

the children's program



# Provider Guide



*Delta Dental of Oregon*



### **Program Description**

Delta Dental of Oregon (DDOR) and OEGB have partnered together to create a much needed program called *The Children's Program*. The program provides basic dental services for children between the ages of 5 and 18 years old who reside in Oregon and are not covered under any dental plan.

Funding for The Children's program is provided by Oregon dentists. In addition, DDOR Premier Dentists that sign up for the program will provide services for reimbursement at 80% of their filed fees. There is no patient responsibility for covered services up to the plan maximum.

Delta Dental of Oregon provides updates regarding The Children's Program once a year so the dental community can see where the dollars have been spent and the number of children served through the program. Delta Dental of Oregon is donating all administrative services to the program, thereby allowing 100 percent of the funds to go directly to the dentists that provide services to the children.

### **Services Covered**

Covered services include preventive, diagnostic, relief of pain and basic restorative services. For your reference, there is a The Children's Program Covered Code List found in the appendix of this guide for a complete list of covered codes.

All services must be provided prior to the plan end date. The child is covered for a year beginning on the date indicated in the Parent Letter. It is recommended that eligibility is verified prior to treatment by viewing Benefit Tracker or the Parent Letter. Both will indicate the coverage begin and end date.

Services will be covered up to an \$800 maximum with certain applicable frequency limitations (see Covered Procedure Code List). Claims that exceed the \$800 maximum will display explanation code, "L30 – Dental Lifetime maximum has been met" on the Payment Disbursement Register.

### **Patient Responsibility**

There is no patient responsibility for covered services up to the \$800 plan maximum.

In the rare situation where the patient's parent or guardian requests non-covered services or services beyond the \$800 coverage maximum, a financial waiver must be signed by the parent or legal guardian in advance to accept financial responsibility. In the absence of a financial waiver this treatment will become a provider write off. Please refer to the financial waiver found in the appendix of this guide.

Should the need arise for antibiotics to be prescribed to a child; it will be the responsibility of the parent or guardian to obtain and pay for the prescription.

### **ID Numbers**

ID cards will not be issued for this program. Each child will receive their own plan identification number. The number will be indicated on the Parent Letter that will be mailed to the child's parent or guardian.

If a child is accepted for re-enrollment into this plan in a subsequent year, a new identification number will be provided.

It is very important your claims to Delta Dental of Oregon be billed with the ID number provided.

The children enrolled in The Children's Program will show the group name of The Children's Program on the Payment Disbursement Register and Benefit Tracker.

### **Submitting Claims**

Submitting a claim for members of The Children's Program is just the same as submitting claims for all of your other Delta Dental of Oregon patients.

Be sure that you use the appropriate member identification number assigned for the child. Remember that after a child re-enrolls onto the plan, they will be assigned a new member identification number.

Predeterminations are not necessary for this plan. As long as eligibility is active and their maximum has not been met, all treatment performed from the covered codes list should be a benefit.

### **Timely Filing Guidelines**

Delta Dental of Oregon requests that all eligible claims for covered services through The Children's Program be received in our office within 3 months after the date of service. Claims received later than 3 months after the date of service shall be invalid and not payable. If a payment disbursement register (PDR) is not received within 45 days of submission of the claim, the billing office should contact Delta Dental of Oregon Customer Service or check Benefit Tracker to verify that the claim has been received. Please verify if your initial claim was received prior to submitting a duplicate. When submitting a claim electronically using an electronic claims service or clearing house, check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing.

### **Enrollment**

The enrollment process for The Children's Program includes identifying the children eligible for the program, issuing acceptance letters and assigning children to dentists that are participating with the program.

The enrollment process will be a collaborative effort with the school districts and county health departments. Referrals from emergency rooms and pediatricians will also be considered. Delta Dental of Oregon staff will screen the applications to confirm they meet the program's criteria. This includes confirming if the child is insured with any commercial dental coverage and reviewing Oregon Health Plan records for coverage. Birthdates and addresses are reviewed to ensure the children are between the ages of 5 and 18 years of age and reside in Oregon.

Children may be eligible to re-enroll in this program if all eligibility requirements are met. The re-enrollment process is to the same as the initial enrollment process where birthdates and uninsured status is identified.

If you identify a child that might be eligible for The Children's Program, refer their parent or guardian to their school nurse or school representative to initiate the enrollment process.

### **Dentist Selection Process**

It is our goal to assign members to a provider within their area. To ensure a convenient travel distance for our members and an even distribution to the provider community, each child will have a recommended dentist listed on their Parent Letter. This recommendation will be based on the address of the child. When there are multiple dentists serving an area, the members will

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be assigned evenly to all dentists participating in the program. The dentist recommended will also get a copy of the letter sent to the parent.

If a patient is already established with your office, and you are signed up to treat children with The Children's program, you are welcome to treat them even if you are not listed on the acceptance letter.

When specialist care is needed, feel free to recommend any specialist participating in The Children's Program to your patient. These will be listed in our online provider directory on our website at [www.modahealth.com](http://www.modahealth.com).

If you are not able to locate a specialist in your area or should special circumstances arise and you are unable to treat a child, please contact Dental Customer Service who will assist you.

### **Dentist Participation Process**

If you are interested in becoming a participating provider with The Children's Program, please contact Dental Professional Relations at 503-265-5720 or toll free at 888-374-8905. Our representatives will be happy to mail or fax a letter of agreement and a list of all covered codes. Please note that if treatment has been provided to a member of The Children's Program and the dentist is not participating, reimbursement will not be issued.

### **Contact Information**

Moda Health Website: [www.modahealth.com](http://www.modahealth.com)

#### **Send Dental Claims to:**

PO Box 40384  
Portland, OR 97240

#### **Dental Customer Service:**

Information regarding benefits, eligibility and claim status  
503-243-4494 800-452-1058  
[dental@modahealth.com](mailto:dental@modahealth.com)

#### **Dental Professional Relations:**

General questions and dental provider enrollment  
503-265-5720 888-374-8905  
Fax: 503-243-3965  
[dpr@modahealth.com](mailto:dpr@modahealth.com)

#### **Benefit Tracker (BT):**

Provides registration and assistance for utilizing this online resource  
877-337-0651 (choose option 1)  
[ebt@modahealth.com](mailto:ebt@modahealth.com)

### **APPENDIX (see the following pages)**

- Covered Codes List
- Financial Waiver Form
- Financial Waiver Form – Spanish

## Covered Procedure Code List

Code	Description	Notes
D0120	Periodic oral evaluation - established patient	
D0140	Limited oral evaluation - problem focused	
D0145	Oral Evaluation for a patient under three years of age	
D0150	Comprehensive oral evaluation - new and established patient	
D0160	Detailed and extensive oral evaluation - problem focused, by report	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	
D0210	Intraoral - complete series (including bitewings)	
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Extraoral - occlusal film	
D0270	Bitewing - single film	
D0272	Bitewings - two films	
D0273	Bitewings - three films	
D0274	Bitewings - four films	
D0460	Pulp vitality tests	
D1110	Prophylaxis - adult	
D1120	Prophylaxis - child	
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	Once every 6 mos.
D1208	Topical application of fluoride	Once every 6 mos.
D1351	Sealant - per tooth	unrestored permanent molars only
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
D2390	Resin-based composite crown, anterior	
D2391	Resin-based composite - one surface, posterior	
D2392	Resin-based composite - two surfaces, posterior	
D2393	Resin-based composite - three surfaces, posterior	
D2394	Resin-based composite - four or more surfaces, posterior	
D2930	Prefabricated stainless steel crown - primary tooth	
D2931	Prefabricated stainless steel crown - permanent tooth	
D2932	Prefabricated resin crown	

Code	Description	Notes
D2933	Prefabricated stainless steel crown with resin window	
D2940	Sedative filling	
D2999	Unspecified restorative procedure, by report	
D3110	Pulp cap - direct (excluding final restoration)	
D3220	Therapeutic pulpotomy (excluding final restoration)	
D3221	Pulpal debridement, primary and permanent teeth	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	
D3230	Pulpal therapy (resorable filling) - anterior, primary tooth (excluding final restoration)	
D3240	Pulpal therapy (resorable filling) - posterior, primary tooth (excluding final restoration)	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	
D3351	Apexification/recalcification - initial visit	
D3352	Apexification/recalcification - interim medication replacement	
D3353	Apexification/recalcification - final visit	
D3470	Intentional reimplantation (including necessary splinting)	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure,	By report
D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	
D4231	Anatomical crown exposure - one to three teeth per quadrant	
D4346	Scaling in presence of generalized moderate or severe gingival inflammation	
D7111	Extraction, coronal remnants - deciduous tooth	Teeth 1,16, 17, 32 excluded
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Teeth 1,16, 17, 32 excluded
D7210	Surgical removal of erupted tooth	Teeth 1,16, 17, 32 excluded
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
D7510	Incision and drainage of abscess - intraoral soft tissue	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated	
D7520	Incision and drainage of abscess - extraoral soft tissue	
D7910	Suture of recent small wounds up to 5 cm	
D8210	Removable appliance therapy	By report
D8220	Fixed appliance therapy	By report
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	
D9440	Office visit - after regularly scheduled hours	
D9920	Behavior management, by report	By report
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	



**THE CHILDREN'S PROGRAM  
PATIENT RESPONSIBILITY WAIVER**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Dental Service(s) including CDT code

\_\_\_\_\_  
Diagnosis

The services outlined above are (check one):

- a)  Not a covered procedure under The Children's Program
- b)  Not covered because the plan maximum has been met for the eligibility year

I, \_\_\_\_\_,  
(Print Parent or Guardian Name)

understand that the services listed above, for the diagnosis listed above, are not covered for payment by The Children's Program. If I choose to obtain the services listed above on this date for my dependent, I agree to be personally responsible for paying the financial charges for these services. The estimated amount that I may be responsible for is \$\_\_\_\_\_, and not to exceed \$\_\_\_\_\_.

\_\_\_\_\_  
PARENT OR GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

Programa de niños sin costo a usted

Nombre del paciente \_\_\_\_\_

Servicios Dentales incluyendo CDT códigos \_\_\_\_\_

Diagnostico \_\_\_\_\_

Los servicios indicados arriba son:

- a) \_\_\_\_\_ Servicio no cubierto en el programa de niños
- b) \_\_\_\_\_ El máximo por año a sido agotado

Yo \_\_\_\_\_

Entiendo que los servicios que están marcados arriba no los cubre el programa de niños. Si decido que mi hijo obtenga servicios marcados arriba yo seré totalmente responsable por el costo de esos servicios

El costo estimado que tengo que pagar es \$ \_\_\_\_\_ pero siempre y cuando no sea más de \$ \_\_\_\_\_

Firma del padre/guardia \_\_\_\_\_

fecha \_\_\_\_\_

Testigo \_\_\_\_\_

fecha \_\_\_\_\_