



DELTA DENTAL OF COLORADO

Participating Provider Handbook

2024 Update

Foreword

This handbook has been prepared to provide information to Colorado providers and their office staff regarding the policies, practices, and procedures employed by Delta Dental of Colorado (DDCO). It is not intended as a legal basis for interpreting any Delta Dental contract. It is designed to provide helpful information on how to complete the various documents used in the administration of Delta Dental's programs. We suggest you keep this copy of the Participating Provider Handbook readily available to serve as a reference and as an informational resource for Delta Dental's dental benefits programs. You can also find a copy of the Handbook on the secure provider portal.

In an effort to ensure the accuracy of the information included in this handbook, from time to time, DDCO will send you a revised handbook and/or additional pages to insert into your Participating Provider Handbook.

If you have questions or would like further information regarding this handbook, contact:

Delta Dental of Colorado
Provider Relations Department
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111
303-889-8677

Neither the Participating Provider Handbook nor the information contained in it constitutes the rendering of dental services or professional dental advice to any patient by DDCO or any director, officer, employee, or consultant of Delta Dental. In addition, claims will be processed based on the patient's individual benefit plan, Delta Dental National Processing Policies, and Delta Dental of Colorado Processing Guidelines.

This Handbook is DDCO's sole and exclusive property and may not be reproduced or otherwise shared with anyone other than the provider(s) in the practice to which the handbook is furnished, members of that provider office staff, their outside billing service, and professional consultants to the practice, without DDCO's prior written consent. The provider to whom DDCO furnishes the handbook must make any other individual with whom they share it aware of DDCO's proprietary interest.

The Delta Dental Difference®

Welcome to Delta Dental of Colorado! Delta Dental of Colorado was founded by dentists more than 65 years ago, and our network providers are an integral and important part of fulfilling our mission and doing business. We value the work our network providers do to help make our members — your patients — oral health a priority.

We have a 97% customer retention rate.

Nationally, the Delta Dental Plans Association provides dental coverage to more than 85 million people in more than 152,000 groups. We are one of 39 independent Delta Dental member companies operating in all 50 states, the District of Columbia, and Puerto Rico, which means you can treat any covered member under your current agreement without having to contract with multiple states.

Members have access to one or both of our networks — our Delta Dental PPO™ network with more than 2,600 providers and our Delta Dental Premier® network, which is a combination of our PPO and Premier providers and consists of more than 3,700 providers across the state. Nationally, members have access to more than 155,000 contracted or network providers practicing in more than 351,000 provider locations.

How do we support our providers?

Delta Dental understands that our providers are an integral part of fulfilling our mission and doing business. Delta Dental's unique relationship with the dental profession sets us apart from commercial dental insurance companies.

Delta Dental enrolls participating providers like you to provide services to covered patients. We work hard to support you through:

- Local provider relations staff who support your office with on-site training, issue resolution, and any other ongoing needs.
- Access to peer-to-peer consultation and to DDCO's leadership team.
- Provider tools on our website including free claims submission, pre-treatment estimates, credentialing, and direct deposit.
- Benefits and eligibility available 24/7 via website or fax back.
- Free CPR classes and workshops.
- Timely claims processing and the opportunity for next-day payments.
- Knowledgeable, local customer service to answer your questions promptly and accurately.

As a participating network provider, you are helping Delta Dental work toward improving the oral health of the communities we serve!

Information Directory

The following directory is for your reference when seeking quick and convenient answers to Delta Dental questions. For patients covered by Delta Dental, please contact the associated member company directly.

Delta Dental of Colorado's provider relations department (303-889-8677) can provide information on the following:

- Provider network participation
- Credentialing/re-credentialing
- Change of address or Tax ID number
- Workshop information
- Creating an online provider account

Visit our website and log in to the secure provider portal at deltadentalco.com for the following:

- Patient eligibility and benefits
- Codes
- Claim status information and new claims submission
- Provider forms

The customer service department (1-800-610-0201) can assist you with the following for patients covered under Delta Dental of Colorado:

- Claims payment explanation
- Coordination of benefits
- Orthodontic claim inquiries
- Processing policy explanation

DDCO's interactive voice response system (IVR) is available by dialing 1-800-610-0201 Press "1" for the provider menu.

Delta Dental Contact Information

Delta Dental Insurance Company – Alabama
(See Delta Dental Insurance Company - Georgia)

Delta Dental of Alaska
Delta Dental of Oregon (Alaska)
P.O. Box 40384
Portland, OR 97204
888-374-8906
www.deltadentalak.com
Payer #CDOR1

Delta Dental of Arizona
P.O. Box 9092
Little Rock, AR 72231-5965
800-352-6132
www.deltadentalaz.com
Payer #86027

Delta Dental of Arkansas
P.O. Box 15965
N. Little Rock, AR 72231-5965
800-462-5410
www.deltadentalar.com
Payer #CDAR1

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330
888-335-8227
www.deltadentalins.com
Payer #77777

Delta Dental of California Federal Government Programs
P.O. Box 537007
Sacramento, CA 95853-7007
844-825-8111
Payer CDCA1

Delta Dental of Colorado
P.O. Box 173803
Denver, CO 80217-3803
800-610-0201
www.deltadentalco.com
Payer #84056

Delta Dental of Connecticut
(See Delta Dental of New Jersey)
Payer #22189

Delta Dental of Delaware
(See Delta Dental of Pennsylvania)
Payer #51022

Delta Dental of the District of Columbia
(See Delta Dental of Pennsylvania)
Payer #52147

Delta Dental Insurance Company – Florida
(See Delta Dental Insurance Company - Georgia)

Delta Dental Insurance Company – Georgia
P.O. Box 1809
Alpharetta, GA 30023-1809
800-521-2651
www.deltadentalins.com
Payer# 94276

Hawaii Dental Service
900 Fort Street Mall, Suite 1900 Honolulu, HI 96813-3705
844-379-4325
www.hawaiidentalinservice.com
Payer #99010

Delta Dental of Idaho
P.O. Box 2870
Boise, ID 83701
800-356-7586
www.deltadentalid.com
Payer #82029

Delta Dental of Illinois
Group Plans
P.O. Box 5402
Lisle, IL 60532
800-323-1743
www.deltadentalil.com
Payer #05030

IL Individual Plans
P.O. Box 103
Stevens Point, WI 54481
855-335-8267
www.deltadentalil.com
Payer WDENC

Delta Dental of Indiana
P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentalin.com
Payer #DDPIN

Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131-9000
800-544-0718
www.deltadentalia.com
Payer #CDIA1

Delta Dental of Kansas
1619 N. Waterfront Parkway
P.O. Box 789769
Wichita, KS 67278-9769
800-234-3375
www.deltadentalks.com

Delta Dental of Kentucky
P.O. Box 242810
Louisville, KY 40224-2810
800-955-2030
www.deltadentalky.com
Payer #CDKY1

Delta Dental Insurance Company – Louisiana
(See Delta Dental Insurance Company - Georgia)

Delta Dental of Maryland
(See Delta Dental of Pennsylvania)
Payer #23166

Delta Dental of Massachusetts
P.O. Box 2907
Milwaukee, WI 53201-2907
800-872-0500
www.deltadentalma.com
Payer #04614

Delta Dental of Michigan
P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentalmi.com
Payer #DDPMI

Delta Dental of Minnesota
P.O. Box 9120
Farmington Hills, MI 48333
800-448-3815
www.deltadentalmn.org
Payer 07000

Delta Dental Insurance Company – Mississippi
(See Delta Dental Insurance Company - Georgia)

Delta Dental of Missouri
P.O. Box 8690
St. Louis, MO 63126-0690
800-335-8266
www.deltadentalmo.com
Payer #43090

Delta Dental Insurance Company – Montana
(See Delta Dental Insurance Company - Georgia)

Delta Dental of Nebraska
P.O. Box 9120
Farmington Hills, MI 48333-9120
866-524-1134
Payer #07027

Delta Dental Insurance Company – Nevada
(See Delta Dental Insurance Company - Georgia)

Delta Dental of New Jersey
P.O. Box 16354
Little Rock, AR 72231
800-452-9310
www.deltadentalnj.com
Payer #22189

Delta Dental of New Mexico

100 Sun Avenue NE
Suite 400
Albuquerque, NM 87109
877-395-9420
www.deltadentalnm.com
Payer #85022

Delta Dental of New York

(See Delta Dental of
Pennsylvania) Payer #11198

Delta Dental of North Carolina

P.O. Box 9085
Farmington Hills, MI 48333-9085
www.deltadentalnc.com
800-662-8856
Payer #56101

Delta Dental of North Dakota

P.O. Box 9120
Farmington Hills, MI 48333
800-448-3815
Payer #07000

Northeast Delta Dental

(Maine, New Hampshire and Vermont)
P.O. Box 2002
Concord, NH 03302-2002
800-832-5700
www.nedelta.com
Payer #02027

Delta Dental of Ohio

P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentaloh.com
Payer #DDPOH

Delta Dental of Oklahoma

P.O. Box 548809
Oklahoma City, OK 73154-8809
800-990-7337
www.deltadentalok.org
Payer #22229 and CDOK1

Delta Dental of Oregon

P.O. Box 40384
Portland, OR 97204
888-873-1393
www.deltadentalor.com
Payer #CDOR1

Delta Dental of Pennsylvania

(DE, DC, MD, NY, WV)
P.O. Box 2105
Mechanicsburg, PA 17055-6999
800-932-0783
www.deltadentalins.com
Payer #23166

Delta Dental of Puerto Rico

P.O. Box 9020992
San Juan, PR 00902-0992
939-205-3300
www.deltadentalpr.com
Payer #680652604

Delta Dental of Rhode Island

P.O. Box 1517
Providence, RI 02901-1517
800-843-3582

www.deltadentalri.com
Payer #05029

Delta Dental of South Carolina

P.O. Box 8690
St. Louis, MO 63126-0690
800-335-8266
www.deltadentalsc.com
Payer #43091

Delta Dental of South Dakota

P.O. Box 1157
Pierre, SD 57501
877-841-1478
www.deltadentalsd.com
Payer #54097

Delta Dental of Tennessee

240 Venture Circle
Nashville, TN 37228-1699
800-223-3104
www.deltadentaltn.com
Payer #CDTN1

Delta Dental Insurance Company -

Texas
(See Delta Dental Insurance Company -
Georgia)

Delta Dental Insurance Company -

Utah
(See Delta Dental Insurance
Company - Georgia)

Delta Dental of Virginia

4818 Starkey Rd.
Roanoke, VA 24018-8510
800-237-6060
www.deltadentalva.com
Payer #54084

Delta Dental of Washington

P.O. Box 75688
Seattle, WA 98175
800-554-1907
www.deltadentalwa.com
Payer #91062

Delta Dental of West Virginia

(See Delta Dental of Pennsylvania)
Payer #31096

Delta Dental of Wisconsin

P.O. Box 828
Stevens Point, WI 54481
800-236-3712
www.deltadentalwi.com
Payer #39069

Delta Dental of Wyoming

P.O. Box 29
Cheyenne, WY 82003-0029
800-735-3379
www.deltadentalwy.org
Payer #CDWY1

Affiliated Delta Dental Programs**AARP Dental Insurance Plan,**

administered by Delta Dental Insurance
Company
P.O. Box 2059
Mechanicsburg, PA 17055-2059
866-261-4275
www.deltadentalins.com/aarp
Payer #AARP1

DeltaCare USA

P.O. Box 1810 Alpharetta, GA 30023
866-774-5595
Claims Payer #DDCA2
Encounter Payer #DDCA3

Deltadentalco.com

The secure provider at deltadentalco.com helps you streamline your office efficiency with 24/7 access to patient benefits, online claims submission, claims status, payment tracking, and more. If you don't have a provider account, click on Sign in/Register at the top of the page, select I am a provider, and click Go. You will then be taken to another page where you will need to select Create an account. Follow the steps on the next page.

If you need help in setting up your account, follow the five simple steps on [Create a Provider Account](#) or call the provider relations department at 303-889-8677. Please be aware that a provider account can only be created after the provider is fully credentialed.

With just one click, deltadentalco.com gives you unlimited access to:

- Patient benefits
- Claims status
- Claims submission
- Recent payments
- Practice information
- Patient appointment tool
- Clinical policies
- Newsletter library
- Forms and documents
- FAQs and practice resources

If you have a patient who is covered by another Delta Dental member company, you can access their eligibility, claims, and benefits information through our single sign on feature on our national website at deltadental.com using the same user name or user ID and password you use on deltadentalco.com. You can also view the national site without having to log in again once you are logged in to the Delta Dental of Colorado provider portal.

Provider Participation

Becoming a Delta Dental Participating Provider

With more than 1.6 million members, Delta Dental of Colorado is committed to ensuring our networks deliver the highest quality care for our members. Our robust credentialing program allows us to closely monitor our network providers' credentials to ensure top quality care for our members. Lawmakers on state levels have also implemented credentialing requirements for certain network products. The Colorado Department of Public Health and Environment and Delta Dental Plans Association (DDPA) require all managed care plans credential and re-credential their Premier® and PPO™ network providers every three years.

Participating Provider Benefits

As a participating provider you gain access to a number of benefits for the service you provide your Delta Dental patients. These include:

- Payment issued directly to you, alleviating collection problems.
- Access to more than 80 million members in more than 148,000 groups throughout the United States and its territories. Your name and office location(s) are listed in our national provider search, and on DDCO's website, deltadentalco.com, and Delta Dental Plan Association's (DDPA) website, deltadental.com.
- Discounts on many popular dental office services and supplies.
- Access to claims status, benefits, and eligibility online at deltadentalco.com or through our fax-back service.
- Direct deposit ensuring prompt payment and security.

We make it easy for you to become a participating Delta Dental provider, through our online enrollment/credentialing tool, dentalxchange.com/partner/landing/ddco.

[Dentalxchange.com](https://dentalxchange.com) makes it easy for you to complete and upload all your credentialing requirements. To become and remain a participating Delta Dental provider, DDCO requires the following (current and valid) information in order to comply with DDCO and Colorado state rules and regulations governing provider credentialing:

- Colorado dental license
- DEA license (copy required)
- Malpractice insurance declaration page (must include renewal date and coverage amount) (copy required)
- Basic Life Support (BLS) certification (copy required)
- Work history from graduation and/or residency date—no gaps greater than 30 days (copy of resume required)
- Completed facility profile—only one per office needed for multiple provider offices (limit of five office locations).
- Specialty certificate (if applicable)
- Dental diploma (copy required)
- National Provider Identifier (NPI)
- W-9 form (copy required, if you are opening a new business, we need this for your tax ID number).

Additionally, providers agree to:

- Not be under suspension by this corporation, the Colorado Dental Board, or any other similar regulatory body.
- File claims for Delta Dental patients and accept payment from Delta Dental, regardless of Delta Dental's benefit determination.
- Agree to abide by the by-laws, rules, and regulations established by DDCO's Board of Directors.
- Agree to abide by Delta Dental claims processing policies:
 - Claims will be processed based on the patient's individual benefit plan, Delta Dental National Processing Policies, and Delta Dental of Colorado Processing Guidelines.
- The participating provider accepts payment directly from Delta Dental based on either the Premier® maximum plan allowance (MPA) or the Delta Dental PPO™ schedule of allowances, whichever is applicable, as established by DDCO. Any difference in fees charged and Delta Dental's allowable fee cannot be charged to Delta Dental members. Amounts that you bill DDCO will not exceed amounts that you typically charge the general public for dental services.
- Sign an organization and participation agreement every three years during the re-credentialing cycle.
- When required, allow Delta Dental to examine and copy office records, and/or provide information to determine compliance with the terms of the agreement.
- Meet and continue to satisfy all of DDCO's credentialing and acceptance requirements.
- Bill Delta Dental no more than the discounted fee for the service provided to enrollees if you discount your provider fees for dental services, whether as a professional courtesy to the patient or as part of a commercial arrangement that provides for discounted fees.
- Participating providers are held to contracted fees for all Delta Dental covered services, even when the patient has exceeded their maximum annual benefit or contractual time limitations, or in cases when benefit criteria are not met.
- For all non-covered services documented as plan exclusions, participating providers may charge the patient their full, submitted fee.

A provider who signs a Delta Dental Participating Agreement is designated as a participating Delta Dental provider with DDCO as well as with all Delta Dental member companies nationwide. Our provider network is re-credentialed every three years, to ensure we maintain current information. DDCO is audited for compliance with these standards, so it is mandatory that we receive this information from you when requested.

Failure to submit credentialing information means you will be in non-compliance with DDCO Participating Provider Rules and DeltaUSA standards. At any time during the application process, applicant providers have the right to receive a status of the application, review information submitted with their application, and correct any erroneous information through the DDS Enroll portal or by emailing Provider Relations at credentialing@ddpco.com. We appreciate your prompt cooperation with any credentialing requests you receive from DDCO.

Record-Keeping

Delta Dental of Colorado requires the following data be made available to us upon request:

- All entries in treatment records should be completed within 36 hours of the date of service.
- Office must submit original or copies of original records.
- Records must be unaltered.

Edits or corrections should only be for clarification and must be clearly indicated with the date of the edit and signed by the doctor.

Delta Dental of Colorado Policy Statements

1. Provider shall complete and submit an ADA-approved dental claim form, paper or electronic, for completed treatment or pre-treatment estimate.
2. Delta Dental of Colorado may request that the provider send all radiographs, study models, and any other information essential to the prompt and efficient processing of the dental claim or when requested for audit requirements. The costs of submitting to Delta Dental any radiographs, models, information, or any other similar materials requested are neither separately payable by Delta Dental nor chargeable to the patient/subscriber by a participating member provider. X-rays will be returned to the provider's office if a self-addressed stamped envelope is included with the X-ray. The exception is if payment of benefits for those diagnostic procedures is covered under provisions of dental plan contracts, subject to contract limitations.
3. Reimbursement for services performed, or to be performed, under a Delta Dental program shall not exceed Delta Dental's maximum plan allowance (MPA) or PPO™ schedule of allowances, whichever is applicable.
4. Provider shall accept paper checks or electronic remittances as payment for benefits covered by Delta Dental programs. Provider shall not charge, or attempt to charge at any time, an amount greater than the patient's share of the cost of the treatment as determined by Delta Dental.
5. A provider shall not discount to the patient any portion of, or all of, the patient's financial obligation to the provider for services rendered, which are benefits of any Delta Dental program, except as outlined in the discount policy.
6. Delta Dental of Colorado may deny payment of a claim submitted more than 12 months after the date of service.
7. Payment for services rendered by a non-participating provider under Delta Dental programs will be made directly to the patient or subscriber unless assignment of benefits is applicable.
8. Provider shall cooperate with Delta Dental in its attempts to review care provided under Delta Dental programs and in problem resolution related to claims.
9. Provider shall schedule and render all dental treatment in accordance with recognized professional standards of care, as well as state and federal law, including but not limited to the Americans with Disabilities Act, the Health Insurance Portability and Accountability Act (HIPAA), and the Public Health Service Act.

10. Provider shall conduct their practice in accordance with the principles of ethics of the American Dental Association, the Colorado Dental Association, and the local component society within whose jurisdiction they practice.
11. Provider shall accept total responsibility for the accuracy of information on the ADA-approved dental claim. The submission of false or inaccurate information on the claim or in support of a claim is grounds for revocation of a member's Delta Dental Participating Agreement.
12. Providing an ADA-approved dental claim for treatment procedures which are not consistent with the demonstrable needs of a patient is grounds for the revocation of a member's Participating Provider Agreement.
13. Completion and submission of paper or electronic claims is not chargeable to the patient or Delta Dental by a participating member provider.
14. Provider who violates Delta Dental national or Colorado Dental Board-established policy shall be considered in violation of their Delta Dental Participating Agreement. DDCO has the right to terminate a Delta Dental Participating Agreement for cause or without cause. Such cause may include but is not limited to irregular billing, falsification of reports, failure to comply with the terms of any service agreement in force, abusive or threatening language or behavior toward employees of DDCO, failure to comply with audit and certification requirements, falsification of patient or office records, failure to meet re-credentialing requirements, or failure to timely file information and reports as the DDCO Board deems necessary and proper. Providers shall be terminated, if appropriate, after the DDCO established termination procedure is complete, except in instances of failure to maintain a license or serious misconduct, in which case their status as participating providers will be immediately terminated. Any provider whose Delta Dental Participating Agreement has been canceled may request reinstatement. Reinstatement will follow the same procedure by DDCO and provider as termination.
15. Any arrangement in which the fee for any covered service is compensated in whole or in part by barter for goods or services must be supported by documentation of the fair market value, in dollars, which is or should be, declared pursuant to the Internal Revenue Code of 1986, Section 61, as gross income from any such barter arrangement.
16. The date of service as defined by Delta Dental of Colorado's Board of Directors is the date treatment is completed. For multiple appointment procedures, the completion date of the procedure is the date that must be submitted on claims for payment. Completion for crowns, cast restorations, and fixed bridges is the cementation or seat date; for removable full and partial dentures it is the insertion date; and for root canal therapy it is the final fill date.
17. By executing a Delta Dental Premier® Participating Dentist Agreement with DDCO, the provider becomes a participating member provider in all Delta Dental Premier programs administered by DDCO, as well as any national Delta Dental Premier programs administered by other Delta Dental member companies. Execution of a Delta Dental PPO™ Participating Dentist Agreement results in the provider becoming a member provider in all Delta Dental PPO programs administered by DDCO, as well as any national Delta Dental PPO programs administered by other Delta Dental member

companies. In any instance where a specific Delta Dental employer, local or national, requires a separate Delta Dental Participating Agreement, the DDCO participating provider is not bound by the specific rules and regulations unless the separate Delta Dental Participating Agreement is executed.

18. If the deductible and/or copayment of a claim has been waived and not reported as a discount in advance of Delta Dental's discovery of such action by the providing provider or if a reasonable effort has not been made by the providing provider to collect the patient's portion of the fee as determined by Delta Dental, then Delta Dental will recover its entire payment, even if the charge to the patient is subsequently reinstated and collection of that portion is accomplished or reasonably attempted by that provider.

19. Payment for incomplete or interrupted treatment will not exceed one-half of Delta Dental's share for comparable completed treatment and will be considered when correctly reported. Delta Dental will have no obligation to make payment for incomplete or interrupted treatment when mis-reported as completed treatment. Any amount refunded to Delta Dental from mis-reporting is not chargeable to the patient.

20. A Delta Dental participating provider shall not use any unapproved DDCO signage. The exception is the indication of the provider's membership with DDCO in telephone directory listings and the display inside a provider's office of Delta Dental awarded certificates or plaques.

Delta Dental of Colorado Fee Discount Policy

1. Cash Discount

The policy established by Delta Dental's Board of Director's provides that participating member providers "shall not charge or attempt to charge the patient at any time an amount greater than the patient's share of the cost of treatment". However, if a patient chooses to make payment in advance of treatment for a cash discount or other fee reduction arrangement, any such arrangement offered is subject to the following policy guidelines:

- a. Any cash discount or any other fee-reduction arrangement must comply with the provisions of the Colorado Statutes, specifically, but without limitation, C.R.S. 18-13-119, as it may be amended from time to time.
- b. Any offer subject to this policy must be limited to payment received prior to, or no later than, the day care is delivered. Any extension of such an offer will be disqualified from consideration under these guidelines.
- c. The amount to which the discount is applied shall be no greater than the sum of the Delta Dental maximum plan allowance for the services involved. Whether a discount is offered on the total fee or on a portion thereof (such as the subscriber's copayment or some other amount less than the total), the actual amount being charged, (that is, the net amount after discount), must be reported on any request for pre-treatment estimate of benefits or claim for payment submitted to Delta Dental; additionally, any such request for pre-treatment estimate or claim for payment must specify the amount of the discount, if any, offered or rendered, as the case may be. Delta Dental shall pay no more than the Delta Dental share of the actual amount charged for the services rendered to the patient.
- d. Any offer subject to this policy must be made available to the provider's Delta Dental-covered patients in the same manner it is made available to any of the provider's other patients: patients with other dental benefit coverage and/or patients without any dental benefit coverage. Any provider making such an offer shall be responsible for complete, detailed records of the services being discounted, the percentage of discount or dollar amount equivalent, the amount on which the discount was based, and payment date and care delivery date coinciding with any such offer. If requested, the provider shall provide Delta Dental with details in writing of the office policy and individual applications of that policy to all of his/her patients covered under Delta Dental programs.

2. Professional or Other Courtesy Discount

A discount, or any other fee reduction arrangement offered as a professional or other courtesy, must meet all of the requirements of a cash discount, outlined above, with the following exceptions:

- a. It must always be applied to the total fee (not merely a portion such as patient copayment).
- b. It does not require payment prior to or on the day of delivery of care.

3. Employer/Employee Discount

A discount or some other fee reduction arrangement may be offered if it meets all of the requirements of a cash discount outlined above with the following exceptions:

- a. The services are actually rendered to the employee by the employing provider or member of the provider's staff authorized by license to perform the services.
- b. A legal employer/employee relationship exists.
- c. It must be applied to the total fee (not merely a portion such as the patient copayment).
- d. It does not require payment prior to or on the day of delivery of care.
- e. The patient is covered by Delta Dental.

4. Provider's Family Discount

- a. The services are actually rendered to the provider's family member by the related provider or by a member of the provider's staff authorized by license to perform the services.
- b. It must be applied to the total fee (not merely a portion such as the patient copayment).
- c. It does not require payment prior to or day of care or delivery.

Provider Reimbursement and Fee Information

Fee schedules may be found by logging into the secure provider account at deltadentalco.com. After logging in, click on the Documents tab on the top navigation.

Delta Dental Premier® and Non Participating Maximum Plan Allowance (MPA)

The highest amount allowed for payment to Premier providers and non-participating providers. Participating Premier providers and non-participating providers are reimbursed at the level of the billed amount, or the maximum plan allowance, whichever is less. Please note that some plans pay non participating providers on a percentile basis of the MPA plan.

Delta Dental PPO™ Schedule of Allowances

The highest amount allowed for payment to PPO providers. Participating PPO providers are reimbursed at the level of the billed amount or the agreed-upon PPO contract rate, whichever is less.

Delta Dental Non-Participating Maximum Plan Allowance (MPA)

The highest amount allowed for payment to non-participating providers. Non-participating providers are reimbursed at the level of the billed amount, or the non-participating maximum plan allowance, whichever is less.

Guidelines for completing the W-9 form correctly

A current W-9 must always be on file from our participating providers. Only one W-9 is needed per Tax ID Number (TIN). Since this information is used for IRS tax reporting purposes, it's imperative we have correct information for your office. Please complete the W-9 form with the Tax ID Number that your office uses.

The W-9 form should be completed by filling in the Name line with the name associated with that Tax ID Number exactly as it appears on Form 941 filed with the IRS. The second line, Business Name, is used only if you have a DBA (doing business as) name. The address line should be completed with the address that your 1099 should be mailed to. The form should be signed and submitted to:

Delta Dental of Colorado
Attn: Provider records
PO Box 5468
Denver, CO 80217-5468

The form can also be emailed to profservices677@ddpco.com or faxed to 303-741-2230 (Attn: provider records).

Direct Deposit

As a participating provider with Delta Dental, you can have your claims paid directly into your bank account without having to wait for a paper check. With direct deposit, payment is received three to four days after a claim is submitted (granting additional information is

not required to process the claim), in comparison to up to 20 days for paper checks to be received. You can also view your check disbursements online 24/7. DDCO does not charge a fee to the office to participate in direct deposit.

To take advantage of this time saving benefit, download the direct deposit form from our website at [deltadentalco.com/dam/jcr:031e7488-462b-452d-a08d-ecf9387d2065/ProviderDirectDeposit_EnrollmentForm_2022%20\(1\).pdf](https://deltadentalco.com/dam/jcr:031e7488-462b-452d-a08d-ecf9387d2065/ProviderDirectDeposit_EnrollmentForm_2022%20(1).pdf). You can choose to participate in direct deposit for DDCO only or for all member companies by selecting the national option on the form.

You will need to submit a voided check or letter from the bank via email to profservices677@ddpco.com. Your provider relations representative will contact you to confirm receipt of the information and verify that all information is correct before finalizing your direct deposit.

Provider Participation

The Delta Dental system is the largest dental benefits provider in the country, which means many of your patients are likely to be covered by us. The key is knowing which of our network(s) are covered by their plan. The network(s) their plan covers can be found on their ID card or via the secure provider portal.

The member can access their ID card using the Delta Dental mobile app or by logging in to their account online. If they don't have an account online, direct them to deltadentalco.com where they can find an easy how-to guide on creating a subscriber account. Determining the network(s) in advance will enable the patient to know if you participate in the network(s) covered by their plan and will help to avoid misunderstandings.

Delta Dental Premier®

Delta Dental Premier is our traditional fee-for-service program. Providers are guaranteed direct payment based on the lesser of your submitted fee or Colorado payment allowance regardless of which Delta Dental processes your claim. Subscribers with Delta Dental Premier coverage are encouraged to seek services from a participating Delta Dental Premier provider.

Delta Dental PPO™

Delta Dental PPO is our reduced fee-for-service program commonly referred to as a "PPO". PPO providers agree to accept payment based on the lesser of their submitted fee or the PPO fee schedule. Like Delta Dental Premier, providers file claims and receive direct payment, regardless of which Delta Dental processes the claim. Members are encouraged to seek services from a participating PPO provider; however, PPO patients may choose to incur higher out-of-pocket expenses and seek services from a participating Delta Dental Premier-only provider if their group contract allows. Please check this prior to treatment.

DeltaCareUSA®

DeltaCare is our managed care program commonly referred to Dental Health Maintenance Organization (DHMO). Reimbursement is based on capitation and member copayment (Delta Dental will also pay an encounter fee per patient visit). DeltaCare patients must seek care from their selected DeltaCare provider and any necessary specialty care referrals must be pre-authorized by DeltaCare. If you are not the patient's selected DeltaCare provider, please ask the patient to call DeltaCare at 1-800-422-4234. Any service rendered by a provider other than a selected DeltaCare provider becomes the patient's full financial responsibility.

Delta Dental Medicare Advantage™ Network

The Delta Dental of Colorado Medicare Advantage is the newest network at DDCO. Participation in this network allows you to see any Medicare Advantage member, covered by several health plan partners including Denver Health, Kaiser Permanente, and Devoted Health. Your network participation will match your DDCO participation, either PPO plus Premier or Premier only. Claims will be reimbursed at the published PPO or Premier rates, based on your participation status. If the provider is not enrolled, the claim will process as out of network and may be denied, not reimbursable by DDCO or the member.

Participation in the DDCO MA network is a great opportunity to increase your patient base and expand members dental home access. Participation does require additional attestation to the annual compliance plan, including fraud, waste, and abuse training, records retention, and Federal database verification.

To participate, please complete the provider attestation and contract addendum found on the secure provider portal at deltadentalco.com and return to profservices677@ddpco.com. For more information, please visit deltadentalco.com/dentists/Medicare-Advantage.html.

Delta Dental National Coverage

When you sign a Delta Dental of Colorado Participating Agreement, your participation is honored throughout the national Delta Dental system. Please keep in mind that if your patient is covered under a Delta Dental national coverage program (Delta Dental Premier®, Delta Dental PPO™ or DeltaCare®), claims must be submitted to the appropriate Delta Dental for processing. Log in to the Delta Dental's national provider portal to find out which Delta Dental member company the patient is a part of. Regardless of which Delta Dental company processes your claims, reimbursement will be issued directly to you and based on the agreed upon Colorado allowable fees. Regardless of which plan the member has (national vs. state) the reimbursement will always be based on CO allowable fees.

Audits and Utilization Reviews

Pre- and Post-Payment Audits Contract Compliance Review

Under the terms of the participating agreements, contracted providers agree to follow all the rules and regulations established by the Board of Directors. This includes policies regarding billing and claims submission practices, as well as terms under which the providers accept payment directly from Delta Dental. Contracted providers agree to allow a representative of DDCO to examine any such records as deemed necessary to determine compliance with their individual provider participating agreement and all Board policies.

Guidance for Contract Compliance

Listed below are some key points to help you comply with the terms of your participating provider agreement and Board of Trustees policies. Please refer to this Provider Handbook and the Update Newsletter for policy clarifications and changes.

Bookkeeping

- Treatment entries recorded in the ledger must also be recorded in the patient chart.
- Submit services under the provider who actually provided the treatment. Every provider rendering and billing for treatment must have a current and unrestricted CO license.
- All charges recorded in the ledger must be submitted on the claim form as well.
- Fees recorded in the ledger must be the same as fees submitted on the claim.
- Discounts (any and all) must be applied to the total fee, not just the patient portion.
- Discounts must adhere to the Delta Dental of Colorado Fee Discount Policy included in the Delta Dental Provider Handbook.
- Participating providers collect only the patient portion at the time of treatment.

Adjustments

- All amounts indicated as “not chargeable to patient” or “provider adjustment” must be recorded as a credit in the patient ledger.
- In the case of dual insurance, adjustments/write-off amounts should be applied after the secondary insurance is received.

Patient Records

- Patient records must reflect the standard as defined by the Colorado Dental Board, the Colorado Dental Practice Act, the Colorado Dental Hygiene Practice Act, and the applicable standard of care.
- Terms and abbreviations must be clear and understood by everyone in the office.
- All entries must be legible.
- Dates and all significant, pertinent data regarding the patient evaluation and/or treatment must be recorded.
- Providers must abide by HIPAA guidelines, all federal, and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, safeguard the privacy of any information that identifies a particular enrollee, and have procedures that specify.
 - a. for what purposes enrollee information will be used by the provider’s office.
 - b. to whom and for what purpose it will disclose such confidential information.

Claims and Procedure Codes

- Procedure codes submitted on the claim must reflect the actual procedure completed.
- Claims must accurately reflect the dates, procedures, and fees recorded in the patient chart and ledger.
- The provider submitted as the treating provider on the claim form must be the provider who actually performed the treatment.
- Multi-appointment procedures (root canals, crowns, bridges, dentures) must be submitted on completion date.

Investigations and Provider Review

Delta Dental of Colorado's program integrity team is responsible for recovery of funds improperly paid and prevention of inappropriate payments, whether resulting from inadvertent billing errors or from fraud, waste and/or abuse, systemic errors, misrepresentation, or concealment of facts. Some cases are investigated as the result of calls or emails to DDCO or our fraud, waste, or abuse mailbox at compliance@ddpco.com. This email address is included on Explanation of Benefit (EOB) forms sent to DDCO members. Providers should pay attention to improper use of identification cards or other practices that defraud DDCO, the provider or other third-party payors. Anyone who becomes aware of a group account, member, or provider who may be engaging in these practices should notify DDCO.

Audits

DDCO's program integrity team performs provider audits. These audits are often performed when providers are identified as outliers in comparison to their peers. The procedure for auditing providers may include the use of statistical sampling and extrapolation. If the audit reveals overpayments issued to the provider, the provider will be required to reimburse DDCO the projected total overpayment. The auditor will assign an error for any incorrect code submitted by the provider. The auditor will document determinations of over-coding and under-coding. Once determined, the audit results will then be extrapolated into overpayments and underpayments, as appropriate, using a ratio method. Extrapolation is calculated by determining the percentage of error in the audited results and then applying the percentage to the overall payment population, (i.e., the provider's reimbursements over the period of the audit.)

Providers may also be selected for audit based on one or more of the following:

- Calls or submitted complaints from members regarding quality of care or billing issues.
- Calls or email referrals from office staff (current or former employees).
- Internal referrals from within DDCO.
- Referral from outside agencies such as the Department of Regulatory Agency, Colorado Attorney General, etc.
- Colorado State Dental Board of Dentistry investigations.
- Information from other Delta Dental member companies.

Typically, DDCO team members who are subject matter experts in provider contracts and external provider consultants performs audits. Upon completion of the audit, a detailed determination letter is issued to the provider and/or facility. All findings are documented, any necessary actions are outlined, and provider dispute rights are included.

Post-payment audits may be conducted on-site at the provider's office or facility or by requesting that dental records be mailed to DDCO. DDCO will typically provide at least one to two weeks advance written notice of intent to conduct an on-site audit. Audits are performed during regular business hours and with as little disruption as possible to the provider's operations as possible.

Auditors will remain on-site until the information needed to complete the audit typically one to two days. DDCO may request to review records for services extending back two years prior to the date of the request.

Pre-payment audits are completed using our focused review process. This process includes clinical review of certain claims prior to payment to ensure submitted treatment is necessary and appropriate based on an individual patient's clinical condition. Any supporting documentation, such as treatment notes, radiographs, financial ledger, etc., required for review will be requested from the provider office. Clinical review of the submitted treatment is carried out by a licensed dentist and the determination is issued via explanation of benefits to the patient and check disbursement to the provider.

Exceptional circumstances may necessitate review of records beyond a two-year period (e.g., occurrence of systemic billing errors, material misrepresentation, potential for fraud, etc.). In addition, certain group accounts or government programs may require longer audit periods.

A provider audit may seek to verify that:

- The patient was eligible at the time of service.
- All completed services were billed to DDCO.
- The service billed was a covered service and documented as completed.
- Billed services were dentally/medically necessary and appropriate.
- Billed tests and procedures were, in fact, ordered, performed, and received.
- Billed charges were adjusted to reflect contracted fees consistent with approved charges (e.g. charge master), where applicable.
- Charges were not discriminatory.
- Coding accurately reflected services performed.
- Coding adhered to recognized guidelines and practices.
- The service date appropriately reflected the treatment completion date.
- Services billed were supported by necessary and appropriate provider orders, medical records, and other documentation.
- Payment was made at the reimbursement rate or allowed amount established in the provider contract.
- Patient deductibles, copayments, and/or coinsurance was collected.
- Any discounts afforded to the patient were properly reported per the DDCO Fee Discount Policy.
- Incorrect payments (duplicates, over/underpayments) were identified.
- Overpayments were recovered and underpaid amounts were paid.

Statistically-valid sampling and extrapolation may be used as a component of provider audits.

Audit Determination

Criteria Used in Audits

In the performance of office audits (whether pre- or post-payment), the auditor will use the following criteria to assess adequacy of documentation:

- The applicable CDT Codes published by the American Dental Association in the Current Dental Terminology book.
- The requirement in DDCO group and individual policies and provider contracts that services be dentally/medically necessary.

Each record must support the service billed and the level of care provided on each unique date. Records that contain inaccurate documentation, conflicting information, or other such irregularities may not be billable to patient. Reimbursement for any record containing any such documentation will be represented in overpayment calculations with zero reimbursement allowed.

Documentation of Findings

To document audit results, DDCO auditors use internally created guidelines. Auditors create a summary worksheet that may be supplemented or annotated with written comments. Providers may wish to analyze the summary worksheets for self-audit to monitor compliance with recognized documentation standards.

Review of Results with Providers

At the conclusion of an audit, the results are submitted in writing to the provider via certified mail and/or encrypted email. The provider is afforded the opportunity to rebut audit findings. Copies of the audit worksheets are made available to the provider and/or facility.

Additionally, the provider may request a face-to-face meeting with DDCO to:

- Ensure the provider understands the audit process and results.
- Answer any questions regarding correct billing or documentation standards.
- Afford the provider an opportunity to furnish additional information.
- Discuss repayment arrangements, if applicable.

Retention of Records

DDCO will maintain audit worksheets and findings for a period of 10 years, in accordance with our corporate record retention policy.

Claims

Participating providers agree to submit claims directly to Delta Dental on behalf of all Delta Dental Premier® or Delta Dental PPO™ patients, regardless of whether Delta Dental is their primary or secondary insurance and regardless of which Delta Dental member company administers the patient's benefits.

When you sign a Delta Dental of Colorado Participating Agreement, your participation is honored throughout the national Delta Dental system. Please keep in mind that if your patient is covered under a Delta Dental national coverage program (Delta Dental Premier®, Delta Dental PPO™ or DeltaCare®), claims must be submitted to the appropriate Delta Dental for processing. Log in to the Delta Dental's national provider portal to find out which Delta Dental member company the patient is a part of. Regardless of which Delta Dental company processes your claims, reimbursement will be issued directly to you and based on the agreed upon Colorado allowable fees.

The claim form provided by DDCO contains all the information necessary to properly calculate payable benefits and are for your use only when filing DDCO claims. If it is currently your office policy to file claims electronically, use standard ADA or computer-generated claim forms, please feel free to continue to do so. Claim forms for DDCO groups are provided to participating dental offices at no cost. Claim forms can be obtained through deltadentalco.com or by calling customer service at 1-800-610-0201.

The American Dental Association claims all right, title, and interest (including all copyrights and other intellectual property rights) to the dental nomenclature and classification entitled Current Dental Terminology and prior editions of that work. DDCO and other Delta Dental member companies use that dental nomenclature and classification by claim of right, and that right has been incorporated into a Copyright License and Settlement Agreement.

Completion of the DDCO Claim Form

Specific instructions on each numbered item of the DDCO claim form are provided below. All applicable data must be entered to prevent delay in processing of the claim. Completed claims must be submitted to Delta Dental within 12 months of the date of service or will be subject to denial.

1	Type of Transaction - Select the appropriate box for type of transaction. Multiple selections may apply.
2	Predetermination/Preauthorization Number - Enter if applicable
3	Company/Plan Name, Address, City, State, Zip Code - Name and address of the employer/company primary subscriber covered by.
3a	Payer ID - An identification number self-assigned by an insurance company or dental benefit plan. The Payer ID is supplemental to the Dental Benefit Plan Information for the third-party payer receiving the claim.
4	Coordination of benefits (COB) - Complete only if patient is covered by another dental plan.

5	Name of Policyholder/Subscriber in #4 - Name of Primary Subscriber covered by other dental plan.
6	Date of Birth - Date of Birth of primary subscriber covered by other dental plan.
7	Gender - Gender of primary subscriber covered by other dental plan.
8	Policyholder/Subscriber ID - ID number of primary subscriber assigned by other dental plan, if known.
9	Plan/Group Number - Policy number of other dental plan
10	Patient's Relationship to Person named in #5 - Select the appropriate box.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code - Name and address of other dental carrier.
11a	Other Payer ID - supplemental to the Other Coverage for the additional dental or medical insurance policies receiving the claim. If the Payer ID is unknown, the field can be left blank.
12	Policyholder/Subscriber Name - Primary subscriber in whose name benefits are contracted.
13	Date of Birth - Date of Birth of primary subscriber.
14	Gender - Gender of primary subscriber.
15	Policy/Subscriber ID - Identification number for primary subscriber named in #12.
16	Policy/Subscriber ID - Identification number for primary subscriber named in #12.
17	Employer Name - Name of employer of primary subscriber.
18	Relationship to Policyholder/Subscriber in #12 above - Refers to the relationship of the patient to the primary subscriber. Check "self" if patient is the primary subscriber. Check Spouse, Child, or other as applicable.
19	Reserved For Future Use - Leave blank.
20	Name - Enter the full name of the patient, not a nickname. Be sure to include surname if different from that of the primary subscriber.
21	Date of Birth - Date of birth of patient. Accurate birth date identifies an individual's record to enable processing of the claim.
22	Gender - Gender of patient.
23	Patient ID/Account # (Assigned by Provider) - Complete if applicable. This is not a number that DDCO will recognize as it is assigned by the provider for their use.
24	Procedure Date - Indicate date of service for completed services only. Do not submit claims on preparation, impression, or start dates. For treatment plans being sent in for predetermination, no completion date should be indicated.
25	Area of Oral Cavity - Identify area of oral cavity where service is performed.
26	Tooth System - Enter JP if using the ADA's Universal/National Tooth Designation System, enter JO if using the International Standards Organization System.
27	Tooth Number(s) or Letter(s) - When service has been provided on a particular tooth, identify the tooth by the applicable number or letter.

28	Tooth Surface - When applicable, indicate the arch, surface, or quadrant where procedures were performed.
29	Procedure Code - Use the appropriate code for procedure(s) if not already pre- printed on the claim form.
29b	Enter 1
30	Information required when the diagnosis may affect claim adjudication. Specific dental procedures may minimize the risks associated with the connection between the patient's oral and overall health conditions. (A through as applicable from Item 34a).
31	Fee - Indicate the fee charged for the service.
32	Total Fee - Total of fees submitted for payment.
33	Missing Teeth Information - Place an X on each missing tooth.
34	Diagnosis Code List Qualifier - AB for ICD-10-CM. 34a. Diagnosis Code(s) - A, B, C, D (up to four, with the primary adjacent to the letter A).
35	Remarks - Any applicable comments or remarks.
36	Patient Consent and Acknowledgement - If applicable, patient to provide signature.
37	Assignment of Benefits - Subscriber must sign if benefits payable to subscriber should be payable and sent elsewhere.
38	Place of Treatment - The physical site where treatment was rendered. Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard. Frequently used codes are: 11 = Office; 12 = Home; 02 = Telehealth or Teledentistry.
39	Place of Treatment - Enter the two-digit Place of Service Code for Professional Claims.
39a	Date Last SRP - Allows for the date of service for the last Scaling and Root planning procedure delivered to the patient. If the data is unknown or not applicable this field can be left blank.
40	Enclosures - Indicate Y or N.
41	Is Treatment for Orthodontics - Mark applicable box.
42	Date Appliance Placed - Please use four-digit year.
43	Months of Treatment - Enter months required for full treatment plan.
44	Replacement of Prosthesis - Mark applicable box.
45	Date of Prior Placement - Please use four-digit year.
46	Treatment Resulting From - Mark applicable box.
47	Date of Accident - Indicate if applicable.
48	Auto Accident State - If applicable.
49	Name, Address, City, State, Zip Code - Address information of the billing provider or dental entity (leave blank if provider or dental entity is not submitting claim on behalf of the patient or insured/subscriber).
50	NPI - if applicable.
51	License Number - Of treating provider.

52	SSN or TIN – If applicable.
53	Additional Provider ID – If applicable.
53a	Locum Tenens Treating Dentist? – Providers acting in a locum tenens capacity may be providing services in order to fill staffing shortages. Reporting a locum tenens dentist does not supersede any payer policies for in-network or out-of-network status.
54	Signature of Treating Provider and Date.
55	NPI – National Provider Identifier of treating provider.
56	License Number – Of treating provider.
57	Address, City, State, Zip Code – Of treating provider.
58	Phone Number
59	Additional Provider ID

Claims Submission Tips

For providers, fast claims processing means fast payment. Claims filled out completely and accurately by dental offices are the key to rapid claim processing.

Whenever a claim is pended due to incomplete or inconsistent information, staff must review the claim, and, often they must request more information from the dental office, a time-consuming and costly process for everyone. Dental offices can help speed payment by submitting claims with complete and correct information.

The following tips have been developed for dental offices to ensure faster and more accurate processing of claims and correspondence.

1. Use the subscriber and patient full names and birthdates.
2. Verify patient eligibility before providing service. You can verify eligibility on the secure provider portal at deltadentalco.com where you will find a complete breakdown of the patient benefits and other useful information. It's suggested that the office utilize the portal to its full capacity. You can find contact information for Delta Dental member companies by visiting deltadental.com/us/en/about-us/contact-us.html.
3. Submit the subscriber's social security or member identification number and date of birth on all claims and correspondence.
4. Include the patient's full mailing address, including zip code, on all claims.
5. Use the full attending Colorado issued provider's license number on every claim.
6. The Tax ID Number (either your SSN or your EIN) submitted on the claim form MUST match the Tax ID Number (TIN) on file with DDCO. Using a different TIN, using your SSN when your EIN is filed, or using your EIN when you filed your SSN can result in claims processing delays or cause your claim to process incorrectly. Your TIN is used for 1099 (IRS) tax reporting purposes and must match what is on file with the IRS. Contact provider relations at 303-889-8677 to determine or to change the TIN on file.
7. Submit a separate claim for each patient.
8. Use the universal tooth numbering system where appropriate (1-32 for permanent teeth, A-T for primary teeth).
9. Use valid tooth surface codes for restorations (M, I, D, L, F, B, or O).

10. Do not submit duplicate claims. You can check the status of a claim on the secure provider portal at deltadentalco.com or by contacting customer service at 1-800-610-0201 or customer_service@ddpco.com.
11. Always submit for all services rendered with a charge, even if the service may not be covered.
12. Submit claim forms within 12 months of the date of service.
13. Always use the final, completion, delivery, or seat date as the date of service for multiple visit procedures. Delta Dental only pays for completed procedures.
14. Provide documentation for emergency and “by report” procedures in the comment section of the claim form.
15. Use the procedure code appropriate to the patient’s age when there are different codes for adults and children. If submitting an adult code for a child due to extenuating circumstances, be sure to note this on the claim form.
16. Occupational Safety and Health Administration (OSHA), infection control, and/or sterilization charges are an integral and inseparable part of the general office overhead and should be incorporated into the overall fee schedule. A separate fee may not be charged by a participating Delta Dental provider.
17. If there is other coverage, indicate relationship of the insured to the patient and the insured’s date of birth. Indicate amount paid by other carrier(s) by enclosing a copy of the Explanation of Benefits (EOB) from the other carrier(s) along with the effective date of coverage.
18. Corrections to an incorrectly submitted claim can be done by contacting our customer service department. Please do not submit a new claim form.
19. When submitting a predetermination benefit voucher for payment, submit only the original predetermination voucher. Please do not also submit a claim form.
20. If you receive a request for additional claim information from Delta Dental, please respond promptly using the request form. Please do not submit a new claim form.
21. Radiographs should be of diagnostic quality, dated, labeled left to right or with tooth numbers, and identified with both patient and provider name.
22. Verify whether pre-operative/post-operative radiographs are required for the procedure and submit with the claim. If radiographs are not available, provide supporting documentation for the necessity of the procedure.
23. Photocopies of radiographs, scanned radiographs, or digital radiographs printed on paper are acceptable for benefit determination and will not be returned unless requested.

Requirements for Claims

Radiographs are required for the following procedures:

- Surgical extractions (D7210-7251)
- Partial dentures
- Bridges (full arch or bitewings of both sides of the arch)
- Implants, surgical placement and restorations
- Onlays, and veneers
- Retreat RCT D3346-3348 (if covered benefit) D3430, D3471-3473, 3920, 4249, 4260, 4263, 4264, 4266, 4267, and 4268
- Crowns, core build-up, cast post and core, or prefabricated post and core

Treatment notes indicating clinical need are required for:

- 3230, 3240, 3331, 3332, 3333, 3346, 3347, 3348, 3430, 3501-3503, 4346, 4355
- Implant restorations and repairs
- 7241, 7251, 7260, 7261
- Biopsies and excision of lesion codes
- 7320, 7321, 7955
- 7911, 7912,

Perio charting is required for:

- 4210, 4211, 4240, 4241, 4245
- 4260, 4261, 4263, 4264
- 4266, 4267, 4268,
- 4270, 4273, 4274, 4275, 4276, 4277, 4278, 4283, 4285
- 4341, 4342

Additional clinical documentation may be required and will be requested, as needed.

Supporting Documentation Requirements for Medicare Advantage Pre-Determinations

As of September 1, 2020, Delta Dental of Colorado recommends a pre-determination of benefits be submitted for all Basic and Major dental services for Medicare Advantage members. Requests must be submitted directly to DDCO as an undated claim, like any other pre-determination, not just a faxback. Below is a list of all the codes that require supporting documentaiton for pre-determinations.

Code	Description
D0419	Assessment of salivary flow by measurement
D1551	Re-cement or re-bond bilateral space maintainer — maxillary
D1552	Re-cement or re-bond bilateral space maintainer — mandibular
D1553	Re-cement or re-bond unilateral space maintainer — per quadrant
D1556	Removal of fixed unilateral space maintainer — per quadrant
D1557	Removal of fixed bilateral space maintainer — maxillary
D1558	Removal of fixed bilateral space maintainer — mandibular
D2753	Crown - porcelain fused to titanium and titanium alloys
D5284	Removable unilateral partial denture — one-piece flexible base (including clasps and-teeth) - per quadrant
D5286	Removable unilateral partial denture — one-piece resin (including clasps and teeth) - per quadrant
D6082	Implant-supported crown — porcelain fused to predominantly base alloys
D6083	Implant-supported crown — porcelain fused to noble alloys
D6084	Implant-supported crown — porcelain fused to titanium or titanium alloys
D6086	Implant-supported crown — predominantly base alloys
D6087	Implant-supported crown — noble alloys
D6088	Implant-supported crown — titanium and titanium alloys

D6097	Abutment-supported crown — porcelain fused to titanium or titanium alloys
D6098	Implant-supported retainer — porcelain fused to predominantly base alloys
D6099	Implant-supported retainer for FPD — porcelain fused to noble alloys
D6120	Implant-supported retainer — porcelain fused to titanium and titanium alloys
D6121	Implant-supported retainer for metal FPD — predominantly base alloys
D6122	Implant-supported retainer for metal FPD — noble alloys
D6123	Implant-supported retainer for metal FPD — titanium and titanium alloys
D6195	Abutment-supported retainer — porcelain fused to titanium and titanium alloys
D6243	Pontic — porcelain fused to titanium and titanium alloys
D6753	Retainer crown — porcelain fused to titanium and titanium alloys
D6784	Retainer crown 3/4 — titanium and titanium alloys
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D8696	Repair of orthodontic appliance — maxillary
D8697	Repair of orthodontic appliance — mandibular
D1550	Re-cement or re-bond space maintainer
D1555	Removal of fixed space maintainer
D8691	Repair of orthodontic appliance
D8692	Replacement of lost or broken retainer
D8693	Re-cement or re-bond fixed retainer
D8694	Repair of fixed retainer, includes reattachment

Narratives as documentation are not considered legal entities, nor are they contemporaneous in nature. The patient record/clinical treatment notes are considered a legal document and are the only acceptable, legal written documentation for utilization review.

Electronic Claims

Our Payer ID number is **84056**.

Electronic claims processing saves your office money by reducing costs associated with generating paper claims, allows for faster processing of claims, and enables your staff to spend more time with patients and other duties. To submit claims electronically, you will need a computer with a modem and an agreement with a practice-management software vendor or an Electronic Data Interchange (EDI) vendor. There are many vendors to choose from, with a variety of products and services to suit any budget. You can also submit claims by logging in to your provider account on the secure provider portal at deltadentalco.com. Search for the patient then click on Submit Claim or Treatment Plan on the right side of the screen.

You may submit all claims electronically, including claims for payment, predetermination, coordination of benefits, and orthodontic claims. We accept electronic claims for all of our products including Delta Dental Premier® and Delta Dental PPO™.

If you use a clearing house from which we currently do not accept claims, the clearinghouse will automatically generate and mail a paper claim for processing. If you submit claims electronically, please do not submit a paper copy of the same claim. This will slow the processing of your claims. If you are unsure whether a specific claim transmitted, you can quickly and efficiently check the status by logging in to our secure provider portal at deltadentalco.com or by calling customer service at 1-800-610-0201. Your software vendor should also be able to provide you with a list of claims successfully transmitted.

Electronically submitted claims are normally viewable on the secure provider portal the day after submittal. Paper claims are normally viewable on the website within three days after receipt.

For claims requiring attachments (radiographs, perio charting, etc.) and submitted electronically without the required attachment, please do not submit a paper copy of the claim with the attachment. Please wait for a request for additional information to be issued to your office and then submit the required attachment with the form issued to your office. Submitting another claim form with the same information will result in the claim being denied as a duplicate and will further delay claim processing. If you do not use electronic attachments (see below), either submit a paper claim with the attachment or submit the claim electronically and wait for the request for additional information.

Electronic Attachments

Electronic attachments (radiographs, perio charting, etc.) allow providers to take full advantage of electronic claims filing. Electronic attachments allow all of your claims to be processed electronically, save on duplication and mailing costs, and speed claims processing. In order to submit electronic attachments, you will need equipment that produces an electronic copy of a document or image. The type of equipment and other requirements depend on which vendor you choose to support this capability. Two notable vendors are NEA (National Electronic Attachments, Inc.) and Tesia. Contact information for these companies is provided below.

If you are already submitting electronic attachments, please be advised that DDCO cannot accept an electronic attachment without an electronic claim or without reference to a DDCO claim number.

Electronic Claims and Attachments Contact Information

Company	Web Address	Phone Number
Dental Xchange	dentalxchange.com	1-949-438-1550
Optum/Change Healthcare	optumproportal.com	n/a
Vyne	vynedental.com	1-463-217-4654
NEA	fast-attach.com	1-800-782-5150

Request for Information 30 Day Notice

Claims or predeterminations that are submitted with missing, incomplete, or illegible information are pended, causing a delay in processing. DDCO produces a request for additional information that indicates the missing information. Processing will continue only when the request for additional claim information is returned to DDCO with the information requested. Please do not submit duplicate claims. Review and carefully follow

the instructions on the form. If you do not understand the instructions, please contact our customer service department at 800-610-0201. For information and tips on how to avoid receiving these requests and delaying your claims, please be sure to read the **“Claims Submission Tips”** section.

Claim Payment

Payment for care provided to a Delta Dental patient is made directly to you, the participating provider. Because of this direct payment process, we require participating providers to seek payment from Delta Dental before billing patients for anything other than the appropriate copayment, deductibles, or other obligations stated under the group contract.

Delta Dental makes every effort to process claims quickly and accurately. You can help us improve the speed at which we process claims by making sure all the necessary information is provided on the claim form. See the **“Claims Submission Tips”** section of this handbook for valuable information that will speed claims processing.

Delta Dental abides by state laws governing the timely processing of claims and language is included in all Delta Dental Participating Agreements entered into after July 1, 1999 regarding compliance with Colorado State Regulations. Please refer to your contract for specifics.

Delta Dental also includes performance guarantees in contracts with groups who purchase coverage. These guarantees include claim turnaround, claim accuracy, average call wait time, and customer satisfaction. Our performance goal for processing “clean” claims is 90% of claims in fifteen (15) calendar days and 99% in thirty (30) calendar days, which we continue to meet on a regular basis.

Check Disbursements

The checks DDCO mailed to your office include payment on behalf of those patients whose claims are processed in the current payment cycle. Checks are mailed on a weekly basis. The check disbursement that accompanies the check contains the following information:

- **Business Name:** The business name on file with Delta Dental associated with your Tax ID.
- **Check Number:** The check number of the attached check.
- **Amount:** The total amount of the check attached.
- **Subscriber Name:** The name of the person who holds the membership of the policy.
- **Subscriber ID:** The ID number of the subscriber.
- **Provider ID/Loc:** The treating provider’s provider ID and the number of the location where services were performed.
- **Patient Name:** The patient receiving services.
- **Birthdate:** Patient’s birthdate.
- **Claim Number:** Claim number assigned by DDCO.
- **Code:** The CDT code submitted and/or the CDT code used to process the claim.
- **Tooth Number:** The tooth number services were performed on, if applicable.
- **Date of Service:** The date this service was completed.
- **Submitted:** The amount submitted to Delta Dental for a dental service.

- **Contract Allowance:** The contracted or allowable fee participating providers agree to accept for the service.
- **Plan Allowance:** The amount Delta Dental will consider for this service based on plan design and provider status.
- **Deduct:** Indicates deductible, if any, applied to the claim.
- **Over Max:** The dollar amount the patient has exceeded their plan maximum.
- **Coordination of Benefits (COB):** The amount primary insurance paid, if there was coordination of benefits.
- **DDCO Payment:** The amount of Delta Dental's responsibility for this service.
- **Patient Pays:** The amount calculated as the patient share and due to the provider office.
- **Provider Adjustment:** The amount determined not chargeable to the patient and removed from patient responsibility by the participating provider.
- **Plan Coins %:** The percentage used to calculate Delta Dental's portion of the benefits based on the group contract.
- **Message Codes:** Message codes, when needed, are applied for proper benefit allowance according to the group dental contract. If a policy number appears, refer to bottom of the disbursement. If there are multiple pages, refer to the last page for an explanation.
- **Total:** Total of line items for the claim above by column.

If multiple providers are listed on the check disbursement, the bottom of the disbursement will list each provider ID and the total (net payment by DDCO) for that provider. This is to assist offices who track individual provider data.

Explanations of any processing policies listed will follow at the end of the disbursement. There may also be a brief informational message from DDCO that appears on all disbursements.

Orthodontic Claims

Claims for orthodontic services should only be submitted once to DDCO for payment. Providers should not submit the same claim each month. Two payments are made, on most plans. The first payment is made at banding date and the second payment is made 12 months later. Diagnostic and preparatory services are payable from the patient's orthodontic benefits and claims submitted for these services should include "for orthodontic purposes" written on the claim form. Fees for records should be listed with the appropriate CDT codes and the fee charged.

An orthodontic claim should include the following information:

- Date of initial banding or initial aligner delivery*
- Total case fee. Including cost of retention.
- Initial down payment amount.
- Number of months estimated treatment time.

*An orthodontic claim should also include if the patient was banded prior to eligibility. If so, please submit the total paid by the prior carrier and the original banding date.

Copayments/Overbilling

Waiving a deductible, copayment, and/or coinsurance is considered an unreported discount. The most common form occurs when a provider accepts a third-party carrier's payment as payment in full, and forgives all or part of the patient's deductible, copayment, and/or coinsurance portion.

Besides being a violation of the Delta Dental Participating Agreement, this waiver of the patient portion violates the contract between an employer and their employees concerning their dental benefits and may also violate the Colorado Dental Practice Law.

Appeals, Grievances, & Reconsideration Requests

Delta Dental of Colorado will, upon written request from the Member or treating provider on behalf of the Member, re-evaluate benefit determinations when appropriate. The review will be premised on the submission of additional information, documentation, and/or narrative, by the treating provider, which could affect the benefit determination previously made, according to the terms of the benefit plan, clinical review, Delta Dental's processing policies and/or the provider handbook. See below for specific guidelines applicable to Commercial Plans, Medicare Advantage Plans, and Expedited Appeals and Reconsiderations.

Requirements for claim benefit reconsideration can include, but are not limited to:

- Narration or other additional documentation supported by narrative, addressing the prior decision and stating why this should alter the prior benefit/consultant decision.
- Patient clinical notes and/or other portions of the patient record.
- Original claim number.
- Re-submission of all documentation, as needed.

DSCO will not alter records of services performed or dates of treatment, from the original claim form without written request from the provider office. Requests by provider offices to alter the original claim, indicating clerical error in the entry of services performed, or treatment dates, will be by exception only and only if supported by the patient clinical record.

Commercial Plans

Any review of an "Adverse Determination" (as defined in the Code of Colorado regulations) for Members of Risk or Commercial groups shall be defined and processed as an "Appeal." Reviews of benefit denials due to contract limitation or exclusion shall not be subject to the Appeal procedures set forth in the Code of Colorado Regulations unless the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion or limitation does not apply.

All appeals and any other grievances for commercial plan members must be received in writing within 180 days of the date Delta Dental sent the initial benefits determination and must be sent to the following address:

Delta Dental of Colorado
Appeals Analyst
PO Box 172528
Denver, CO 80217-2528

Delta Dental will make a determination on any Appeal filed by a commercial plan member within 30 days of receiving the Appeal, except where an extension of time is allowed pursuant to the Code of Colorado Regulations.

Where Delta Dental makes an Adverse Determination and a commercial group Member or treating provider on behalf of the Member exhausts the internal appeals process, the Member/treating provider has the right to request an independent external review. Any request for external review must be received within 120 days of the completion or exhaustion of the internal appeals process. Requests for an independent external review must be in writing and must include a completed external review request form as specified

Medicare Advantage Supplemental Dental Plans

Reviews for Members with Medicare Advantage (MA) Supplemental plans shall be defined as a Reconsideration Request and is subject to additional reconsideration measures, as specified by the Code of Federal Regulations §422.592 to §422.616

All Reconsideration Requests and other grievances for MA plan members must be received within 60 days of the date Delta Dental sent the initial benefits determination and must be sent to the following address:

Delta Dental of Colorado Appeals
PO Box 172528
Denver, CO 80217-2528

DCCO or the appropriate Medicare Advantage Organization will make a determination on any reconsideration request filed by an MA member within 60 days of receiving the Reconsideration Request, except where an extension of time is allowed pursuant to the Code of Colorado Regulations.

If the Medicare Appeals Council either denies the request or the amount remaining in controversy continues to meet the threshold requirement, the MA Member, treating provider on behalf of the MA Member or representation attorney may request judicial review by filing a civil action with the district court where the MA Member resides or where the treating provider on behalf of the MA member has his/her place of business, within 60 days of notice from the Medicare Appeals Council.

Expedited Appeals and Reconsiderations for Predeterminations

A Member or treating provider on behalf of the Member may request an expedited Appeal or reconsideration when the time for a standard review would seriously jeopardize the life or health of the Member, would jeopardize the Member's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Delta Dental will process an expedited Appeal within 72 hours, except where the covered person has failed to provide sufficient information for Delta Dental to determine whether, or to what extent, the benefits requested are covered benefits or payable under the covered person's plan.

Submission requirements for all Appeals and Reconsiderations include:

- Additional documentation supported by a narrative that addresses the prior decision and how the documentation should alter the prior benefit/consultant decision.
- Original claim number and/or claim form (if applicable).
- Re-submission of all documentation, as required, per procedural guidelines.

Coordination of Benefits

Coordination of benefits was developed to eliminate the potential for profit when a person is covered by more than one group health care plan. It limits the total benefits received to the actual amount incurred for care. Only group plans coordinate benefits. There is no coordination of benefits with individual policies.

Birthday Rule

The “Birthday Rule” is the primary method for determining which of the two or more plans pays first. This ruling states that children will be considered primary by the plan of the parent whose birthday (month and day) occurs earlier in the calendar year. Therefore, the plan covering the parent whose birthday falls later in the year pays second. If the parents’ birthdays are identical, the primary carrier will be the one that has covered the child for the longest time.

Custody Cases

It is important to note that there are exceptions to the birthday rule, considering dependent minor children of legally or separated or divorced parents including:

1. When there is a court decree that places financial responsibility for health care expenses upon one parent, that parent will be primary.
2. When the parent who has custody has not remarried, that parent’s plan will be primary.
3. When the parent who has custody has remarried, that parent’s plan will be primary and the plan of their new spouse will be secondary. The parent without custody pays third.
4. If the custodial parent does not have coverage but the stepparent does, then the stepparent’s coverage pays first, and the non-custodial parent’s coverage pays second.

Dual Coverage on Predetermination Cases

In a case where Delta Dental is the secondary carrier and a claim is submitted for predetermination, the provider will be advised of the amount DDCO would pay as if there were no dual coverage. When DDCO’s predetermined benefit voucher is submitted for payment, attach a copy of the primary carrier’s payment. DDCO will issue its payment subject to eligibility at the time services are rendered, plan limitations, processing policies, and coordination of benefits if applicable, so that the combined payments do not exceed 100% of the allowed amount. Coordination of benefits is calculated only on actual payments from the primary carrier, and not predetermined benefits.

Note: It is important that all coordination of benefits information, such as primary subscriber name and birth date, name and effective date of other carrier, etc., be included on the original claim for determination.

Coordination of Benefits with Capitation

If both Delta Dental and a capitation plan cover your patient, all rules for determining which plan is primary still apply.

When Delta Dental is the primary carrier, the claim will be processed up to our full liability under the patient’s group contract. When Delta Dental is the secondary carrier, benefits are calculated based on the patient’s actual out-of-pocket copayments. For this reason, it’s important that you include a copy of the patient’s particular program indicating services provided by the capitation plan and the applicable copayments when submitting the Attending Dentist’s Statement to Delta Dental for payment.

Two examples of coordination of benefits with a capitation plan as primary and Delta Dental as secondary are provided as follows:

Example 1	
Procedure Code	2750
Maximum Plan Allowance	\$450
Patient’s Contractual Coinsurance	50%
Delta Dental’s Liability	$\$450 \times 50\% = \225
Capitation Plan Copayment*	\$200
Delta Dental’s Payment	\$200

*Since Delta Dental’s payment will never exceed the patient’s copayment in a capitation plan, Delta Dental’s payment was \$200.

Example 2	
Procedure Code	2750
Maximum Plan Allowance	\$450
Patient’s Contractual Coinsurance	50%
Delta Dental’s Liability**	$\$450 \times 50\% = \225
Capitation Plan Copayment	\$150
Delta Dental’s Payment	\$150

**Since Delta Dental’s true liability exceeds the patient’s actual out-of-pocket expense, Delta Dental’s payment is reduced to \$150. If the patient’s out-of-pocket expense had been \$225 or above, Delta Dental would be liable for the entire \$225. But in no case will our copayment exceed our full liability under the patient’s group contract.

Coordination of Benefits with Medical Plans

Services performed by a licensed provider are sometimes covered under a patient’s medical benefit plan as well as their dental plan. This occurs most often with oral surgery procedures.

Should your office perform services that are covered by the patient's medical program, the claim should be submitted to the appropriate medical plan administrator/carrier for payment according to Colorado state regulations. Once the explanation of benefits is received, it should be submitted to Delta Dental along with the claim form and pertinent diagnostic materials.

Delta Dental will provide reimbursement according to Colorado state regulations and the group benefit plan for those procedures covered by the group contract.

As a reminder, Delta Dental does not provide coverage for hospital expenses.

Overpayments

Except in cases where a member has an individual plan not covered by the Coordination of Benefits regulation, the combined payments by all dental carriers may not exceed your total fee for the services provided. If the provider or the patient receives more than 100 percent of the provider fee, the amount in excess doesn't belong legally to either party, and must be refunded to the secondary carrier.

Submitting Dual Dental Coverage Claims

If the patient has dental coverage in addition to Delta Dental:

1. File the claim with the carrier who has primary responsibility to pay the claim. Information about the first plan's payment is used by DDCO to determine its payment.
 - If it is unclear whether Delta Dental is the primary carrier, contact customer service at 800-610-0201.
2. If the other carrier has primary responsibility, file the claim with Delta Dental after payment is received from the other carrier. DDCO timely filing still applies.
 - Complete the coordination of benefits information on the claim form in addition to all other items and attach a copy of the primary carrier's explanation of benefits (EOB) form or Electronic Remittance Advice (ERA) form and effective date (except in the case of Medicaid). The primary carrier EOB or ERA is typically included in the primary carrier ACH, usually in the form of remittance advice. Note: If the primary carrier's EOB or ERA does not include a breakdown of charges per line of service, please indicate the primary carrier's telephone number. Note: It is important that all coordination of benefits information, such as primary subscriber name and birth date, name and effective date of other carrier, etc., be included on the original claim for determination.
 - Mail the claim form to the appropriate Delta Dental processing site.

Predetermination of Benefits

Predetermination was pioneered by Delta Dental and has proven to be of such value that it has been incorporated in most group dental care programs. The submission of the treatment plan and pre-operative radiographs to Delta Dental prior to completion of various dental services will allow the patient the opportunity to make proper financial arrangements for their portion of the treatment costs before the actual work is begun. It eliminates confusion on the part of the patient and produces goodwill between the provider, patient, and Delta Dental. Delta Dental strongly urges the provider to make predetermination a habit, except in emergency and routine situations.

Participating providers will not charge a fee to the patient or Delta Dental for submitting predetermination of benefits. Predetermination is recommended for treatment plans that involve prosthetic and orthodontic procedures, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics, and oral surgery, except for simple extraction of a single tooth. Predetermination of benefits is valid for ninety (90) days. When Delta Dental receives a treatment plan for predetermination, it proceeds through the following steps:

- It is determined if the patient is eligible for benefits under that particular group's contract. The fact that the patient is eligible at the time of predetermination, does not guarantee eligibility at the time services are actually rendered. Make sure to check the patient's eligibility again, right before the treatment.
- It is determined if the proposed services are covered under the group's dental plan.
- Any deductibles are applied and maximum benefits used to date are verified.

Delta Dental will issue a predetermined benefit voucher to the provider. This form is notification of Delta Dental's estimated liability and should then be reviewed with your patient.

Once the services have been performed, the provider need only fill in the service dates, sign the form, and return it to Delta Dental for payment. Use of this form will expedite payment. Please do not submit a claim form for services that have been preauthorized.

Delta Dental encourages the treating provider to discuss any predetermination they do not understand with our provider relations or customer service representatives.

The predetermination of benefits does not guarantee payment. Delta Dental's liability, if any, will depend upon the patient's eligibility at the time the work was actually performed and the amount of benefits payable under any other insurance or prepaid dental program. Actual benefits will be subject to eligibility at the time services are rendered, plan limitations, processing policies, and coordination of benefits, if applicable, and may reduce or eliminate amount shown as estimated Delta Dental payments. Monies preauthorized are subject to change based on the provider's participating status at the time of treatment and does not guarantee direct payment.

Diagnostic Aids

It may be necessary to submit radiographs and/or rationale when predetermining benefits. Please indicate all missing teeth and list the teeth to be replaced by proposed appliances. Make mention of teeth that are endodontically involved or fractured and include, when appropriate, a written narrative explaining circumstances that require a more extensive or costly treatment.

Optional or Alternative Treatment Plans

Various factors, such as the condition of the patient's oral and overall health, can contribute to the recommended course of treatment for them. Depending on the circumstances, there can be a choice of treatment plans for certain patients. After consulting with the patient, a more expensive covered benefit than the one Delta Dental determines is permitted by the maximum plan allowance (MPA) for the diagnosis or treatment of the patient's condition can be chosen. Payment will be made only for the applicable percentage of the least costly course of adequate treatment. The patient may

be responsible for the entire balance of the provider fee for the more expensive covered benefit.

In all cases in which the primary subscriber or eligible dependent selects a more expensive service or benefit than is deemed necessary, Delta Dental will pay the applicable percentage of the fee for the service or benefit that is needed to restore the tooth or dental arch to contour and function. The primary subscriber or eligible dependent will be responsible for the remainder of the provider's fee. This need not change the plan of treatment, but establishes a cost allowance toward the service upon which patient and provider decide.

Claims Processing

Professional Review

Delta Dental wants to make sure that our members always receive the care they deserve and need. That's why we focus not only on the quality of care which means that we ensure that the care they're receiving aligns to what is medically correct. We have a team dedicated to reviewing routine claims and their supporting radiographs, and/or narratives when processing them. Delta Dental's professional review staff has dental business experience and/or education and has received extensive training in dental procedures and claims review. Their professional judgment is required to process claims according to Delta Dental Plans Association guidelines and specific group contracts.

More complex claims those involving extensive work or unusual circumstances are reviewed by dental consultants. Our dental consultants are licensed providers who assist the professional review staff in the processing of claims.

Delta Dental of Colorado Processing Policies and Descriptions

The procedure codes and descriptions that follow are used by DDCO in processing claims. If, in an individual case, they cause a change in benefit coverage and/or payment, the relevant processing policy numbers are indicated on the predetermination benefit vouchers, check disbursements, and patient explanation of benefits.

Glossary of Dental Benefit Terminology

ALLOWABLE FEES: The amount of payment for covered services, which are provided to covered persons, as determined by the company.

ALTERNATE BENEFITS: The amount allowed based on the least costly, most commonly accepted service used to treat a dental problem when a covered person selects more costly treatment options.

ALTERNATE ID: Assigned identification number created to replace use of Social Security numbers for identification of enrollees.

APPROVED AMOUNT: The total fee that must be paid by the member or company and the patient. For PPO™ providers, the lesser of the PPO provider's allowable fee or the fee actually charged. For Premier® participating providers, the lesser of the Premier maximum plan allowance (MPA) or the fee actually charged. For all other providers, the lesser of the non-participating maximum plan allowance (MPA) or the fee actually charged.

ASSIGNMENT OF BENEFIT (AOB): An arrangement by which a patient requests that their benefit payments be made directly to a designated person or facility, such as a provider or dental group office.

ATTENDING DENTIST'S STATEMENT (ADS): See claim form definition.

BALANCE-BILLING: Practice in which participating providers choose to bill the member on charges that were DENIED and NOT chargeable to the patient.

BENEFIT PERIOD: The 12-month period used in determining service limitations and renewals of the individual and family deductibles and maximums is identified as follows:

1. Fiscal Year - July 1 to June 30.
2. Contract Year — All members of the group have benefits renewed on the same date.
3. Calendar Year — January 1 to December 31

BY REPORT: An explanation of the need for a specific procedure. This explanation may be included in area 32 of the claim or on an attached note.

CARRIER: The party to the dental plan contract who agrees to pay claims and/or provide administrative services.

CHECK DISBURSEMENT: A claims payment check that reimburses for the dental services rendered and statement listing the payment information for use in reconciling dental office records.

CHILD AGE (Child Age Limitations): The age to which dependent children are eligible. Student age extensions are available as long as the child remains enrolled in an accredited educational institution on a full-time basis (12 or more classroom hours per week or the equivalent of 12 or more hours as defined by the institution).

CLAIM ADJUSTMENT REASON CODE (CARC): These codes communicate a reason for a payment adjustment that describes why a claim or service line was paid differently than it was billed.

CLAIM FORM: A statement listing services rendered, the date of service, and itemized costs. Includes a certification signed by the beneficiary and provider that services have been rendered. The completed form serves the carrier as the basis for payment of benefits.

COINSURANCE: The percentage of a covered amount which is payable by Delta Dental. The coinsurance for each type of covered service is shown on the schedule of benefits. The coinsurance applicable will vary depending upon the type of dental service.

CONNECT FOR HEALTH COLORADO (C4HCO): Nonprofit organization that gives access to discounted health/dental insurance plans for individuals, families, and small businesses through the state insurance marketplace. It is part of the Affordable Care Act (ACA).

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA): Federal legislation that requires employers to offer continued health insurance coverage to employees and their dependents who have had their health insurance coverage terminated. It allows enrollees, spouses, and children to pay to continue their health benefits coverage for up to 18 months after their coverage is terminated (up to 29 months if the individual is disabled and up to 36 months in the case of divorce).

CONTRACT COMPLIANCE REVIEW/AUDIT: The examination by dental consultants of covered patients, on a random sample basis, to assure that the treatment listed on the claim form has been provided and has been accurately and completely reported.

COORDINATION OF BENEFITS (COB): When a person is covered by more than one benefit plan (for example, a child who is covered by both parents' insurance plans), it's referred to as dual coverage. When a claim is submitted, the two sets of benefits are coordinated so that no more than 100 percent of the total covered expense is paid. Non-duplication of benefits is a contract provision that further limits coverage.

COPAYMENT: The amount or percentage of the total approved amount that the subscriber is obligated to pay.

COVERAGE YEAR: A 12-month period of time over which deductibles and maximums apply for each covered person. Could be a contract year or calendar year.

COVERED SERVICES: Services for which payment is provided under the terms of the dental benefit contract.

CREDENTIALING: Review of documentation pertaining to a provider and their practice, including verification of licenses, specialty certification (if applicable), malpractice insurance, state and local licensing board actions, infection control procedures, and Occupational Safety and Health Administration (OSHA) requirements.

CURRENT DENTAL TERMINOLOGY (CDT): Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Dental Association's CDT codes are the required standard for dental claims.

DATE OF SERVICE (DOS): The actual date the service was rendered. With multi-stage procedures, except orthodontics, the date of service is the final completion date. Example: The insertion date of partial denture or the cementation of a permanent crown is considered the date of service.

DEDUCTIBLE AMOUNT: That portion of the covered dental care expense that the subscriber must pay before the plan's benefits begin.

DENTAL CONSULTANTS: Providers contracted by Delta Dental to review claims to determine the covered benefits.

DENTAL PLAN: An organization established for the financing and administration of dental care.

DENTAL PREPAYMENT: A system for budgeting the cost of dental services in advance of their receipt.

DENY AND NOT CHARGEABLE TO THE PATIENT: A denial by a payer for portions of the claimed amount that a patient is responsible for paying.

DEPENDENTS: Generally, the spouse and children, as defined in a contract, of a subscriber covered by a dental plan.

DIAGNOSTIC AND PREVENTIVE PROCEDURES (D&P): In the standard client contract, these procedures include oral examinations, cleanings, X-rays, fluoride treatment, and space maintainers.

DUAL COVERAGE: When a member has coverage under more than one benefit plan. The primary and secondary carriers coordinate the two plans so that the primary carrier pays its portion first and the secondary carrier may pay the remainder.

EFFECTIVE DATE: The date the dental benefits contract goes into effect and from which benefits are afforded.

ELECTRONIC FUNDS TRANSFER (EFT): Provides for electronic payments to providers and vendors, also known as direct deposit.

ELIGIBLE INDIVIDUAL: A person entitled to benefits under a dental plan.

EMPLOYER GROUP: The employer who buys the dental plan, pays the required dues, and provides eligibility of subscribers to the carrier.

EVIDENCE-BASED DENTISTRY (EBD): Evidence-based dentistry integrates the provider's clinical expertise, the patient's needs and preferences, and the most current, clinically relevant evidence.

EXCLUSIVE PANEL OPTION (EPO): A dental benefit plan design in which members must have treatment provided by a PPO provider in order to receive any benefits. If an out-of-network provider provides treatment, the plan will not cover the treatment.

EXCLUSION: Dental services not provided under a dental plan.

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES: Those services not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

EXPLANATION OF BENEFITS (EOB): The notice that members receive after a claim is processed. The EOB provides information about fees charged, procedures provided, and the member's payment portion.

EXTENDED COVERAGE: Delta Dental of Colorado will not cover services after coverage is terminated unless covered service started before coverage ended and only if completed within 60 days after the coverage ended.

FEE VERIFICATION: In-office verification of participating providers' fees to assure that the fees charged to Delta Dental patients are the same as the fees charged to non-covered patients. Also verifies that the patient has not been billed amounts exceeding the determined amount to be paid by the patient.

GROUP OR INDIVIDUAL CONTRACT: A contract for dental benefits between the purchasing group or individual and the Delta Dental member company.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA): This federal initiative became effective in stages over several years. Title I of HIPAA was enacted to ensure that people can keep their health insurance when changing jobs. Title II of HIPAA requires adherence to coding and transmission standards for electronic health care transactions as well as to privacy and security requirements to protect health care information and anti-fraud measures.

LIMITATIONS: Services that are limited or excluded from a dental plan.

MAXIMUM ALLOWABLE CHARGE (MAC) PLAN: A feature of Delta Dental PPO™, a MAC plan limits the amount Delta Dental will pay for a procedure to the PPO discounted fee schedule for all providers. A Premier® provider can balance-bill the patient the difference between the PPO fee and Premier maximum plan allowance (MPA).

MAXIMUM BENEFIT: The maximum dollar amount a dental plan will pay toward the cost of dental care incurred by an individual or family during a coverage year.

MAXIMUM PLAN ALLOWANCE (MPA): The highest amount allowed for payment to Premier providers. Premier participating providers are reimbursed at the level of the billed amount or the maximum plan allowance, whichever is less

NATIONAL PROVIDER FILE (NPF): A data warehouse of providers' filed fees used by local Delta Dental Plans to facilitate the central claims administration.

NATIONAL PROVIDER IDENTIFIER (NPI): HIPAA-mandated standard provider identifier in electronic claims processing. All providers are required to have an NPI.

NON-PARTICIPATING PROVIDERS: A provider who does not have a contractual agreement with Delta Dental to provide dental services to members of a Delta Dental benefit plan.

NOT BILLABLE TO THE PATIENT: A denial by a payer for portions of the claimed amount that a patient is not responsible for paying. The provider must write off the amount per contract agreement.

OVERBILLING: The term for overstating the provider's true fees in order to collect more money from dental carriers.

PARTICIPATING PROVIDER: A licensed provider who has signed a participating agreement with Delta Dental and who agrees to rules and regulations.

PPO SCHEDULE OF ALLOWANCE: A list of the maximum fees for each procedure for PPO reimbursement.

PREDETERMINATION OF BENEFITS: A review of the provider's recommended treatment plans submitted to verify eligibility and to identify covered benefits, plan allowances, and limitations and exclusions prior to dental treatment.

PREFERRED PROVIDER ORGANIZATION (PPO): A PPO is a fee-for-service program that allows members to choose any provider but provides financial incentives to choose lower-priced providers who are part of the PPO network.

PROVIDER: The provider or independent hygienist providing the dental services.

REMITTANCE ADVICE REMARK CODE (RARC): Used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing.

SCHEDULED ALLOWANCES: A list of specified amounts that will be paid toward the cost of dental services rendered; the patient pays the difference between the allowance and the actual cost of service, up to the maximum plan allowance.

STUDENT AGE (Student Age Limitations): See CHILD AGE definition.

SUBSCRIBER: The employee or retiree who represents the family unit in relation to the pre-payment plan.

TAX IDENTIFICATION NUMBER (TIN): All providers must have a TIN on file for tax-reporting purposes. The TIN can be a Social Security number or an employer identification number (EIN).

TERMINATION DATE: The date on which the dental benefits contract terminates.

WAITING PERIOD: A period of time that a person must be enrolled on the dental plan before becoming eligible for a particular class of procedures.

Message Codes

Message codes provide guidance to providers and members on reasons as to why a claim (or code within a claim) was not chargeable to the patient and appear on a patient's EOB.

CODE	DESCRIPTION
UMD130	This service is not payable as history indicates this tooth is not present. Refer to the Benefits/Coverage section of the benefit booklet.
UMD131	This service is not payable as history indicates this tooth is not present. Refer to the Benefits/Coverage section of the benefit booklet.
UMD132	Osseous surgery, bone and tissue grafts, and other periodontal procedures are payable only for natural teeth, not for implants; extraction, apicoectomy or hemisection sites; or ridge augmentation. Refer to the Benefits/Coverage section of the benefit booklet.
UMD133	Osseous surgery, bone and tissue grafts, and other periodontal procedures are payable only for natural teeth, not for implants; extraction, apicoectomy or hemisection sites; or ridge augmentation. Refer to the Benefits/Coverage section of the benefit booklet.
UMD134	This procedure is not payable because the tooth/teeth were extracted prior to the member's effective date of coverage. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD135	This procedure is not payable because the tooth/teeth were extracted prior to the member's effective date of coverage. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD140	The procedure code was changed based on the information submitted, the information in Delta Dental's records, or for compliance with Delta Dental processing policies. Refer to the Benefits/Coverage section of the benefit booklet.
UMD150	An interim partial denture (stayplate) is a benefit only for the replacement of permanent anterior teeth. Refer to the Benefits/Coverage section of the benefit booklet.
UMD151	An interim partial denture (stayplate) is a benefit only for the replacement of permanent anterior teeth. Refer to the Benefits/Coverage section of the benefit booklet.
UMD160	This procedure is excluded from coverage of the benefit plan. Refer to the Benefits/Coverage section of the benefit booklet.
UMD161	This procedure is excluded from coverage of the benefit plan. Refer to the Benefits/Coverage section of the benefit booklet.
UMD162	Based on information in Delta Dental's records, this procedure is not billable to the member. Refer to the Benefits/Coverage section of the benefit booklet.
UMD196	A refund has been received and an adjustment has been made to the claim.
UMD197	A refund has been received and an adjustment has been made to the service code.

UMD238	The fee displayed is the Provider Adjustment due to exceeding contracted fee for submitted procedure
UMD244	The CDT code was missing or invalid for the submitted service line. A miscellaneous code was entered to allow for notification to your office. Please re-submit with the corrected code for consideration.
UMD250	From the narrative or information provided, this procedure does not meet the requirements of the benefit contract and is the responsibility of the member. Refer to the Benefits/Coverage section of the benefit booklet.
UMD251	Cores and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries or fracture. Benefit determination was made by consultant review. Refer to the Benefits/Coverage section of the benefit booklet.
UMD252	Cores and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries or fracture. Benefit determination was made by consultant review. Refer to the Benefits/Coverage section of the benefit booklet.
UMD253	Restorative services are payable only when there is extensive tooth loss due to caries or fracture. Services to restore tooth structure lost due to attrition, erosion, abrasion, abfraction, or wear are not a benefit. Refer to the Benefits/Coverage section of the benefit booklet.
UMD257	Appliances, restorations, or services to replace or stabilize tooth structure lost by wear, attrition, abrasion, erosion, and abfraction are not a benefit. Refer to the Limitations/Exclusions section of the employee booklet.
UMD263	The charges for the orthodontic treatment is denied because the treatment ended prior to the effective date of dental coverage.
UMD265	Restorative services are payable only when there is extensive tooth loss due to caries or fracture. Services to restore tooth structure lost due to attrition, erosion, abrasion, abfraction, or wear are not payable. Refer to the Benefits/Coverage section of the benefit booklet.
UMD270	This claim is denied because requested information has not been received. Benefit determination cannot be made. Please submit a new claim with information previously requested.
UMD300	Pulp testing is a benefit per visit, not per tooth. Refer to the Benefits/Coverage section of the benefit booklet.
UMD301	Pulp testing is a benefit per visit, not per tooth. Refer to the Benefits/Coverage section of the benefit booklet.
UMD308	Services associated with overdentures are not payable. Refer to the Benefits/Coverage section of the benefit booklet.
UMD309	Services associated with overdentures are not payable. Refer to the Benefits/Coverage section of the benefit booklet.
UMD310	Patient history does not show prior definitive periodontal treatment (i.e. D4260, D4341) to allow payment for periodontal maintenance. Allowance has been made for prophylaxis (cleaning).

UMD311	Patient history does not show prior definitive periodontal treatment (i.e. D4260, D4341) to allow payment for periodontal maintenance. Allowance has been made for prophylaxis (cleaning).
UMD312	A prophylaxis (cleaning) is not payable when provided on the same date as root planing. Refer to the Benefits/Coverage section of the benefit booklet.
UMD313	A prophylaxis (cleaning) is not payable when provided on the same date as root planing. Refer to the Benefits/Coverage section of the benefit booklet.
UMD316	The allowance for a denture repair (including relines or rebases) will not exceed one half the Maximum Plan Allowance (or PPO fee if applicable) for a new denture. Refer to the Benefits/Coverage section of the benefit booklet.
UMD317	The allowance for a denture repair (including relines or rebases) will not exceed one half the Maximum Plan Allowance (or PPO fee if applicable) for a new denture. Refer to the Benefits/Coverage section of the benefit booklet.
UMD322	Only two quadrants of Root Planing and Scaling (D4341) on the same day of service are benefited. More than two quadrants performed on the same date with no documentation of special need are not billable to the member.
UMD350	This procedure is not payable when performed by a provider that has opted out of Medicare. Member signed waiver and fee is denied. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD351	This procedure is not payable when performed by a provider that has opted out of Medicare. Member has not signed waiver and total fee for this service, or any difference between the submitted and the approved fee, is not billable to the member. Refer to the Limitations/Exclusions section of the employee booklet.
UMD402	The orthodontic maximum has been exceeded for the specified time period. Refer to the Schedule of Benefits section of the benefit booklet.
UMD411	Benefit determination was made based on Delta Dental policy and/or consultant review. Fee for this service is billable to the patient. Refer to the Benefits/Coverage section of the benefit booklet.
UMD414	This procedure does not meet the contract requirements for benefit payment. Refer to the Benefits/Coverage section of the benefit booklet.
UMD415	This procedure does not meet the contract requirements for benefit payment. Refer to the Benefits/Coverage section of the benefit booklet.
UMD416	Your check has been reduced by the amount displayed due to a non-recovered requested refund. Please refer to the request for refund letter notification sent prior to this action.
UMD417	No service was rendered. Refer to the Benefits/Coverage section of the employee booklet.
UMD418	Date of insertion and date of completed extractions are required for payment of procedure. Refer to the Benefits/Coverage section of the benefit booklet.
UMD420	This service was previously paid/predetermined or it is on a claim form currently being processed by Delta Dental.
UMD421	The time limitation for filing a claim has expired. Refer to the Claims Procedures section of the benefit booklet.

UMD422	The time limitation for filing a claim has expired. Refer to the Claims Procedures section of the benefit booklet.
UMD423	Benefits for this service were applied to member's combined medical deductible. Refer to the How to Use the Delta Dental Plan section of the benefit booklet.
UMD424	An exception was provided for payment of this service.
UMD430	Only one treatment plan is allowed per pretreatment estimate. Additional pretreatment estimates should be submitted separately.
UMD431	Delta Dental is the primary carrier for this member; the net amount processed is based on the plan provisions in effect at the time of service. All benefits paid on this claim represent reimbursement to Medicaid.
UMD432	Coordination of benefits was not applied as this plan does not include a coordination of benefits clause. Please resubmit another claim through the other group plan. If a new claim has been submitted or payment received, please disregard this notice.
UMD500	Based on additional information provided, this procedure was reconsidered and the initial determination overturned. Refer to the Benefits/Coverage Section of the benefit booklet.
UMD501	This procedure was reviewed and the policy previously applied indicating not billable to the patient was overturned. Based on additional information provided, the fee is now billable to the patient. Refer to the Benefits/Coverage Section of the benefit booklet.
UMD502	This procedure was reviewed and the policy previously applied was correct. If the dentist does not agree with the determination, a written provider dispute may be submitted. Refer to the Benefits/Coverage Section of the benefit booklet.
UMD638	This procedure is covered only once per lifetime. Refer to the Benefits/Coverage section of the benefit booklet.
UMD639	This procedure is covered only once per lifetime. Refer to the Benefits/Coverage section of the benefit booklet.
UMD640	This service exceeds the procedure frequency limitation allowed by the benefit plan. Refer to the Benefits/Coverage section of the benefit booklet.
UMD641	This service exceeds the procedure frequency limitation allowed by the benefit plan. Refer to the Benefits/Coverage section of the benefit booklet.
UMD708	An allowance has been made for surface(s) not previously paid. Refer to the Benefits/Coverage section of the benefit booklet.
UMD709	Payment is made for a surface once within the benefit's restorative limit period. An allowance has been made for surface(s) not previously paid. Refer to the Benefits/Coverage section of the benefit booklet.
UMD710	Payment is made for a surface once within the benefit's restorative limit period, regardless of the number or combination of restorations placed on that surface. Retreatment of any surface by the original dentist is not billable to the member. Refer to the Benefits/Coverage section of the benefit booklet.

UMD740	This fee is considered part of the fee for the original / complete procedure. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD741	This fee is considered part of the fee for the original / complete procedure. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD746	The payment made for active periodontal therapy includes 30 days of post-operative care. Refer to the Benefits/Coverage section of the benefit booklet.
UMD747	The payment made for active periodontal therapy includes 30 days of post-operative care. Refer to the Benefits/Coverage section of the benefit booklet.
UMD750	The fee for a complete or partial denture includes the fee for any reline/rebase, adjustment or repair required within six months of delivery. Refer to the Benefits/Coverage section of the benefit booklet.
UMD751	The fee for a complete or partial denture includes the fee for any reline/rebase, adjustment or repair required within six months of delivery. Refer to the Benefits/Coverage section of the benefit booklet.
UMD752	A posterior fixed bridge done in conjunction with a removable appliance in the same arch, or to replace the same teeth as a previously placed removable appliance, is not payable. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD753	A posterior fixed bridge done in conjunction with a removable appliance in the same arch, or to replace the same teeth as a previously placed removable appliance, is not payable. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD800	Mail order or online orthodontic kits do not meet our guidelines as a professionally provided treatment.
UMD801	Mail order or online orthodontic kits do not meet our guidelines as a professionally provided treatment.
UMD804	Covered Services are not payable when treatment is completed by a non-PPO provider. Refer to the Schedule of Benefits section of the benefit booklet.
UMD806	This procedure is a benefit only when the procedure is within the scope of practice for the treating practitioner. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD807	This procedure is a benefit only when the procedure is within the scope of practice for the treating practitioner. Refer to the Limitations/Exclusions section of the benefit booklet.
UMD808	This portion of the orthodontic treatment plan in progress is not payable. The member's dental coverage or the orthodontic coverage was not in effect when this orthodontic treatment plan was started.
UMD809	This portion of the orthodontic treatment plan in progress is not payable. The member's dental coverage or the orthodontic coverage was not in effect when this orthodontic treatment plan was started.
UMD810	This portion of the orthodontic treatment plan in process is not payable. The orthodontic dental coverage was not in effect when this orthodontic treatment plan was started.
UMD811	This portion of the orthodontic treatment plan in process is not payable. The orthodontic dental coverage was not in effect when this orthodontic treatment plan was started.
UMD812	Orthodontic benefits are paid annually, this represents the initial payment. Payment for the remaining allowable benefit are issued 1 year after the banding based on participation in this benefits plan.

UMD813	The amount paid on this claim represents the total benefit allowed for submitted treatment plan.
UMD814	The amount paid on this claim represents the total benefit allowed for submitted treatment plan.
UMD815	It is not necessary to submit monthly orthodontic claims. Delta Dental automatically issues payments once a treatment plan has been processed. When submitting a complete treatment, include the total fee, initial fee, banding date, and number of months of active treatment.
UMD816	Covered Services are not payable when treatment is completed by a non-participating provider. Refer to the Schedule of Benefits section of the benefit booklet.
UMD850	A panoramic radiograph with bitewings and/or intraoral radiographs is processed as a full mouth series. Refer to the Benefits/Coverage section of the benefit booklet.
UMD851	A panoramic radiograph with bitewings and/or intraoral radiographs is processed as a full mouth series. Refer to the Benefits/Coverage section of the benefit booklet.
UMD852	Multiple radiographs taken on the same date of service are processed as a full mouth series. Refer to the Benefits/Coverage section of the benefit booklet.
UMD853	Multiple radiographs taken on the same date of service are processed as a full mouth series. Refer to the Benefits/Coverage section of the benefit booklet.
UMD854	Any supplemental film taken in conjunction with a full mouth series (D0210) is considered part of the full mouth series. Refer to the Benefits/Coverage section of the benefit booklet.
UMD855	Any supplemental film taken in conjunction with a full mouth series (D0210) is considered part of the full mouth series. Refer to the Benefits/Coverage section of the benefit booklet.
UMD856	Diagnostic photographs, images, cephalometric films and casts are payable only when done in conjunction with covered Orthodontic services. Refer to the Schedule of Benefits section of the benefit booklet.
UMD857	Diagnostic photographs, images, cephalometric films and casts are payable only when done in conjunction with covered Orthodontic services. Refer to the Schedule of Benefits section of the benefit booklet.



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