

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-26	Appendix 1	35,36	Edit Codes 611-615 were added in reference to Referring/Ordering NPI.
07-01-26	1-Admin. & Billing Manual	13	Updated policy for ORP providers enrollment requirements and claims billing requirements with ORP provider's NPI
04-15-26	Appendix 2		Updated Carrier Codes
04-01-26	Admin. & Billing Manual	9	Added policy for compliance with Anti-kickback state and federal laws.
01-01-26	Appendix 1		Removal of Edit Code 974: This edit code was removed to comply with Program Area requirements. The MCO's are no longer responsible for this 90-day Payment. The service will be covered by FFS payments.
01-01-26	Appendix 2		Updated Carrier Codes
01-01-26	Appendix B	77-79, 115	Added codes D9224, D9225, D9244, D9245, D9246, D9247, D8091, D8671. Removed discontinued code D9248. On 02-26-26: Corrected typo for codes D9244 and D9245. Changed the PPR requirement to "NO" to align with the previous policy for children and ID/RD members
11-01-25	Appendix 1		For Edit Code 636: Co-payments are no longer subject to cost-sharing. It reads as follows: For dates of service up to 6/30/2024 , the Medicaid recipient is responsible for a Medicaid copayment for this service/date of service. The allowed payment amount is less than the recipient's copayment amount; therefore, no payment is due from Medicaid. Please collect copayment from the Medicaid recipient. Do not submit a new claim. For dates of service on or after 07/01/2024 , covered services are no longer subject to cost-sharing. The payment amount is the allowed Medicaid amount and is considered payment in full.
11-01-25	Admin. & Billing Manual	Section 1 Pg. 15	Removed language regarding the reimbursement of interns practicing under the supervision of a licensed professional. Interns have an enrollment pathway. Also, the requirements for Ordering and Rendering Physicians were removed as the list is outdated and to comply with PERM Audit findings. An updated list will be provided, when available.
10-27-25	Appendix 2		Updated Carrier Codes
07-01-25	Appendix 2		Updated Carrier Codes
07-01-25	Admin & Billing Manual Section 1	4-5	- Changed citation for the definition of SCMSA to State Regulations. - Added language about proof of residency requirement for certain provider types. - Added definition of In-State and Out-of-State providers and licensure requirements. Clarified enrollment of out of state providers as permitted or required by state or federal law.
07-01-25	Utilization Management, Billing Guidance	19, 84	Notes on the DPH Children's Rehabilitative Services program have been added with regard to Orthodontic Transfer cases (Page 84) and for Prior Authorization for Orthodontic Services (Page 19).
07-01-25	Forms	14, Orthodontic CoC submission form	A note on transferred cases and requirements under such circumstances was added below the form information.
05-01-25	Appendix 1		Update to Edit Codes 721, 722 and 989.
05-01-25	Appendix 2		Updated Carrier Codes that were effective 04-01-25.

04-1-25	Forms	10-13, HLD Assessment form	Updated language specifying that qualifiers #4 and #13 have overjet lengths that are 8 mm or greater and 3.5 mm and greater respectively. Specific language has been changed, and condition #6 was redesigned to include an additional qualifier for #6.
04-01-25	Appendix B	61, 64	Codes D5520 and D5640 had their descriptions modified. D7259 (Nerve Dissection), was added to the Dental Extractions section
01-28-25	Appendix 2		Updated Carrier Codes that were effective 01-01-25.
11-01-24	Appendix 1		Codes were updated as of October 1, 2024 Edit Code 719- • Claim Status: REJECT -Check the prior authorization number, procedure code(s) and modifier(s) to ensure that the information on the claim matches the information on the prior approval letter. Attach appropriate documentation to the claim for review and consideration for payment. Refer to the applicable provider manual for the specific documentation requirements. • Claim Status: SUSPEND -The service/procedure has to be reviewed by Medicaid prior to payment. No further action by the provider is necessary. Edit Code 560- ☐ Verify the accuracy of the procedure/revenue code: Verify the correct revenue code (field 42) was billed. If the revenue code is incorrect, make the appropriate correction to the new claim. ☐ UB CLAIM: Enter the correct revenue code (Field 42) for that line.
11-01-24	Appendix 2		October updates to Carrier Codes
07-01-24	Appendix 1	34, 80	Removed edit codes 636 and 977
07-01-24	TPL Supplement	4	Removed reference to Medicaid copayments
07-01-24	Copayment Schedule	All	Removed Copayment Schedule from manual homepage.
07-01-24	Admin & Billing Manual. Section 1	7	Clarified policy on Medical Necessity definition to cite with the South Carolina code of Regulations 126-425 (A)(9).
07-01-24	Admin & Billing Manual. Section 1	24-27	Health Record Retention: Updated policy regarding the retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. Health Record Documentation: Clarified policy related to health records date and signature requirements, documenting progress notes and services billed.
07-01-24	Admin & Billing Manual. Section 1	54	Updated Appeals section to emphasize that Providers must exhaust the claim reconsideration process (when applicable) before requesting an appeal. The reconsideration denial must be submitted with the appeal request.
07-01-24	Admin & Billing Manual. Section 2	55-56	Beneficiary Co-Payment was revised to read Beneficiary Cost Sharing. Added language that services are covered without cost sharing. Removed references to copayment and cost sharing throughout the manual. Removed Copayment Exclusions.
07-01-24	Appendix B	49-50 and 55	Updated clinical criteria for prefabricated crowns to align with AAPD guidelines. Updated tooth numbers for procedure D2931 to remove anterior teeth, and D2932 to remove posterior teeth.
07-01-24	Various sections	Various Pages	Removed reference to Medicaid copayments throughout the manual
07-01-24	Various Sections	Various Pages	Corrected grammatical errors, replaced references of "should" with "must" throughout the manual to reflect that policy is required.
04-29-24	Admin & Billing Manual	14-22	The omission of the application fee and hardship waiver request for revalidation of enrollment.
04-29-24	Appendix 2		Updated Carrier Codes
03-20-24	Admin & Billing Manual	Various Pages	"Remittance advice is accessible for three years after payment date via Web Tool" was added to the following sections: South Carolina Medicaid Web-Based Claims Submission Tool (Web Tool), Trading Partner Agreement, Duplicate Remittance Advice and Remittance Advice sections.
02-13-24	Appendix 2		Updated Carrier Codes (effective 1-1-24)
01/01/24	Cover Page		Updated Publication Date
01/01/24	Section 4 – Definitions	10	Corrected the CFR and SSA citation for EPSDT

01/01/24	Section 5 – Utilization Management	20	Replaced the reference to KEPRO with QIO with regard to inpatient service authorization
01/01/24	Section 5 – Utilization Management	21	Added contact information and step for the Peer-to-Peer Review
01/01/24	Appendix B	44-47	Updated the caries arresting medicament application criteria and frequency limitations. Updated benefit table for D1354
01/01/24	Appendix B	49	Removed limitation on reimbursement for restorative services when SDF has been applied within 6 months.
01/01/24	Appendix B	54	Updated description for D2335 based on 1/1/24 code changes from ADA
01/01/24	Appendix B	66-68	Updated policy regarding sedation services in-office setting. Clarified that in-office sedation administered by a provider under the direction of the treating dentist must be billed under the treating dentist NPI, and provider is prohibited to bill the patient for these services even if the administering provider is not a network provider. Revised the clinical criteria for in-office sedation removing the word “excessive” as it relates to treatment.
01/01/24	Appendix B	70	Limit of deep sedation (D9223) and intravenous moderate sedation (D9239) changed from 1 unit (15 minutes) to 5 units (75 minutes)
01/01/24	Administrative and Billing Manual	7	Updated the definition of medical necessity to align with State law and regulations.
01/01/24	Administrative and Billing Manual	24-31	Updated Health records retention policy from five (5) years to four (4) years from the last payment date, with exception of nursing homes and hospitals that must retain such records for six (6) years. Updated health record documentation policy related to signature, date, and progress notes requirements.
01/01/24	Administrative and Billing Manual	32	Removed the examples of beneficiary information protected under HIPAA in the Safeguarding Beneficiary Information section.
01/01/24	Administrative and Billing Manual	39	Removed the 3 years limitations for claims filing timeline for members with retroactive eligibility.
01/01/24	Administrative and Billing Manual	49	Added language to clarify that the claims reconsideration process must be exhausted before a provider requests an administrative hearing
01/01/24	Administrative and Billing Manual	5	Added language to clarify that providers delivering services via telehealth may not be subject to the SCMSA location requirement.
10/01/2023	Cover Page		Updated Publication Date
10/01/2023	Section 4-Definitions	11	Updated the definition of Medical Necessity to align with the SC Code of regs
10/01/2023	Section 6- Documenting and Reporting	23	Updated the federal citations for record retention and clarified the 4 year timeline starts after the last payment was made for the service delivered.
10/01/2023	Section 7-Billing Guidance	32	Updated the link for ADA claims completion instructions
07/01/2023	Appendix 2		Updated Carrier Codes
07/01/2023	Cover Page		Updated publication date
07/01/2023	Appendix B	62	Corrected requirements for radiographs, from submission with the claim to maintaining the radiographs in the patient records.
07/01/2023	Appendix B	63	Removed age-based reference from benefit tables for primary teeth for D7140, D7210, D7250
07/01/2023	Appendix B	63	Corrected typo for PPR requirement for procedure D7250 to reflect No PPR
05/11/2023	Cover Page		Updated publication date
05/11/2023	Appendix B	43-46	Added clinical criteria, benefit limitation and frequency for caries arresting medicament application

05/11/2023	Appendix C	81	Deleted Appendix C
05-11-2023	Admin. and Billing manual	7 10, 11	- Added to Provider Enrollment requirements that providers must "Be located within the South Carolina Medical Service Area (SCMSA), which is defined as the State of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina State border as detailed in South Carolina Code of Laws, Section 44-6-110." - Added section related to clinical trials.
05-11-23	Appendix 3	1,2	Added language referencing ARPA requirements around COVID-19 copayments
05-01-23	Appendix 2		Updated Carrier Codes
01/01/2023	Cover Page		Updated publication date
01/01/2023	Section 6-Reporting/Documentation	23-25	Updated the entire section.
01/01/2023	Appendix B- Diagnostic Services	40-41	Updated benefit limitations table for all radiographic images- procedure codes (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330)
01/01/2023	Appendix B- Diagnostic Services	42	Added 2023 new codes D0372, D0373, and D0374 along with benefit limitations.
01/01/2023	Appendix B- Restorative Services	45-47	Updated the criteria for restorative services for children and ID/RD waiver. Updated criteria for prefabricated crowns to add limitations for application of caries arresting medicament.
01/01/2023	Appendix B- Dental Surgery	60-61	Removed PPR requirement for codes D7220 and D7230 w for third molars only and for children and ID/RD waiver members only. Added limitations based on age patterns for exfoliation of primary teeth for procedure codes D7140, D7210 and D7250. Updated criteria for dental extractions to add limitations for caries arresting medicament and age-based eruption and exfoliation patterns...
01/01/2023	Appendix B- EMC Services	68	Updated the documentation required for emergency and Exceptional conditions. Added requirement for the referring provider NPI to be included on the referral form.
01/01/2023	Appendix B- EMC Services	70	Added the 2023 new procedure codes D7509, D0801, D0802, D0803, D0804. Deleted code D0351.
01/01/2023	Appendix B- EPSDT Services	75-77	Updated the score for the HLD Assessment form to 25 for orthodontic services
01/01/2023	Appendix C	79	Updated the maximum allowed payment for multiple applications of SDF per date of service for children and ID/RD waiver members
10/01/2022	Appendix 2		Updated Carrier Codes
08/01/2022	Appendix 2		Updated Carrier Codes
07/01/2022	Forms		Updated the Handicapping Labio-Lingual Deviation Index (HLD) Assessment
05/01/2022	Appendix 2		Updated Carrier Codes
02/01/2022	Admin. & Billing Manual	23	Added the following paragraph: "When submitting documents for claims, Providers must follow the specific guidelines outlined within each Provider Manual to ensure that the correct documentation and signature is provided."
01/01/2022	Appendix 2		Updated Carrier Codes
01/01/2022	TPL	3	Under "Cost Avoidance vs. Pay & Chase", Medicaid no longer covers Pay & Chase for prenatal claims and claims related to child enforcement policies; therefore, this information was removed.
01/01/2022	Admin. & Billing Manual	31	Under "Health Insurance", Maternal Health was deleted and (after 100 days) was added.

11/01/2021	Appendix 2		Updated Carrier Codes
10/01/2021	Appendix 1		Added Edit codes 607 & 608 to the Appendix
10/01/2021	Cover Page		Updated publication date
10/01/2021	Section 3: Value -Added Provider Benefit	6-7	Updated Provider Partners' contact information and county assignment map
09/01/2021	Forms		The Electronic Funds Transfer (EFT) was removed.
08/01/2021	Appendix 2		Updated Carried Codes that were effective 6-1-21.
07/01/2021	Cover Page		Updated publication date
07/01/2021	Section 2: Documenting Beneficiary Eligibility	3-4	Updated language for requirement of the verification date of the beneficiary's eligibility
07/01/2021	Section 3: Value -Added Provider Benefit	6-7	Updated Provider Partners' contact information and county assignment
07/01/2021	Section 3: Eligible Provider	5-9	Removed all references to 837P Guide and CPT procedure codes
07/01/2021	Section 4: Covered Services	12-13	Revised the description of the Emergency & Exceptional Medical Conditions (EMC); revised the Benefits Summary table to reflect the revisions of the EMC as well as the annual maximum for the Adult Dental Benefit.
07/01/2021	Section 4: Reimbursement and Charge Limits	14	Revised the annual maximum for Adult Dental Benefit
07/01/2021	Section 5: Prior Authorizations for ASC or Inpatient Services	19	Updated language for authorization requirements for inpatient services; planned services rendered in an ASC or OR
07/01/2021	Section 5: Members Grievances and appeals	20-21	Changed the timeline for providing a resolution to members complaint/ grievances to 14 calendar days.
07/01/2021	Section 5: Utilization Management	16-20	Removed all references to CMS 1500 claim form and CPT procedure codes
07/01/2021	Section 7: Claim Submission for Emergency & Exceptional Medical Conditions	36-37	Revised language for claim submission for Emergency & Exceptional Medical Conditions, updated the annual maximum for Adult Dental Benefit
07/01/2021	Section 7: Claim Submission for EPSDT Services	37	Added policy for claim submission of EPSDT services delivered necessarily on the same day as diagnosis.
07/01/2021	Section 7: Claim Submission for ASC or Inpatient Services	38	Updated language for claim submission for planned services rendered in an ASC or OR and inpatient services
07/01/2021	Section 7: Billing Guidance	32-40	Removed all references to CMS 1500 claim form and CPT procedure codes
07/01/2021	Section 7: Adjustments	39	Revised language for Void /replacement claims
07/01/2021	Appendix B: Diagnostic Services	44	Updated policy for reimbursement of multiple radiographs, including panorex in the bundle
07/01/2021	Appendix B: Diagnostic Services	44	Revised policy to exclude diagnostic services form the Adult Dental Benefit annual maximum; updated the annual maximum to \$1,000
07/01/2021	Appendix B: Diagnostic Services	45	Added benefit limitations for D0160
07/01/2021	Appendix B: Diagnostic Services	45-47	Revised benefit limitations for the following State Plan diagnostic services: D0120; D0140; D0145; D0150; D0210; D0220; D0230; D0240; D0270;

			D0272; D0274; D0330.Changed age limitation for children as follows: D0120 to 3-20, D0220 to 0-20, D0230 to 0-20, D0240 to 0-20, D0274 to 8-20.
07/01/2021	Appendix B: Restorative Services	50-54	Added supernumerary teeth to the policy limitations for restorative services.
07/01/2021	Appendix B: Adjunctive Services	65	Updated the Adult Dental Benefit annual maximum to \$1,000
07/01/2021	Appendix B: Adjunctive Services	69	Added benefit limitations for procedure D9310- Consultation
07/01/2021	Appendix B: Emergency & Exceptional Medical Conditions	70-71	Revised description and services of Emergency & Exceptional Medical Conditions;
07/01/2021	Appendix B: Emergency & Exceptional Medical Conditions	72	Added benefit limitations for the following diagnostic codes for Emergency and Exceptional Medical Conditions: D0160; D0170; D9310; D0250; D0251; D0310; D0330; D0351; D0364; D0365; D0366; D0367; D0368; D0369; D0370; D0371; D0391; D0472; D0473; D0474; D0475; D0476; D0478; D0486
07/01/2021	Appendix B: Emergency & Exceptional Medical Conditions	73	Added benefit limitations for the following Maxillofacial prosthetic codes range for Emergency& Exceptional Medical Conditions D5992-D5999
07/01/2021	Appendix B: Emergency & Exceptional Medical Conditions	73	Added benefit limitations for the following Oral & Maxillofacial surgical codes for Emergency& Exceptional Medical Conditions D7260; D7261; D7270; D7272; D7285; D7286; D7287; D7288; D7295; D7310; D7311; D7320; D7321; D7410; D7411; D7412; D7413; D7414; D7415; D7440; D7441; D7450; D7451; D7460; D7461; D7465; D7471; D7472; D7473; D7485; D7490; D7510; D7511; D7520; D7521; D7530; D7540; D7550; D7560; D7610; D7620; D7630; D7640; D7650; D7660; D7670; D7671; D7680; D7710; D7720; D7730; D7740; D7750; D7760; D7770; D7771; D7780; D7810; D7820; D7910; D7911; D7912; D7920; D7922; D7941; D7943; D7944; D7945; D7946; D7947; D7948; D7949; D7950; D7955; D7979; D7980; D7981; D7982; D7983; D7990; D7991; D7993; D7994; D7995; D7996; D7997; D7998; D7999.
07/01/2021	Appendix B: Emergency & Exceptional Medical Conditions	74	Updated benefit limitations for additional dental services rendered for Emergency & Exceptional Medical Conditions D0120-D9999
07/01/2021	Appendix B: EPSDT Services	75	Removed all references to CPT Codes; updated the range of dental codes for EPSDT services;
07/01/2021	Appendix C: COVID-19 Temporary Dental Policies	76-78	Deleted policy, criteria and benefit limitations for oral evaluations (D0140, D0160) and telehealth encounter (D9992) for the COVID-19 Temporary policies.
07-01-21	Manual Homepage		Updated Managed Care Supplement
07-01-21	Admin. & Billing Manual	50,51	Tapes, Diskettes, CDs and Zip files were deleted as a means of filing claims directly to SCDHHS.
04/01/2021	Forms		Added DentaQuest Provider Update Form – Sedation Permit Only
04/01/2021	Forms		Added DentaQuest Request for Reconsideration Form
10/01/2020	Cover		Updated Publication date
10/01/2020	Appendix B: Exceptional Medical Conditions	73-74	Added reimbursement fee description for consistency with Charge Limits section and expanded the documentation required from the treating medical provider.
10/01/2020	Appendix B: Emergency Services	70-72	Updated the definition of services and corrected the omission of CPT 21347 and 21470.
10/01/2020	Appendix B: Restorative Services	50	Added "billing entity" to clarify the same provider and provider location
10/01/2020	Section 7: Adjustments	39-40	Added information and address for filing void or void/replace for dental services. General information is currently in the Administrative and Billing Guide

10/01/2020	Section 7: Claim Completion Instructions	35	Added signature requirements on the claim for rendering, supervising or authorizing provider and treatment location
10/01/2020	Section 6: Documentation for Treatment Records	28	Added signature requirements in the treatment records for rendering, authorizing and supervising providers
10/01/2020	Section 5: Beneficiary Appeals	21	Added timeline requirement for filing a State Fair Hearing to be consistent with Billing and Administrative Guide
10/01/2020	Section 5: Claims Reconsideration	20	Added timeline requirement for filing a State Fair Hearing to be consistent with Billing and Administrative Guide
10/01/2020	Section 5: Reasons for Denials	20	Created a unified paragraph for the purpose of combining similar language throughout section 5 for better flow
10/01/2020	Section 5: Authorization for Services in Outpatient Setting	19	Added exceptions for PA in outpatient settings
10/01/2020	Section 4: Reimbursement and Charge Limits	14-15	Updated entire section to combine and remove duplicate language
10/01/2020	Section 4: Covered Services	11-13	Updated State Plan services to expand and detail covered services for each beneficiary sub-group (child; adult; ID/RD Waiver); updated Emergency services and Exceptional Medical conditions to add Social Security Act reference; updated EPSDT services for language clarification.
10/01/2020	Section 4: Definitions	10-11	Updated definitions for dental services; emergency services; medically necessary
10/01/2020	Section 3: Provider Enrollment Requirements	6	Updated provider enrollment requirement to reflect inclusion of authorizing and supervising providers and prohibition of terminated or excluded providers
10/01/2020	Section 3: Provider Training	6-7	Updated contact information for Provider Representative and added information about virtual provider office visits
10/01/2020	Section 3: Eligible providers	5	Updated definition of qualified providers to align with SCDHHS regulations and participation requirements for rendering, authorizing or supervising provider
10/01/2020	Section 2: Beneficiaries Ineligible for Dental benefit	2	Updated criteria of beneficiaries ineligible for dental benefits
04/01/2020	Cover		Updated Publication Date
04/01/2020	Appendix C	75-78	Added Appendix C- COVID -19 Temporary Dental Services Policy.
01/01/2020	Appendix B	45	Typo Correction- Corrected child's age limitation for procedure D0150 to age 3-20. Previous entry was incorrect as of 7/1/2019.
07/01/19	Cover		Updated Publication Date
07/01/19	Appendix B	54	Added Procedure D2390 on the Benefit Criteria and Limitations
07/01/19	Appendix B	74-75	Added Initial Dental Encounter for foster children under the EPSDT services
07/01/19	Appendix B	57	Updated the Benefit Criteria and Limitations section for documentation required for endodontic services- requiring post- operative radiographs.
07/01/19	Appendix B	48	Updated the Benefit Criteria and Limitations section for reimbursement policy for bilateral fixed space maintainers
07/01/19	Billing Guidance	39-40	Added claims submission for the EPSDT services delivered as Emergency and Initial Dental Encounter for Foster Care children
07/01/19	Utilization Management	21	Added Initial Dental Encounter for Foster Care children as exempted from the PA requirement for EPSDT services
07/01/19	Section 3: Eligible Providers	7	Added County Assignment for Provider Partners Map

07/01/19	Appendix B	44-75	Replaced and revised formatting of Exhibits A, B, C of the Dental Office Reference Manual (ORM)
07/01/19	Dental Services Provider Guide	1-75	Revised formatting, sections and headings of the Dental Office Reference Manual (ORM)
05/01/19	Cover		Updated Publication
05/01/19	Exhibit A & C		Removed Procedure D2940
05/01/19	Exhibit A & C		Updated narrative for reimbursement fee for Restorative procedures to be inclusive of temporary or protective restorations
05/01/19	Appendix E		Inserted the updated SCDHHS Provider Manual General Information Section 1- effective 4/1/2019
01/01/19	Cover		Updated Publication Date
01/01/19		14	Corrected reference in Statement of Provider Rights and Responsibilities #8
01/01/19	1.02		Updated Provider Partner Information
01/01/19	2.04		Updated Copayment Age Exclusion
01/01/19	3.03		Removed reference of treatment plan required
01/01/19	9.00		Updated Phone information to include Option #4 added Fax number
01/01/19	A.01		Removed reference of treatment plan required (#N)
01/01/19	D-2		Corrected typo on record retention requirement from "three" years to "five" years
01/01/19	C.04		Submission requirement – replaced "treatment plan" with "supporting documentation"
01/01/19	C.09		Submission requirement – replaced "treatment plan" with "supporting documentation"
01/01/19	Exhibit A-C		Updated Narrative for Adjunctive Services to include dental sedation permit requirements.
01/01/19	Exhibit A-C		Updated CDT and CPT codes to reflect procedure code changes (ADA and CMS) effective for 01/01/2019
10/01/18	Cover		Update Publication Date
10/01/18	3.00- 3.03		Clarified Authorization of Treatment
10/01/18	3.04		Added section on Prior authorization for services requiring inpatient stay.
10/01/18	4.05		Revised language on Paper Claim submission
10/01/18	4.16		Revised Claims submission for services delivered in an outpatient setting (ASC/ OR)
10/01/18	4.17		Added section: Claims submission for dental services requiring inpatient stay

10/01/18	C.04		Revised criteria for dental services delivered in a ASC or OR
10/01/18	C.09		Revised criteria for general anesthesia/ IV sedation in the dental office
10/01/18	C.10		Revised criteria for services rendered in conjunction with Behavioral Management services and created a separate section.
10/01/18	9.03		Removed DentaQuest General Information Section
10/01/18	Exhibit A-C		Updated Narrative for approval of services delivered in an ASC/ OR
10/01/18	Exhibit A-C		Updated CPT Medical codes to remove Inpatient only procedures
08/06/18	Appendix E		Updated SCDHHS Provider Manual- General Information (Section 1)
07/01/18	Cover		Updated Publication Date
07/01/18		13	Updated Statement of Provider Rights and Responsibilities
07/01/18		14	Updated Statement of Beneficiaries Rights
07/01/18	3.02		Updated Prior Authorization for Non-State Plan Services
07/01/18	3.03		Updated Authorization for Operating Room (OR) and Ambulatory Surgical Center (ASC)
07/01/18	4.11		Updated the Charge Limits
07/01/18	4.14		Revised Appeal process with Request for Reconsideration
07/01/18	6.01-6.02		Updated Grievances, Appeals and State Fair Hearing
04/01/18	Cover		Updated Publication Date
04/01/18		2	Updated Fax Number
04/01/18		13	Updated Statement of Provider Rights and Responsibilities
04/01/18	2.01 (A-B)		Updated Medicaid Beneficiaries eligible for Dental Benefits & Medicaid Beneficiaries ineligible for Dental Benefits
04/01/18	2.04		Updated Copayment Exclusions to include "medical" emergency services
04/01/18	2.06		Updated Transportation
04/01/18	3.04		Updated Prior Authorization for Non-State Plan Covered Services Medically Necessary EPSDT Services
04/01/18	4.07		Updated language Filing Claims for the Provision of Dental Services in preparation or as the result of Exceptional Medical
04/01/18	4.08		Updated language Filing Claims for the Provision of Adult Dental Services

04/01/18	Exhibit A- C		Updated problem focus exam(D0140) narrative
04/01/18	Exhibit A- C		Updated restoration narrative
04/01/18	Exhibit B		Added primary teeth to restoration codes D2140- D2394
04/01/18	Exhibit B		Updated "Prepayment Review Required" for D7220, D7230, D7240, D7241, D7250 to Yes
02/01/18	4.11		Clarified Procedure fee inclusions
02/01/18	Exhibits A-C		Clarified Procedure fee inclusions per Service Category
01/01/18	1.02		Updated Provider Engagement Contact
01/01/18	Exhibit A and C		Added new codes D5511& D5512 (replacing D5510) and D5611 & D5612 (replacing D5610); Deleted non valid codes D5510 & D5610
01/01/18	Exhibit A-C		Added new codes D9222 & D9239; Updated benefits limitation for D9223 & D9243; Updated code edits for D9222,D9223, D9230, D9239, D9243, D9248
01/01/18	Exhibit A-C		Updated code description D3320, D3330, D7111, 99217, 99218, 99219, 99220, 99235, 20185
01/01/18	Exhibit A and C		Removed "Teeth Covered" requirements D5110 & D5120
01/01/18	Exhibit A and C		Updated codes required for monitoring in the sedation records
06/08/17	Exhibit A & C		Corrected typo on "Benefit Limitations" D0120, D0150,D1510, D1515, D2950, D2951, D2954, D9420 and "Teeth Covered" 41822,41823,41830, 41830,41874
06/08/17	Exhibits A-C		Updated "Documentation Required" for D9230, D9248
06/08/17	Exhibit B		Added CPT codes 42330,42335,42340,42408,42409,42440
05/02/17	Exhibits A-C		Corrected typo on "Benefit Limitations" for D9230, D9248. Removed D9248 from D9230 benefits limitations; removed D9230 from D9248 benefits limitations.
05/01/17	Exhibits A and C		Clarified "Benefits Limitations" for D0120, D0145, D0150
05/01/17	Exhibits A and C		Added the following CPT codes: 11900, 12011, 12013- 12015, 12020, 12051- 12055, 13131, 13133, 13151-13153, 15120, 15121, 20005, 20694, 21046- 21049, 21076, 21081, 21085, 21110, 21209, 21210, 21215, 21230, 21235, 21240, 21242, 21243, 21336- 21339, 21480, 21490, 21497, 30580, 30901, 30903, 30905, 30906, 31020, 31030, 31032, 31500, 40490, 40525, 40700- 40702, 40720, 40800, 40801, 40808, 40810, 40812, 40814, 40816, 40818, 40819, 40830, 40831, 41005-41007, 41015- 41018, 41100, 41105, 41108, 41110, 41115, 41251, 41252, 41805, 41806, 41822, 41823, 41827, 41828, 41830, 41850, 41874, 42100, 42104, 42140, 42180, 42182, 42200, 42205, 42210, 42215, 42220, 42300, 42305, 42310, 42320, 42330, 42335, 42340, 42500, 42505, 42650, 42720, 42725, 64722, 64774, 64788, 67930, 67935.
05/01/17	Exhibit B		Corrected typo on "Benefits Limitations" for D0150 and D0210 to 1 per 36 months; and "Prior Authorization required" for D9420 to Yes
05/01/17	Exhibits A and C		Corrected typo on "Benefits limitations" for D0140 to Per Provider OR Location; and "Pre Payment Review Required" for 13132 to Yes
05/01/17	Cover		Updated Publication Date and SCDHHS Logo

05/01/17	2.01		Updated Eligibility and Identification Card Samples
05/01/17	2.04		Updated Copayment Exclusions
05/01/17	3.01		Updated the year of the ADA claim form
05/01/17	3.01		Updated Treatment Prior Authorization and Pre-Payment Review
05/01/17	3.05		Added Provision of EPSDT for Beneficiaries under the age 21
05/01/17	4.05		Updated the year for the ADA claim form
05/01/17	4.05		Updated Place of Service Code
05/01/17	4.10		Updated Coordination of Benefits Under EPSDT
05/01/17	9.03		Updated Out of State Providers
05/01/17	Appendix A-2		Added TPL form (DHHS931) to the list of attachments
05/01/17	Appendix C- C.02		Updated Criteria for Prefabricated Crowns
05/01/17	Appendix D		Updated The Dental Treatment Record Bullet-# 11
05/01/17	Appendix E		Section 1- updated on 10/01/2016
05/01/17	Exhibit A and C		Updated "Benefit Limitations" for Codes: D2929, D2930, D2931, D2932, D2934, D3220
05/01/17	Exhibits A-C		Added Prior Authorization Column
05/01/17	Exhibits A-C		Updated the nomenclature and/ or descriptor of the 2017 CDT and 2017 CPT Medicaid State Plan covered codes
05/01/17	Exhibits A-C		Updated the Documentation Required for each procedure code
08/01/16	Cover		Updated Publication Date
08/01/16	Multiple Locations		Updated Physical Mailing Address for Appeals
08/01/16	1.02	16	Updated Contact Information for Provider Engagement Staff
08/01/16	Exhibit A and C		Updated Age Limitations for D0330 and D1351
02/01/16	Appendix E		Updated to reflect Medicaid Bulletin dated January 26, 2016 – Updates to Section 1 – All Provider Manuals
01/01/16	Cover		Updated Publication Date
	2.01	19	Update the Adult Dental Benefit Language

	Appendix E		Updated to reflect Medicaid Bulletin dated December 9, 2015 – Charge Limits.
	Exhibit A, B, and C		Replaced code D9220 with D9223. Replaced code D9241 with D9243
	Exhibit A and C		Added code D2929
	4.08	32	Updated the language –Remove the emergency adult dental filing period
05/26/15	Cover		Updated publication date
	4.04	29	Clarification of Electronic Signature
	4.05	30	Paper Claim Submission Acceptable Signature
	4.09	32	Clarified Third Party Liability policy regarding primary carrier copayments
	4.11	33	Added reference to Adult Benefit Structure Change in Fee and Charge Limits
	5.0	38	Updated Reference to CDT and CPT Terminology
	9.04	45	Updated Information on Generic Provider Information Form
	A-2	48	Added to Resources Available on Provider Web Portal
	C.01	52	Criteria: Extractions that do not meet the criteria
02/01/15	4.03	28	Corrected email address of DQ EDI Department
	C		Updated introductory language to Clinical Criteria
	D-2	61	Expanded recommendations to adequate documentation of treatment within the patient record.
	Exhibit A		Updated the limitation for the following codes: D0145
	Exhibit B		Updated the limitation for the following codes: D0140, D0150
	1.00	15	Added reference to Adult Benefit Structure Change
	1.04	16	Added reference to Adult Annual Maximum Accumulator
	2.01	17-18	Added reference to Adult Benefit Structure Change and Naming of IDR Waiver
	2.04	19-20	Clarified application of copayments to Adult Benefits and Naming of IDR Waiver
	3.04	24	Added reference to Adult Benefit Structure Change
	4.06	29	Added reference to Adult Benefit Structure Change

	4.07	29-30	Added reference to Adult Benefit Structure Change
	4.08	30	Added reference to Adult Benefit Structure Change
	4.16	33	Clarified Prior Authorization Process for Outpatient Treatment
	Appendix A		Added reference to Adult Benefit Structure Change and Naming of IDRD Waiver
	B		Added reference to Adult Benefit Structure Change and Naming of IDRD Waiver
	C.09		Clarified Naming of IDRD Waiver
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
	Exhibit B		Revised Benefit Tables for Adult Benefit Structure Change
	Exhibit C		Clarified Naming of IDRD Waiver
11/01/14	2.0	18	Added reference to "Healthy Connections Checkup"
	2.04	20	Added reference to "Healthy Connections Checkup"
	3.02	23	Clarified Prior Authorization Process for Outpatient Treatment
	4.16	33	Clarified Prior Authorization Process for Outpatient Treatment
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
	Exhibit B		Added CPT codes to the covered code set for Adults
3/27/14	Cover		Updated publication date and SCDHHS Logo
	Table of Contents	12-14	Added Section 4.08 regarding Emergency Adult Services and Revised Numbering
	1.00	15	Added Reference to Adult Emergency Services
	2.01	17	Added Reference to Adult Emergency Services
	2.04	19-20	Added Reference to Adult Emergency Services
	2.06	20-21	Added Reference to Adult Emergency Services
	3.01	22	Added Reference to Adult Emergency Services and CMS 1500 Claim Format Requirement
	4.05	28	Added Reference to CMS 1500 Claim Format Requirement
	4.06	29	Added Reference to Adult Emergency Services

	4.08	30	Added Section Regarding Adult Emergency Services
	4.09-4.18	30-34	Revised Section Numbering
	5.00	35	Updated AMA and ADA Copyright Dates
	Appendix A	43	Added Reference to Adult Emergency Services, Revised Numbers
	A-2	45	Added Reference to CMS 1500 Claim Format Requirement
	Appendix B	46	Added Reference to Adult Emergency Services
1/17/14	Provider Rights & Responsibilities	9	Updated Provider Rights & Responsibilities to reflect SCDHHS policy on private payment by a beneficiary for noncovered services that are not medically necessary
	2.00	16	Updated Healthy Connections ID Cards and Explanations
	3.00	21	Added reference to Noncovered Service Prior Authorization Request Requirement – found in Section 3.04
	3.04	23-24	Added SCDHHS Policy Interpretation for Request of Noncovered Services under EPSDT
	4.10	30	Added reference to Fee Schedule for Frequently Submitted Noncovered Codes
	4.16	32	Corrected Phone Number for SCDHHS Provider Enrollment
	Appendix A	41	Updated EPSDT Definition
	A-2	43	Updated Additional Resources found on DentaQuest Provider Web Portal
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
6/3/13	4.02-4.03	26	Revised instructions for electronic claim submission
	4.08	29	Modified Coordination of Benefits Section to Differentiate Claim Filing Under EPSDT
	4.09	29-30	Added Coordination of Benefits Section Specific to EPSDT
	4.09-4.17	29-32	Corrected Section Numbers
	Clinical Criteria	46	Updated Clinical Criteria for Removable Prosthodontics
4/4/13		2	Removed obsolete email address
	4.02	26	Updated list of clearinghouses for electronic claim submission
	4.03	26	Updated email address for questions on electronic claim submission
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1

	Exhibits A and C		Corrected limitation on the following codes: D2950, D2954
	Exhibits A, B, and C		Added language on biopsies on biopsies of oral tissue to covered oral surgical codes
1/15/13	Contacts	2	Added SCDHHS Fraud and Abuse email address
	Provider Rights & Responsibilities	9	Updated Provider Responsibilities to include adherence to state and federal requirements for the practice of dentistry.
	4.10	30	Clarified timely filing policies
	7.05	37	Added SCDHHS Fraud and Abuse email address
	9.01	39	Updates SCDHHS Requirements for Provider Participation
	Appendix A	41	Corrected definition of clean claim
	Appendix B	44	Added reference to ADA standard for tooth numbering
	Appendix C	46	Added criteria for the use of behavior management
	Appendix D	54-59	Clarified documentation requirements for dental record
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
	Exhibits A and C		Replaced CDT Codes D1203 and D1204 with D1208
	Exhibits A, B, and C		Clarified guidance on same tooth restorations done within six month timeframe, extractions and orthodontia, and sedation/anesthesia billing and documentation.
10/2/12	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
8/2/12	9.00	39	Added link to electronic contact for Provider Enrollment
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
5/1/12		11	Updated Table of Contents
	1.00	14	Updated language on adult coverage
	2.01	16	Updated language on adult coverage
	2.06	19	Updated language on adult coverage
	4.06 and 4.07	28-29	Updated language on adult coverage
	Appendix B	44	Updated language on adult coverage
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1

4/2/12	2.01	16	Updated sample member card
	Appendix E		Updated SCDHHS Dental Services Provider Manual Section 1
2/2/12		2	Updated email address for dental claim submission
		3	Added reference to addition of SCDHHS Provider Manual Section 1 as Appendix E
	2.01	16	Updated language on adult coverage
	2.06	19	Updated language on adult coverage
	2.07	20	Included information on broken appointment tracking
	4.03	26-27	Updated email address for dental claim submission
	4.06	28	Updated language on adult coverage
	4.07	28-29	Updated language on adult coverage
	4.12	30-31	Clarified language on timeframe for appeal requests
	4.14	31	Clarified language on dental charges associated with OR/ASC usage
	6.01	34	Clarified language on timeframe for appeal requests
	Appendix B	44	Updated language outlining available benefits
	Appendix D	54	Included information on broken appointment tracking
	Appendix E		Added Dental Services Provider Manual Section 1
8/19/11	2.06	19	Updated beneficiary transportation information
4/14/11	2.04	18	Removed reference to copayment requirements for ID/RD Waiver members
4/7/11	1.00	14	Clarified language related to adult coverage
	1.02	14	Updated Provider Relations phone number
	2.01	16	Clarified language related to adult coverage
	2.04	18	Updated copayment requirements
	2.06	19	Updated language related to adult coverage
	3.00	21	Clarified review processes for prepayment review (PPR) and prior authorization (PA); clarified language related to adult coverage

	4.06	28	Clarified language related to adult coverage
	4.07	28-29	Clarified language related to adult coverage
	4.08	29	Updated copayment requirements
	4.16	32	Updated Provider Enrollment phone number
	4.17	32	Updated terminology for web portal
	6.00	34	Clarified appeal process
	9.00	39	Updated Provider Enrollment phone number
	Appendix A	41	Added definition for "medical condition"
	Appendix B	44	Clarified language related to adult coverage
	Exhibits A-C		Updated the following codes: D0140, D0240
	Exhibit B		Clarified language related to adult coverage; removed the following codes: 40700, 40701, 40702, 40720, 40761
10/21/10		2	Added fax number for submitting appeals
	3.03	22	Added instruction for submission of emergency authorization requests
	4.06	28	Clarified methods for indicating emergency services
	Exhibit A		Updated the limitation of following codes: D0140, D0150, D0240, D0330, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2392, D2393, D2394
	Exhibit B		Updated the limitation of following codes: D0140, D0240, D7140, D7210
	Exhibit C		Updated the limitation of the following codes: D0120, D0145, D0150, D1110, D1120, D1203, D1204, D1206, D1351, D1510, D1515, D0210, D0270, D0272, D0330, D5110, D5120, D5211, D5212, D5510, D5520, D5610, D5640, D0140, D0240, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2392, D2393, D2394
7/12/10	Appendix B	44	Added instruction for tooth surface designation.
	Exhibits A - C		Revised instructions for codes requiring review and authorization requirements for planned Hospital or Ambulatory Surgical Center (ASC) usage. D9420 (hospital call) is to be included in authorization requests for planned Hospital or ASC usage.
	Exhibits A – C		Updated descriptions of the following codes: 21116, 21497, 31000, 31020, 31030, 31603, 31605, 40500, 40510, 40520, 40530, 40650, 40652, 40654, 40700, 40701, 40702, 40720, 40761, 41000, 41008, 41009, 41015, 41016, 41017, 41018, 41112, 41113, 41116, 41120, 41130, 41135, 41140, 41145, 41150, 41155, 41250, 41252, 41828, 42106, 42120, 42200, 42220, 42225, 42235, 42260, 42330, 42335, 42408, 42409, 42440, 42450, 88160
	Exhibit A		Updated descriptions of the following codes: D0120, D0145, D0150, D7280, D7550, D7671, D7771, D7910, D7911, D7912, D9420, 21210, 21215, 21240, 21242, 21243, 21340, 21356, 21360, 21365, 21385, 21423, 21433, 21436, 21454, 21461, 21462, 31040, 41874, 42205, 42210, 42215, 42550

	Exhibit B		Updated descriptions of the following codes: D0140, D0210, D0220, D0230, D0240, D0270, D0272, D0330, D7550, D7910, D7911, D7912, D9230, D9248, D9420, D7671, D7771, D9230, 20900, 20902, 21029, 21210, 21215, 21240, 21242, 21243, 21340, 21356, 21360, 21365, 21385, 21423, 21436, 21454, 21461, 21462, 31040, 42200, 42205, 42210, 42215, 42550, 88300
	Exhibit C		Updated the following codes: D7550, D7910, D7911, D7912, D9420, 21210, 21215, 21240, 21242, 21243, 21340, 21356, 21360, 21365, 21385, 21423, 21433, 21436, 21454, 21461, 21462, 31000, 31040, 41874, 42205, 42210, 42215, 42550
	Exhibit C		Changed Age Limitation from "All" to "21 and Older"
6/21/10		All	Removed references to <i>Healthy Connections Kids</i> (HCK)
	2.05	19	Clarified federal claim filing guidelines for dually eligible Medicare and Medicaid recipients.
	3.01	21	Revised definition of prior authorization.
	Appendix C	46	Clarified criteria for dental extractions do not extend to prophylactic removal of asymptomatic teeth such as third molars.
6/10/10	1.05	15	Expanded value-added service language regarding authorization coordination.
	3.01	21	Added clarification that "authorization" can be obtained via a prior authorization or pre-payment review.
	4.02	25	Updated address for claim submission.
	4.05	28	Updated paper claim completion instructions.
	6.01	34	Clarified that complaint or appeal requests must be received within 30 calendar days.
	Appendix A	44	Revised definitions for "clean claim" and "prior authorization."
	Appendix C	46	Updated documentation and procedure criteria to reflect what's necessary for prepayment review as opposed to prior authorization.
	Appendix D.2	55	Dental Record recommendation language changed from "must" to "should."