not Covered
D1782	vaccine administration – human papillomavirus – Dose 2	Not Covered
D1783	vaccine administration – human papillomavirus – Dose 3	Not Covered
D4000-D4999	**V. Periodontics**	
D4286	removal of non-resorbable barrier	Inclusive with D7957 - Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site
D6000-D6199	**VIII. Implant Services**	
D6105	removal of implant body not requiring bone removal or flap elevation	50% of negotiated rate for D7140
D6106	guided tissue regeneration – resorbable barrier, per implant	Not Covered
D6107	guided tissue regeneration – non-resorbable barrier, per implant	Not Covered
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	100% of negotiated fee for D2391

CDT 2023 Code[1]	Nomenclature	Contracted Fees for CDT 2023 codes are based on the following:
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7509	marsupialization of odontogenic cyst	100% of negotiated fee for D7450
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	Not Covered
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Not Covered
D9000-D9999	**XII. Adjunctive General Services**	
D9953	reline custom sleep apnea appliance (indirect)	Not Covered

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Network Bulletin

Date: December 2021

From: Anna Huck, Director, Dental Network Operations

Subject: New CDT 2022 codes

Applies to: PPO and Extend networks

This bulletin is part of your *Dental Office Guide*.

New CDT® 2022[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2022**. We've listed them below.

Fee information for the new CDT 2022 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2022 Code[1]	Nomenclature	Contracted Fees for CDT 2022 codes are based on the following:
D3000-D3999	**IV. Endodontics**	
D3911	Intraorifice Barrier	Inclusive to root canals
D3921	Decoronation or Submergence of an Erupted Tooth	Not Covered
D4000-D4999	**V. Periodontics**	
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered

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CDT 2022 Code[1]	Nomenclature	Contracted Fees for CDT 2022 codes are based on the following:
D5000-D5999	**VI. Prosthodontics (Removable)**	
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)	100% of negotiated fee for D5225
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)	100% of negotiated fee for D5226
D5725	Rebase Hybrid Prosthesis	100% of negotiated fee for D5720
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect	100% of negotiated fee midpoint for D5750/D5760
D6000-D6199	**VIII. Implant Services**	
D6198	Remove Interim Implant Component	Inclusive to permanent restoration
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7298	Removal of Temporary Anchorage Device [Screw Retained Plate], Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)
D7299	Removal of Temporary Anchorage Device, Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)
D7300	Removal of Temporary Anchorage Device Without Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)
D9000-D9999	**XII. Adjunctive General Services**	
D9912	Pre-visit Patient Screening	Inclusive with record keeping requirements
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	Not Covered
D9948	Adjustment of Custom Sleep Apnea Appliance	Not Covered
D9949	Repair of Custom Sleep Apnea Appliance	Not Covered

Network Bulletin

Date: September 2021

From: Anna Huck, Director, Network Management

Subject: Claim administration policy change

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following changes that will take effect for all Aetna Dental® plans on **January 1, 2022**:

D9910 – Application of desensitizing medicament - Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations.

Based on above descriptor, we consider D9910 inclusive with the restoration being performed on the same day of service. Members cannot be billed for this service.

We're here to help

If you have questions, call us at **1-800-451-7715**. You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental® plans.

Network Bulletin

Date: October 2020

From: Michelle Neuman, Senior Director, Dental Network Operations

Subject: New CDT 2021 codes

Applies to: PPO and Extend networks

This bulletin is part of your *Dental Office Guide*.

New CDT® 2021[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2021**. We've listed them below.

Fee information for the new CDT 2021 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2021 Code[1]	Nomenclature	Contracted Fees for CDT 2021 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0604	Antigen testing for a public health related pathogen including coronavirus	Not Covered
D0605	Antibody testing for a public health related pathogen including coronavirus	Not Covered
D0701	Panoramic radiographic image – image capture only	40% of negotiated fee for D0330
D0702	2-D cephalometric radiographic image – image capture only	40% of negotiated fee for D0340
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	40% of negotiated fee for D0350
D0704	3-D photographic image – image capture only	40% of negotiated fee for D0351

MD-2036-20

CDT 2021 Code[1]	Nomenclature	Contracted Fees for CDT 2021 codes are based on the following:
D0705	Extra-oral posterior dental radiographic image – image capture only	10% of negotiated fee for D0251
D0706	Intraoral – occlusal radiographic image – image capture only	10% of negotiated fee for D0240
D0707	Intraoral – periapical radiographic image – image capture only	5% of negotiated fee for D0220
D0708	Intraoral – bitewing radiographic image – image capture only	10% of negotiated fee for D0708
D0709	Intraoral – complete series of radiographic images – image capture only	40% of negotiated fee for D0210
D1000 - D1999	**II. Preventive**	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	Not Covered
D1355	Caries preventive medicament application – per tooth	80% of negotiated fee for D1354
D2000-D2999	**III. Restorative**	
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.
D3000-D3999	**IV. Endodontics**	
D3471	Surgical repair of root resorption – anterior	60% of negotiated fee for D3427
D3472	Surgical repair of root resorption – premolar	80% of negotiated fee for D3427
D3473	Surgical repair of root resorption – molar	100% of negotiated fee for D3427
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	60% of negotiated fee for D4245
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	80% of negotiated fee for D4245
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	100% of negotiated fee for D4245
D5000-D5899	**VI. Prosthodontics (Removable)**	
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not Covered
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not Covered

CDT 2021 Code[1]	Nomenclature	Contracted Fees for CDT 2021 codes are based on the following:
D6000-D6199	**VIII. Implant Services**	
D6191	Semi-precision abutment – placement	Not Covered
D6192	Semi-precision attachment – placement	Not Covered
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7961	Buccal / labial frenectomy (frenulectomy)	100% of negotiated fee for D7960
D7962	Lingual frenectomy (frenulectomy)	100% of negotiated fee for D7960

Network Bulletin

Date: May 1, 2020

From: Michelle Neuman, Senior Director, Dental Network Operations

Subject: Claim administration policy changes

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. The following changes will start on **August 1, 2020** for all Aetna Dental® plans:

D0431 - ADJUNCTIVE PRE-DIAGNOSTIC TEST THAT AIDS IN DETECTION OF MUCOSAL ABNORMALITIES INCLUDING PREMALIGNANT AND MALIGNANT LESIONS, NOT TO INCLUDE CYTOLOGY OR BIOPSY PROCEDURES.

We consider the use of any tools and/or devices that assist in a diagnosis to be an adjunctive technique that is part of the oral evaluation or primary service. Members cannot be billed for this service.

D4355 - DEBRIDEMENT, FULL MOUTH TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS

To align with the ADA descriptor of D4355, the following changes are being made to our claim processing policies:

- D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355.
- D1110, D1120, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.

We're here to help
If you have questions, call us at **1-800-451-7715.** You can also visit **aetnadental.com** to see updates to our Clinical Policy Bulletins.

Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: October 2019

From: Michelle Neuman and Larry Walsh, Senior Directors, Dental Network Operations

Subject: New CDT 2020 codes

Applies to: PPO and Extend networks

This bulletin is part of your *Dental Office Guide*.

New CDT® 2020[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2020**. We've listed them below.

Fee information for the new CDT 2020 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2020 Code[1]	Nomenclature	Contracted Fees for CDT 2020 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0419	Assessment of salivary flow by measurement	Not covered
D1000 - D1999	**II. Preventive**	
D1551	re-cement or re-bond bilateral space maintainer – maxillary	100% of negotiated fee for D1550
D1552	re-cement or re-bond bilateral space maintainer – mandibular	100% of negotiated fee for D1550
D1553	re-cement or re-bond unilateral space maintainer – per quadrant	50% of negotiated fee for D1550
D1556	removal of fixed unilateral space maintainer – per quadrant	50% of negotiated fee for D1555

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CDT 2020 Code[1]	Nomenclature	Contracted Fees for CDT 2020 codes are based on the following:
D1557	removal of fixed bilateral space maintainer – maxillary	50% of negotiated fee for D1555
D1558	removal of fixed bilateral space maintainer – mandibular	50% of negotiated fee for D1555
D2000-D2999	**III. Restorative**	
D2753	crown - porcelain fused to titanium and titanium alloys	100% of negotiated fee for D2751
D5000-D5899	**VI. Prosthodontics (Removable)**	
D5284	removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	50% of negotiated fee for D5225
D5286	removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	50% of negotiated fee for D5211
D6000-D6199	**VIII. Implant Services**	
D6082	implant supported crown – porcelain fused to predominantly base alloys	100% of negotiated fee for D6060
D6083	implant supported crown – porcelain fused to noble alloys	100% of negotiated fee for D6061
D6084	implant supported crown – porcelain fused to titanium and titanium	100% of negotiated fee for D6066
D6086	implant supported crown – predominantly base alloys	100% of negotiated fee for D6063
D6087	implant supported crown – noble alloys	100% of negotiated fee for D6061
D6088	implant supported crown – titanium and titanium alloys	100% of negotiated fee for D6063
D6097	abutment supported crown – porcelain fused to titanium and titanium	100% of negotiated fee for D6751
D6098	implant supported retainer – porcelain fused to predominantly base	100% of negotiated fee for D6073
D6099	implant supported retainer for FPD – porcelain fused to noble alloys	100% of negotiated fee for D6061
D6120	implant supported retainer – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6084
D6121	implant supported retainer for metal FPD – predominantly base alloys	100% of negotiated fee for D6086
D6122	implant supported retainer for metal FPD – noble alloys	100% of negotiated fee for D6087
D6123	implant supported retainer for metal FPD – titanium and titanium alloys	100% of negotiated fee for D6088
D6195	abutment supported retainer – porcelain fused to titanium and titanium	100% of negotiated fee for D6120
D6200-6999	**IX. Prosthodontics, fixed**	
D6243	pontic – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6241

CDT 2020 Code[1]	Nomenclature	Contracted Fees for CDT 2020 codes are based on the following:
D6753	retainer crown – porcelain fused to titanium and titanium alloys	100% of negotiated fee for D6751
D6784	retainer crown ¾ – titanium and titanium alloys	100% of negotiated fee for D6781
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7922	placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Inclusive to the procedure performed
D8000-D8999	**XI. Orthodontics**	
D8696	repair of orthodontic appliance – maxillary	100% of negotiated fee for D8691
D8697	repair of orthodontic appliance – mandibular	100% of negotiated fee for D8691
D8698	re-cement or re-bond fixed retainer – maxillary	100% of negotiated fee for D8693
D8699	re-cement or re-bond fixed retainer – mandibular	100% of negotiated fee for D8693
D8701	repair of fixed retainer, includes reattachment – maxillary	100% of negotiated fee for D8694
D8702	repair of fixed retainer, includes reattachment – mandibular	100% of negotiated fee for D8694
D8703	replacement of lost or broken retainer – maxillary	100% of negotiated fee for D8692
D8704	replacement of lost or broken retainer – mandibular	100% of negotiated fee for D8692
D9000-D9999	**XII. Adjunctive General Services**	
D9997	dental case management – patients with special health care needs	Inclusive to the procedure performed

Network Bulletin

Date: September 2018

From: Michelle Neuman and Larry Walsh, Senior Directors, Dental Network Operations

Subject: New CDT 2019 codes

Applies to: PPO and Extend networks

This bulletin is part of your *Dental Office Guide*.

New CDT® 2019[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2019**. We've listed them below.

Fee information for the new CDT 2019 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2019 Code[1]	Nomenclature	Contracted Fees for CDT 2018 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0412	Blood glucose level test – in-office using a glucose meter	Not covered
D1000 - D1999	**II. Preventive**	
D1516	Space maintainer – fixed – bilateral, maxillary	100% of negotiated fee for D1515
D1517	Space maintainer – fixed – bilateral, mandibular	100% of negotiated fee for D1515
D1526	Space maintainer – removable – bilateral, maxillary	100% of negotiated fee for D1525
D1527	Space maintainer – removable – bilateral, mandibular	100% of negotiated fee for D1520

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CDT 2019 Code[1]	Nomenclature	Contracted Fees for CDT 2018 codes are based on the following:
D5000-D5899	**VI. Prosthodontics (Removable)**	
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	100% of negotiated fee for D5281
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	100% of negotiated fee for D5281
D5876	Add metal substructure to acrylic full denture (per arch)	100% of negotiated fee for D5512
D9000-D9999	**XII. Adjunctive General Services**	
D9130	Temporomandibular joint dysfunction – non-invasive physical therapies	Not covered
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	$170.00
D9944	Occlusal guard – hard appliance, full arch	115% of negotiated fee for D9940
D9945	Occlusal guard – soft appliance, full arch	100% of negotiated fee for D9940
D9946	Occlusal guard – hard appliance, partial arch	60% of negotiated fee for D9940
D9961	Duplicate/copy patient's records	Not covered
D9990	Certified translation or sign-language services per visit	Not covered

Network Bulletin

Date: **June 18, 2018**

From: Michelle Neuman and Larry Walsh, Senior Directors, Dental Network Operations

Subject: Claim administration policy changes

Applies to: All Aetna Dental® plans

From time to time, we update our dental claims administration policies. The following changes will start on September 18, 2018 for all Aetna Dental® plans:

D2940* – Protective Restoration Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration.

> D2940 is no longer a separately eligible procedure when performed in conjunction with endodontic therapy on the same date of service. This procedure is included in the primary procedure and is therefore considered incidental to that procedure and does not warrant separate reimbursement. Members should not be billed for this service.

D7260* -- Oroantral Fistula Closure Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.

> According to ADA CDT code nomenclature, D7260 - Oroantral Fistula Closure should not be billed when repairing a perforation on the same date as an extraction. The correct code would be D7261 – Primary Closure of a Sinus Perforation. Aetna will not reimburse D7260 when billed in conjunction with extraction(s) on the same date of service.

D7261* -- Primary Closure of a Sinus Perforation Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulus tract.

> D7261 is a separately eligible procedure when performed in conjunction with extraction(s) on the same date of service.

D4320* – Provisional Splinting- Intracoronal - This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved.
D4321* -- Provisional Splinting- Extracoronal - This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved.

> D4320 and D4321 will no longer be reimbursed per tooth, but per span. Please include the teeth numbers within the span when submitting either of these codes.

* Washington state providers: Starred (*) items are subject to Washington state insurance regulatory requirements. Washington providers will receive a separate communication.

We’re here to help

If you have questions, call us at **1-800-451-7715.** You can visit **aetnadental.com** to see updates to our claim administration policies.

Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: September 2017

From: Lisa Stepanian, Executive Director, Dental Network Operations

Subject: New CDT 2018 codes

Applies to: PPO*

This bulletin is part of your *Dental Office Guide*. After reviewing this information, please keep it with your guide for future reference.

New CDT® 2018 codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes effective January 1, 2018. We've listed them below.

We're here to help

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

CDT 2018 Code	Nomenclature	Contracted Fees for CDT 2018 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0411	HbA1c in-office point of service testing	Not covered
D5000-D5899	**VI. Prosthodontics (Removable)**	
D5511	repair broken complete denture base, mandibular	100% of negotiated fee for D5510
D5512	repair broken complete denture base, maxillary	100% of negotiated fee for D5510
D5611	repair resin partial denture base, mandibular	100% of negotiated fee for D5610
D5612	repair resin partial denture base, maxillary	100% of negotiated fee for D5610
D5621	repair cast partial framework, mandibular	100% of negotiated fee for D5620
D5622	repair cast partial framework, maxillary	100% of negotiated fee for D5620

CDT 2018 Code	Nomenclature	Contracted Fees for CDT 2018 codes are based on the following:
D6000-D6999	**VIII. Implant Services**	
D6096	remove broken implant retaining screw	50% of negotiated fee for D6090, with a minimum allowance of $50.00
D6118	implant/abutment supported interim fixed denture for edentulous arch – mandibular	Not covered
D6119	implant/abutment supported interim fixed denture for edentulous arch – maxillary	Not covered
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7296	corticotomy - one to three teeth or tooth spaces, per quadrant	Not covered
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	Not covered
D7979	non-surgical sialolithotomy	50% of negotiated fee for D7980
D8000-D8999	**XI. Orthodontics**	
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	Not covered
D9000-D9999	**XII. Adjunctive General Services**	
D9222	deep sedation/general anesthesia – first 15 minutes	125% of negotiated fee for D9223
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	125% of negotiated fee for D9243
D9995	teledentistry – synchronous; real-time encounter	Inclusive to the procedure performed
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	Inclusive to the procedure performed

Network Bulletin

Date: **April 17, 2017**

From: Lisa Stepanian, Executive Director, Dental Network Operations

Subject: Claim administration policy changes

Applies to: All Aetna Dental® Plans

From time to time, we update our dental claims administration policies. This Bulletin is to let you know of the following changes that will take effect for all Aetna Dental® plans on **July 17, 2017**:

D4355 - Debridement, full mouth to enable comprehensive periodontal evaluation and diagnosis

To align with the ADA descriptor of D4355, the following changes are being made to our claim processing policies:

- D4355 will be denied when performed on the same date of service as D0120.
- D0145, D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355.
- D1110, D1120, D4910, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.

D0210 - Intraoral - complete series of radiographic images

To align with the ADA descriptor of D0210, additional intraoral periapical D0220 & D0230 and bitewing radiographic images D0270, D0272, D0273, D0274 and D0277 will not be separately eligible when performed on the same date of service as D0210.

D0277 - Vertical bitewings - 7 to 8 radiographic images

Bitewing radiographic images D0270, D0272, D0273 and D0274 will be denied when performed on the same date of service as D0277.

D3310, D3320, D3330, D3331, D3332 and D3333 – Endodontic therapy with intraoral periapical radiographic images

To align with the ADA nomenclature for endodontic therapy, periapical radiographic images D0230 will be denied when performed in conjunction with endodontic therapy on the same date of service. D0230 is part of the endodontic therapy. Diagnostic evaluation and images are not part of the endodontic therapy.

D3310, D3320 and D3330 – Endodontic therapy

Claims submitted for D3310, D3320 or D3330 will be denied if there is a history of Root Canal Therapy on the same tooth. Endodontic retreatment should be submitted under codes D3346, D3347 and D3348 for consideration.

D4910 - Periodontal maintenance and D4341/D4342 - Periodontal scaling and root planing

The descriptor for D4910 periodontal maintenance includes removal of bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing as well as polishing where indicated. D4341/D4342 periodontal scaling and root planing is not separately eligible when performed on the same day as a D4910.

Reminder - D2950 - Core build up, including any pins when required

To assure that benefits are being applied appropriately, and to gather data on submitted buildups to inform future plan designs, we now require pre-and post-operative radiographic images or photographs that illustrates the need for and placement of a buildup.

We're here to help

If you have questions, call us at **1-800-451-7715.** You can visit **aetnadental.com** to see updates to our claim administration policies.

Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: January 2017

From: Lisa Stepanian, Executive Director, Dental Network Operations

Subject: Changes to the provider appeal process

Applies to: All Aetna Dental® Plans

Starting May 1, 2017, the provider appeal policy for members enrolled in commercial plans is changing. Here are the changes:

- Elimination of Level 2 appeals for practitioner
- Require the use of a specific form when submitting appeal requests

If you want to appeal a claim

Submit it in writing using the Practitioner and Provider Complaint and Appeal Request form. There is only **one** opportunity to appeal, so be sure to include all supporting documentation.

The form will not be required until **May 1, 2017**, but we encourage you to start using it now.

Why the changes

This will eliminate unnecessary steps and help ensure that we have the information we need to do a full review of the request. These changes apply to all providers, participating and nonparticipating.

What's not changing

You can still ask for an informal reconsideration of your claim before you file a formal appeal.

Also, the member's appeal rights have not changed. If you are filing an appeal as a member's designated representative, the member still has the number of appeals set forth in the member's plan documents.

We're here to help

If you have questions, call us at **1-800-451-7715**. Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: September 2016

From: Joel Hodge, Head of Dental Networks and Administration

Subject: New CDT 2017 codes

Applies to: PPO

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

Below are the new CDT-2017[1] codes

In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2017[1] codes starting January 1, 2017.

Fee information for the new CDT-2017 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have any questions, please call our Dentist Contracting Hotline at **1-800-776-0537**. Thanks for your participation in our dental network and continued support of Aetna Dental® plans.

CDT 2017 Code[1]	Nomenclature	Contracted Fees for CDT 2017 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not covered
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	Not covered
D1000-D1999	**II. Preventive**	
D1575	distal shoe space maintainer – fixed – unilateral	110% of negotiated fee for D1510
D4000-D4999	**V. Periodontics**	
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	115% of negotiated fee for D1110

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.

In Texas, the dental PPO is known as the Participating Dental Network (PDN).

MD-1024-16

CDT 2017 Code[1]	Nomenclature	Contracted Fees for CDT 2017 codes are based on the following:
D6000-D6999	**VIII. Implant Services**	
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	50% of negotiated fee for D4342
D6085	provisional implant crown	100% of negotiated fee for D2799
D9000-D9999	**XII. Adjunctive General Services**	
D9311	consultation with a medical health care professional	Not covered
D9991	dental case management - addressing appointment compliance barriers	Not covered
D9992	dental case management – care coordination	Not covered
D9993	dental case management – motivational interviewing	Not covered
D9994	dental case management – patient education to improve oral health literacy	Not covered

Network Bulletin

Subject: New Aetna Leap℠ and Innovation Health Leap℠ plans

Applies to: All contracted Aetna dental Preferred Provider Organization (PPO) providers

This bulletin is part of your *Dental Office Guide*. After reviewing this, place it in your guide for future reference.

Important changes

On January 1, 2016, we began offering our new Individual plans in these areas/counties:

- AZ – Maricopa
- PA – Bucks, Chester, Delaware, Philadelphia, Montgomery
- NC– Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanley, Union
- SC – Lancaster, York
- VA – Alexandria City, Arlington County, Clarke County, Fairfax City, Fairfax County, Falls Church City, Frederick County, Fredericksburg City, Loudoun County, Manassas City, Manassas Park City, Page County, Prince William County, Shenandoah County, Spotsylvania County, Stafford County, Warren County, Winchester City

Although we offer the plans in select areas, members may still seek benefits nationally.

What this means for you

As a contracted dentist in our Dental PPO network, you may have Aetna Leap and Innovation Health Leap medical plan members coming to your office for pediatric oral services. These will be covered services for dependent children up to the age of 19 (or higher age if your state requires).

Your patients will have “Aetna Leap” or “Innovation Health Leap” in their plan name listed on their medical ID card. These pediatric benefits plans/programs use the Dental PPO fee schedule.

Digital member ID card is key to care

Members can get and print their digital member ID card from their secure member website. They can also ask for a plastic ID card. Look for the **12-digit numeric ID number** beginning with “10.”

Here are sample ID cards:

Sending claims and correspondence

- For all plans except Innovation Health, keep sending claims electronically via payer ID# 60054.
- For Innovation Health claims, use payer ID# 40025.

For paper claims and correspondence, send to:

Charlotte (NC & SC) and AZ
Aetna
PO Box 14079
Lexington, KY 40512-4079

Southeastern PA
Aetna
PO Box 981106
El Paso, TX 79998-1106

Northern VA
Innovation Health
PO Box 981106
El Paso, TX 79998-1106

Checking eligibility and general questions

To check eligibility:

- Go to **www.aetnadental.com** and use real-time eligibility, if registered.
- Call **1-888-MDAetna (1-888-632-3862)** for Aetna Leap plans.
- Call **1-844-289-4503** for Innovation Health Leap plans.

If you have general questions, just call us at the numbers above.

In Texas, the dental PPO is known as the participating dental network (PDN).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Innovation Health Insurance Company and Innovation Health Plan, Inc. (Innovation Health) members receive dental benefits from Aetna. Aetna and its affiliates provide certain management services for Innovation Health.

JR-418-16 (1/16)

Network Bulletin

Date: September 2015

From: Joel Hodge, Head of Dental Networks and Administration

Subject: New CDT 2016 codes

Applies to: PPO

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

Below are the new CDT-2016 codes

In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2016[1] codes effective January 1, 2016.

Fee information for the new CDT-2016 codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

We're here to help

If you have any questions, please call our Dentist Contracting Hotline at **1-800-776-0537**. Thanks for your participation in our dental network and continued support of Aetna Dental® plans.

CDT 2016 Code[1]	Nomenclature	Contracted Fees for CDT 2016 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0251	**extra-oral posterior dental radiographic image**	75% of negotiated fee for D0250
D0422	**collection and preparation of genetic sample material for laboratory analysis and report**	Not covered
D0423	**genetic test for susceptibility to diseases – specimen analysis**	Not covered
D1000-D1999	**II. Preventive**	
D1354	**interim caries arresting medicament application**	100% of negotiated fee for D1351
D4000-D4999	**V. Periodontics**	
D4283	**autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site**	55% of negotiated fee for D4273

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.

CDT 2016 Code[1]	Nomenclature	Contracted Fees for CDT 2016 codes are based on the following:
D4285	**non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site**	55% of negotiated fee for D4275
D5000-D5899	**VI. Prosthodontics (Removable)**	
D5221	**immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)**	115% of negotiated fee for D5211
D5222	**immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)**	115% of negotiated fee for D5212
D5223	**immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) Includes limited follow-up care only; does not include future rebasing**	115% of negotiated fee for D5213
D5224	**immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	115% of negotiated fee for D5214
D7000-D7999	**X. Oral and Maxillofacial Surgery**	
D7881	**occlusal orthotic device adjustment**	Not covered
D8000-D8999	**XI. Orthodontics**	
D8681	**removable orthodontic retainer adjustment**	100% of negotiated fee for D5421
D9000-D9999	**XII. Adjunctive General Services**	
D9223	**deep sedation/general anesthesia – each 15 minute increment**	50% of negotiated fee for D9220
D9243	**intravenous moderate (conscious) sedation/analgesia – each 15 minute increment**	50% of negotiated fee for D9241
D9932	**cleaning and inspection of removable complete denture, maxillary**	100% of negotiated fee for D9931
D9933	**cleaning and inspection of removable complete denture, mandibular**	100% of negotiated fee for D9931
D9934	**cleaning and inspection of removable partial denture, maxillary**	100% of negotiated fee for D9931
D9935	**cleaning and inspection of removable partial denture, mandibular**	100% of negotiated fee for D9931
D9943	**occlusal guard adjustment**	12.5% of negotiated fee for D9940

Network Bulletin

Date: October 2014

From: Joel Hodge, Head of Dental Networks and Administration

Subject: New CDT 2015 Codes

Applies to: PPO, Discount Dental, Family Preventive, Basic Dental, Aetna Advantage Dental and Aetna Advantage Student Dental

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

Below are the new CDT-2015 codes

In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2015[1] codes effective January 1, 2015.

Fee information for the new CDT-2015 Codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

CDT 2015[1] Code	Nomenclature	Contracted Fees for CDT 2015 codes are based on the following:
D0100 - D0999	**I. Diagnostic**	
D0171	Re-evaluation – post-operative visit	Inclusive to surgery
D0351	3D photographic image	Not covered
D1000-D1999	**II. Preventive**	
D1353	Sealant repair	50% of negotiated fee for D1351
D6000-D6199	**VIII. Implant Services**	
D6110	Implant/abutment supported removable denture for completely edentulous arch - maxillary	100% of negotiated fee for D6053
D6111	Implant/abutment supported removable denture for completely edentulous arch - mandibular	100% of negotiated fee for D6053

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.

CDT 2015[1] Code	Nomenclature	Contracted Fees for CDT 2015 codes are based on the following:
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	100% of negotiated fee for D6054
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	100% of negotiated fee for D6054
D6114	Implant/abutment supported fixed denture for completely edentulous arch - maxillary	100% of negotiated fee for D6078
D6115	Implant/abutment supported fixed denture for completely edentulous arch - mandibular	100% of negotiated fee for D6078
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	100% of negotiated fee for D6079
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	100% of negotiated fee for D6079
D6200-D6999	**IX. Prosthodontics, fixed**	
D6549	Resin retainer – for resin bonded fixed prosthesis	50% of negotiated fee for D6722
D9000-D9999	**XII. Adjunctive General Services**	
D9219	Evaluation for deep sedation or general anesthesia	Covered only when performed by anesthesiologist in conjunction with medically necessary deep sedation or general anesthesia
D9931	Cleaning and inspection of a removable appliance	25% of negotiated fee for D1110
D9986	Missed appointment	Not covered
D9987	Cancelled appointment	Not covered

We are here to help

If you have any questions, please contact our Dentist Contracting Hotline at 1-800-776-0537.
Thank you for your participation in our dental network and your continued support of Aetna Dental® Plans.

[1]Current Dental Terminology. ©American Dental Association. All rights reserved.

Network Bulletin

Date: December 2013

From: Joel Hodge, Head of Networks and Administration

Subject: Dental card suppression

Applies to: All contracted Aetna dental providers

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in your guide for future reference.

Important change

Starting **January 1, 2014**, as a standard practice, Aetna will stop mailing Dental PPO and DMO® only member ID cards. This will include ID cards for new and previous members of our dental plans.

Instead of receiving an ID card, members may get a letter explaining that they no longer need an ID card for dental care. The letter will provide instructions on how to access or request a copy of their member ID card from Aetna Navigator®, our Aetna Mobile app and/or by calling Member Services.

What this means for you

Nothing changes. You will continue to verify benefits online, on your monthly eligibility report (DMO) or by calling our National Dentist Hotline at **1-800-451-7715**.

We're here to help

If you have questions, please call us at **1-800-451-7715.** Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: October 2013

From: Joel Hodge, Head of Dental Networks and Administration

Subject: New CDT 2014 Codes

Applies to: PPO, Discount Dental, Family Preventive, Basic Dental, Aetna Advantage™ Dental and Aetna Advantage™ Student Dental

This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in the *Network Bulletin* section of your guide for future reference.

Below are the new CDT-2014 codes

In accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the terms of our CDT Content License Agreement with the American Dental Association, below is information on the new CDT 2014* codes effective January 1, 2014.

Fee information for the new CDT-2014 Codes

Your negotiated rates for the new CDT codes are based on the fees found in your current schedule for existing procedures. Please follow the guide below to determine your reimbursement for the new CDT codes.

Code	Nomenclature	Negotiated Rates for CDT-2014 codes are based on the following:
	D0100 - D0999 I. Diagnostic	
D0393	treatment simulation using 3-D image volume	Medical - not on fee schedule
D0394	digital subtraction of two or more images or image volumes of the same modality	Medical - not on fee schedule
D0395	fusion of two or more 3D image volumes of one or more modalities	Medical - not on fee schedule
D0601	caries risk assessment and documentation, with a finding of low risk	Inclusive to oral evaluation
D0602	caries risk assessment and documentation, with a finding of moderate risk	Inclusive to oral evaluation

D0603	caries risk assessment and documentation, with a finding of high risk	Inclusive to oral evaluation
	D1000-D1999 II. Preventive	
D1999	unspecified preventive procedure, by report	Not covered
	D2000-D2999 III. Restorative	
D2921	reattachment of tooth fragment, incisal edge or cusp	10% of negotiated rate for D2335
D2941	interim therapeutic restoration – primary dentition	45% of negotiated rate for D2940
D2949	restorative foundation for an indirect restoration	Inclusive to permanent restoration.
	D3000-D3999 IV. Endodontics	
D3355	pulpal regeneration - initial visit	50% of negotiated rate for D3354
D3356	pulpal regeneration – interim medication replacement	15% of negotiated rate for D3354
D3357	pulpal regeneration – completion of treatment	25% of negotiated rate for D3354
D3427	periradicular surgery without apicoectomy	75% of negotiated rate for D3421
D3428	bone graft in conjunction with periradicular surgery - per tooth, single site	100% of negotiated rate for D4263
D3429	bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	100% of negotiated rate for D4264
D3431	biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	100% of negotiated rate for D4265
D3432	guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	100% of negotiated rate for D4266
	D4000-D4999 V. Periodontics	
D4921	gingival irrigation – per quadrant	25% of negotiated rate for D4355
	D5000-D5899 VI. Prosthodontics (Removable)	
D5863	overdenture – complete maxillary	100% of negotiated rate for D5860
D5864	overdenture - partial maxillary	100% of negotiated rate for D5861

D5865	overdenture - complete mandibular	100% of negotiated rate for D5860
D5866	overdenture – partial mandibular	100% of negotiated rate for D5861
	D5900-D5999 VII. Maxillofacial Prosthetics	
D5994	periodontal medicament carrier with peripheral seal – laboratory processed	Medical - not on fee schedule
	D6000-D6199 VIII. Implant Services	
D6011	second stage implant surgery	Inclusive to implant D6010
D6013	Surgical placement of mini implant	55% of negotiated rate for D6010
D6052	semi-precision attachment abutment	50% of negotiated rate for D6056
	D8000-D8999 XI. Orthodontics	
D8694	**repair of fixed retainers, includes reattachment**	100% of negotiated rate for D8693
	D9000-D9999 XII. Adjunctive General Services	
D9985	sales tax	Inclusive to service being taxed.

We are here to help

If you have any questions, please contact our Dentist Contracting Hotline at 1-800-776-0537.
Thank you for your participation in our dental network and your continued support of Aetna Dental® Plans.

Network Bulletin

Date: September 2013

From: Bryan Geremia, Regional Manager

Subject: New dental benefits embedded in Aetna medical plans

Applies to: All contracted Aetna dental PPO providers

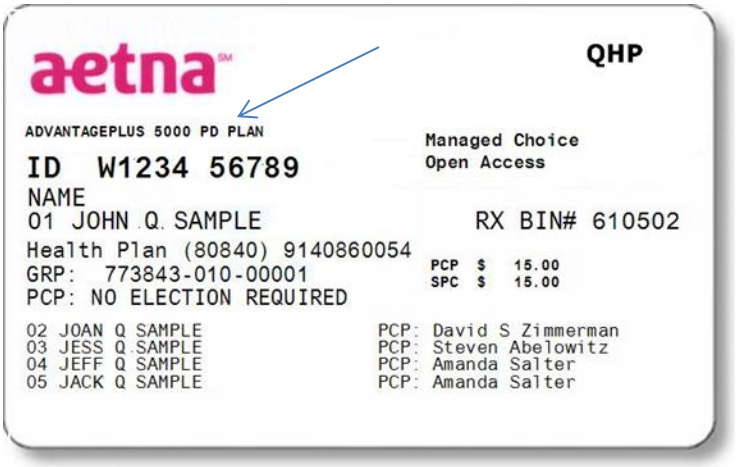
This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in your guide for future reference.

Important changes

On **January 1, 2014**, major parts of the Affordable Care Act (ACA) are going to be implemented. The ACA is adding more required benefits to all new health plans. We have been certified as a Qualified Health Plan (QHP) in several states. As a part of the certification process we will be offering all 10 required Essential Health Benefits (EHB). One of these EHB requirements is pediatric oral services. We will be introducing new certified medical plans with pediatric oral services embedded into the plan designs.

What this means for you

As a contracted dentist in our Dental PPO network, you may have Aetna medical plan members coming to your office for pediatric oral services, as defined by state law. These will be covered services for dependent children up to the age of 19 (or higher age if required by your state). Patients will show you their Aetna medical identification card, which may or may not have a **PD** following the plan name.



Claim filing and reimbursement

Send claims for all covered services as you do normally for Aetna PPO claims. We will pay you based on your PPO fee schedule.

In order to bring your contract into compliance with applicable ACA provisions, your provider agreement will be amended to add the following:

Provider agrees to participate in the following plans/programs, as designated by Aetna from time to time:

Pediatric Dental Plans/Benefits (providing pediatric dental benefits within or in conjunction with a medical plan or as a standalone pediatric dental plan). These pediatric benefits plans/programs utilize the Dental PPO Fee Schedule.

We're here to help

If you have questions, please call us at **1-800-451-7715.** Thank you for your continued participation in and support of Aetna Dental plans.

Network Bulletin

Date: September 2013
From: Bryan Geremia, Regional Manager

Subject: New dental benefits embedded in Aetna and Innovation Health medical plans

Applies to: All contracted Aetna dental PPO providers in DC, MD, and VA

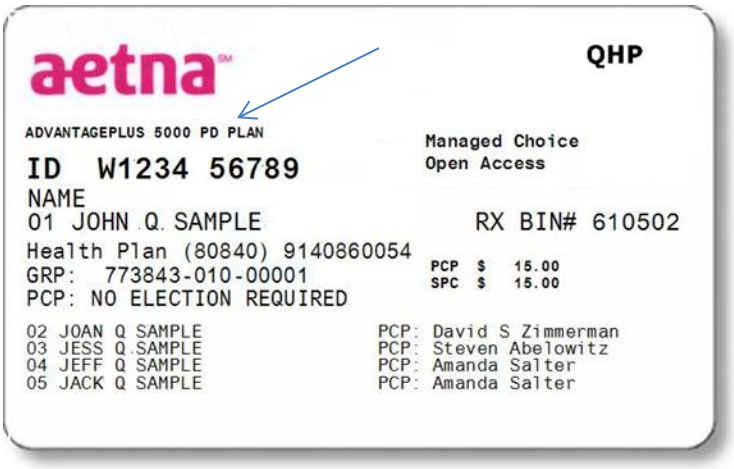
This bulletin is part of your *Dental Office Guide*. After reviewing this information, place it in your guide for future reference.

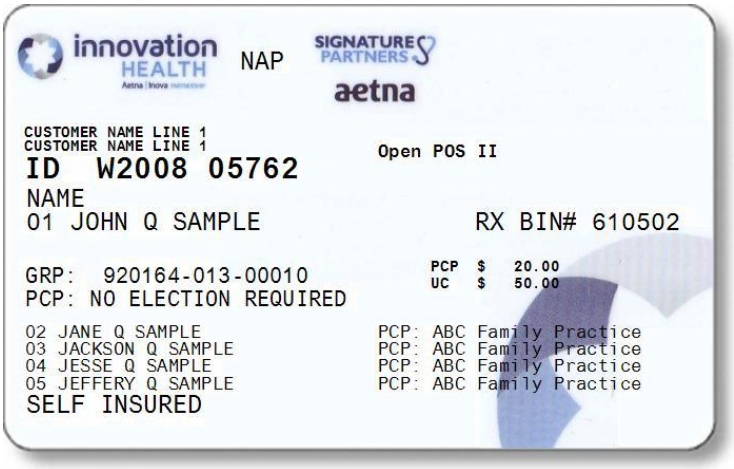
Important changes

On **January 1, 2014**, major parts of the Affordable Care Act (ACA) are going to be implemented. The ACA is adding more required benefits to all new health plans. We have been certified as a Qualified Health Plan (QHP) in several states. As a part of the certification process we will be offering all 10 required Essential Health Benefits (EHB). One of these EHB requirements is pediatric oral services. We will be introducing new certified medical plans with pediatric oral services embedded into the plan designs.

What this means for you

As a contracted dentist in our Dental PPO network, you may have Aetna and Innovation Health medical plan members coming to your office for pediatric oral services, as defined by state law. These will be covered services for dependent children up to the age of 19 (or higher age if required by your state). Patients will show you their Aetna medical identification card, which may or may not have a **PD** following the plan name. In addition, you may have patients that present an **Innovation Health** medical plan identification card. Innovation Health is an affiliate of Aetna.





Claim filing and reimbursement

Send claims for all covered services as you do normally for Aetna PPO claims. We will pay you based on your PPO fee schedule.

In order to bring your contract into compliance with applicable ACA provisions, your provider agreement will be amended to add the following:

Provider agrees to participate in the following plans/programs, as designated by Aetna from time to time:

Pediatric Dental Plans/Benefits (providing pediatric dental benefits within or in conjunction with a medical plan or as a standalone pediatric dental plan). These pediatric benefits plans/programs utilize the Dental PPO Fee Schedule.

We're here to help

If you have questions, please call us at **1-800-451-7715.** Thank you for your continued participation in and support of Aetna Dental plans.

For questions about Innovation Health Plan, call the phone number on the back of the member ID card. You can also call our Provider Service Center at **1-888-632-3862**.

www.aetnadental.com

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