SEPT. 24, 2026

# Ohio Medicaid provider training



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# Meet your presenter

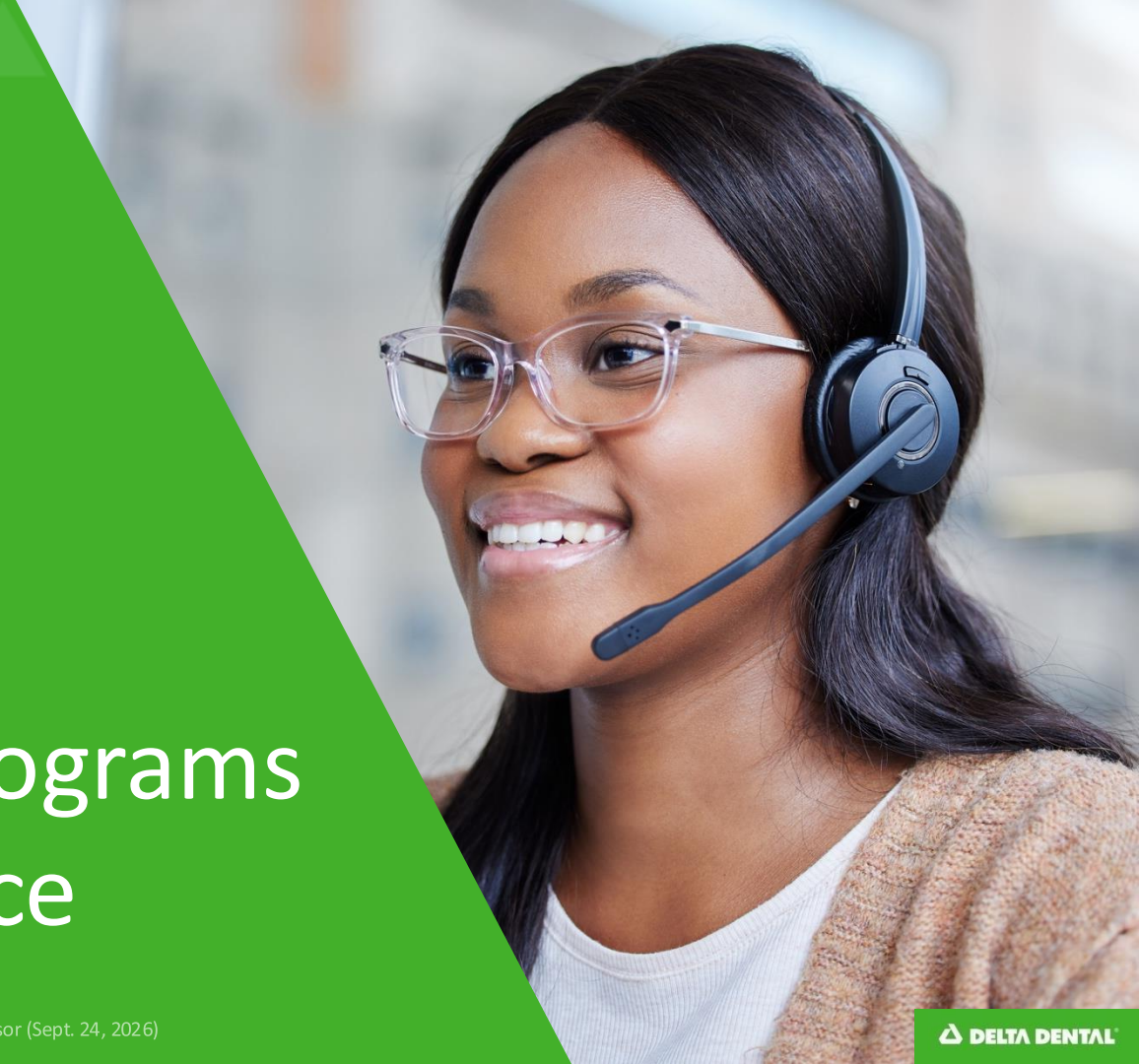
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Professional Services Representative
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## Today's focus:

Non-covered services | Authorization and review | Claim adjustments

HELP US BETTER SERVE YOU

# Government Programs Customer Service



Presented by Kera Tennyson, Government Programs Customer Service Supervisor (Sept. 24, 2026)

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# Agenda

1. Navigating non-covered services
2. Prior authorization vs. pre-payment review
3. Adjustments and provider disputes
4. Provider resources



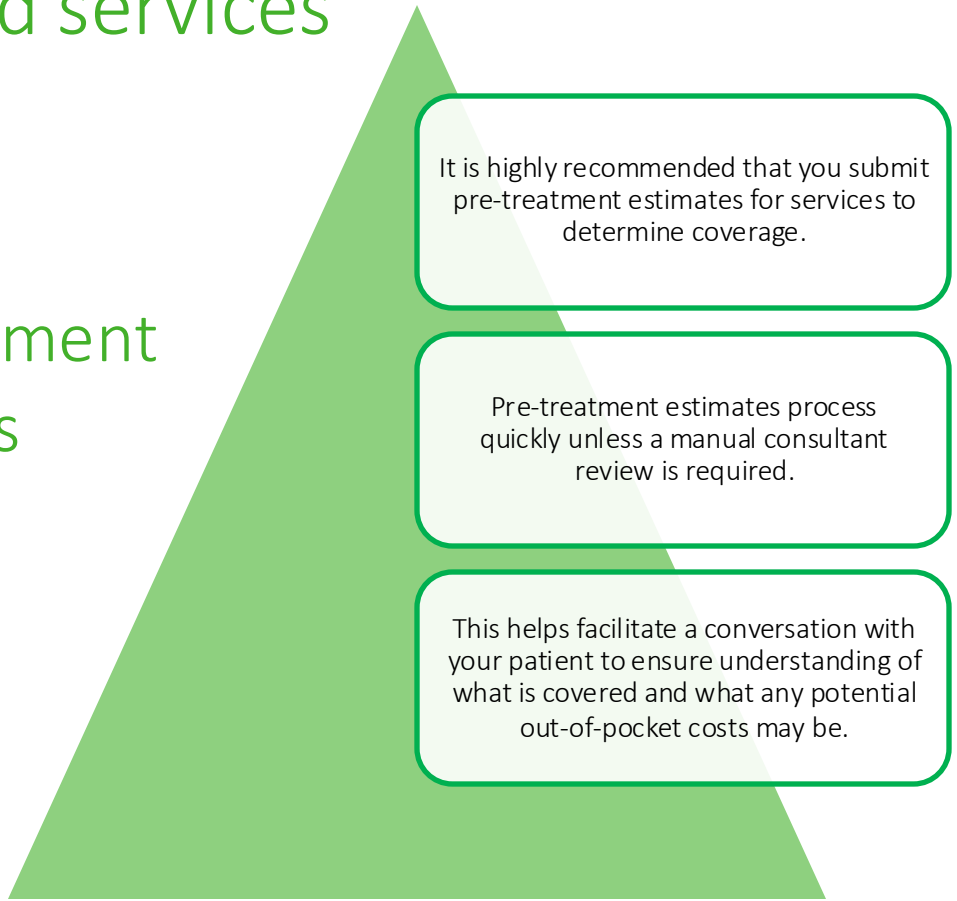
# Navigating non-covered services

- Working with a patient when encountering non-covered services under their Medicaid plan can be difficult.

*Find helpful tips on navigating the situation in the following slides.*

# Navigating non-covered services

## Pre-treatment estimates



# Navigating non-covered services

| | |
|---|---|
| Patient discussion | Once a patient decides to move forward with a non-covered service, the dental office must have the patient sign the **Non-covered Services Form**. |
| Documentation requirements | We recommend using the form located on the deltadentaloh.com website under **Provider Forms**. The form must be signed on or before the date of service by the patient. |
| Why use Delta Dental's form? | Use of this form ensures services and costs are documented according to state and federal guidelines for Medicaid patients. Blanket waiver of liability forms typically do not meet this standard. |

# Navigating non-covered services

## Tips for submitting your claim

All services provided must be billed, even if you have received a pre-treatment estimate stating the service is not covered under the patient's plan.

You do not need to submit the Non-covered Services Form with the in for pay claim.

You must keep the form on file and produce it if requested by Delta Dental of Ohio or CareSource.



# Prior authorization vs. pre-payment review

- Managing prior authorizations and services subject to pre-payment review can feel like you are jumping through many hoops.
- When submitting a prior authorization, you are essentially submitting a pre-treatment estimate.
  - Our system will automatically recognize applicable prior authorization codes and will turn your PTE into a prior authorization.

*Find helpful hints to ensure that your claim is reviewed without additional delays in the following slides.*

# Prior authorization



## What services require a prior authorization (PA)?

Reference your provider manual for all codes that may require a PA. Notable CDT codes are crowns, core build-ups and removable prosthetics (dentures), and orthodontics.



## How long does a PA remain active?

PAs submitted to Delta Dental of Ohio will expire 180 days from the process date.



## What is the PA turnaround time?

Prior authorizations will process within seven calendar days.

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# Prior authorization (continued)

- How should I submit my prior authorization request?
  - Submitting via Dental Office Toolkit™ (DOT) will provide the fastest turnaround time.
  - Referencing your provider manual for all required documents for the CDT code you are submitting
  - Prior authorization requests may still be submitted via clearinghouse.
- How can we submit the documentation needed for the prior authorization?
  - If you are submitting your claim via DOT, you can attach all documents (X-ray, narratives, clinical notes) via the PTE screen.
  - X-rays must be labeled with the patients name, date taken and L and R indicators.
  - You may also continue to use DXC or NEA directly on DOT or your chosen clearinghouse.

# Can a prior authorization review be escalated?

- **Please reference page 136 of the Ohio Tristate Advantage provider manual.** You can call our Government Programs Customer Service number to request a priority review for urgent PA.
  - Please note, there are specific requirements for priority review. Please limit them to needs in **controlling pain, treating infections** and providing **treatment to prevent permanent damage to a patient's health.**

*"Delta Dental will respond to requests for prior authorization within seven calendar days for any request that is not for an urgent dental care procedure. Urgent dental care procedures are defined as procedures that must be provided without delay in controlling pain, treat infections and provide treatment to prevent a dental problem from causing permanent damage to a patient's health. Delta Dental will respond to prior authorization requests for urgent dental care procedures within 72 hours of receiving the request."*

# Requesting priority review for a prior authorization



WHEN SPEAKING WITH OUR CUSTOMER SERVICE REPRESENTATIVE, PLEASE HAVE ALL PATIENT INFORMATION AT HAND.



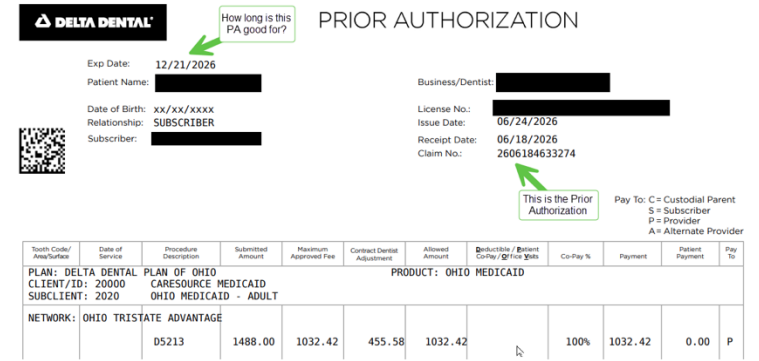
OUR CSR WILL REVIEW THE CLAIM TO ENSURE THAT ALL REQUIRED DOCUMENTATION HAS BEEN INCLUDED WITH THE ORIGINAL CLAIM SUBMISSION.



YOU MUST GIVE A VALID REASON LISTED FROM PAGE 136 IN THE PROVIDER MANUAL.

# Examples: Prior authorization vs. pre-treatment estimate

**Prior authorization:**
Provider EOB



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How long is this PA good for?

PRIOR AUTHORIZATION

Exp Date: 12/21/2026
Patient Name: [redacted]

Date of Birth: xx/xx/xxxx
Relationship: SUBSCRIBER
Subscriber: [redacted]

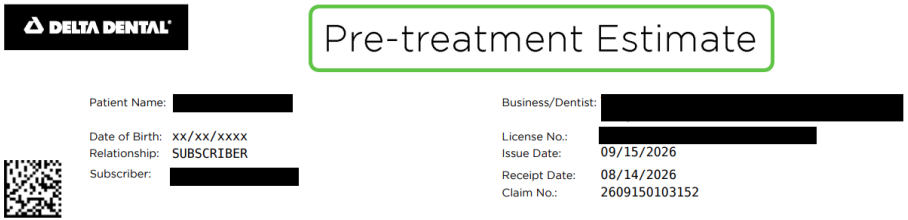
Business/Dentist: [redacted]
License No.: [redacted]
Issue Date: 06/24/2026
Receipt Date: 06/18/2026
Claim No.: 2606184633274

This is the Prior Authorization

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

| Tooth Code/ Area/Surface | Date of Service | Procedure Description | Submitted Amount | Maximum Approved Fee | Contract Dentist Adjustment | Allowed Amount | Deductible / Patient Co-Pay / Office Visits | Co-Pay % | Payment | Patient Payment | Pay To |
|---|---|---|---|---|---|---|---|---|---|---|---|
| PLAN: DELTA DENTAL PLAN OF OHIO PRODUCT: OHIO MEDICAID<br>CLIENT/ID: 20000 CARESOURCE MEDICAID<br>SUBCLIENT: 2020 OHIO MEDICAID - ADULT | | | | | | | | | | | |
| NETWORK: OHIO TRISTATE ADVANTAGE | | | | | | | | | | | |
| | | D5213 | 1488.00 | 1032.42 | 455.58 | 1032.42 | | 100% | 1032.42 | 0.00 | P |

**Pre-treatment estimate:**
Provider EOB



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Pre-treatment Estimate

Patient Name: [redacted]

Date of Birth: xx/xx/xxxx
Relationship: SUBSCRIBER
Subscriber: [redacted]

Business/Dentist: [redacted]
License No.: [redacted]
Issue Date: 09/15/2026
Receipt Date: 08/14/2026
Claim No.: 2609150103152

# Pre-payment review



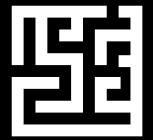
## What is pre-payment review?

A clinical review of certain dental care services designated within the benefit grids which is conducted after claim submission prior to receiving reimbursement to confirm medical necessity.



## If I submit a PTE, does the code still qualify for PPR?

Yes. Your PTE will designate that the service is provisionally estimated and will be reviewed further once submitted in for pay.



## How do I know which codes require PPR?

You can reference your provider manual and look in the Benefits Chart for more specific information about required documentation.

# Pre-payment review (continued)



- Most notable CDT codes that are subject to PPR are:
  - **Oral surgery** (D7270, D7284–D7286, D7310 and D7311)
  - **Anesthesia** (D9222, D9223, D9230, D9239, D9243, D9610)
- Reminder that pre-payment review does not guarantee payment and additional documentation may be requested for review.
- Documentation follows all general guidelines and may be attached directly to the claim via DOT, or you may submit using NEA or DXC.

# Provider manuals

## Prior authorization:

| | | | | |
|---|---|---|---|---|
| D2740 | Crown - porcelain/ceramic | Age 0-20, 21+: One of (D2740, D2751, D2752, D2794) per 60 month(s) per tooth. Teeth 1-32 | PA | Pre-operative x-ray(s) Narrative of medical necessity |
| D2751 | Crown - porcelain fused to predominantly base metal | | | |
| D2752 | Crown - porcelain fused to noble metal | | | |

## Pre-treatment estimate:

| | | | | |
|---|---|---|---|---|
| D9222 | Deep sedation/general anesthesia – first 15 minutes | Age 0-20, 21+: One of (D9222, D9239) per 1 day(s) Not allowed on same day as D9239, D9243 | PPR | Narrative of medical necessity |
| D9223 | Deep sedation/general anesthesia – each subsequent 15-minute increment | Age 0-20, 21+: Four of (D9223) per 1 day(s) | PPR | Narrative of medical necessity |

# Adjustment requests and provider disputes

## Adjustment requests

- Adjustments are requests to change or correct items on a previously processed dental claim to update payment amounts or fix billing errors.
- Procedure Codes, Date of Service and Teeth Numbers are examples of adjustment requests.
- If an adjustment is completed, you will receive an updated EOB.

## Provider disputes

- Any provider inquiries, complaints or requests for reconsideration ranging from general questions about a claim to a provider disagreeing with a claim denial.
- They include any level of dissatisfaction with claims determination, such as reconsiderations, appeals and escalated provider claim inquiries.
- Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial or partial denials of a timeline claim submission—whichever is later.

## Submission guidelines

- DOT
  - Adjustments and provider disputes may be submitted via DOT for Medicaid and FIDE claims.
- Adjustments may also be submitted via email to gpclaimadjustment@mydeltadental.com by using the **claim adjustment form** found on deltadentaloh.com under **Provider Forms**.
- Provider disputes may also be initiated by calling the GP Customer Service number or mailing the request to Delta Dental of Ohio.

# Submitting claim adjustments and provider disputes via DOT



- Do you need to register for DOT?
  - deltadentaloh.com/dentists/dental-office-toolkit

- Once registered, this video will walk you through how to submit claim adjustment requests and provider disputes for Ohio TriState Advantage network members.
  - youtube.com/watch?v=xZtIK5yFpIU

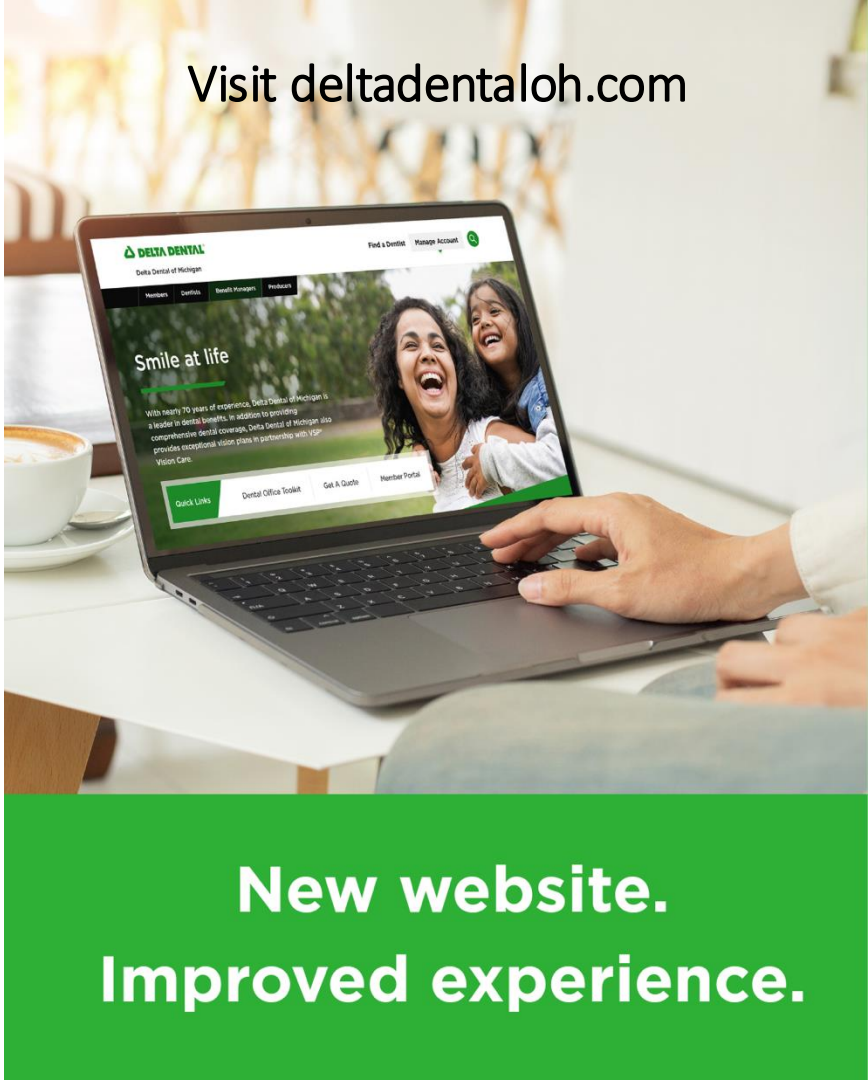


# Provider resources

*Find helpful links and documents to guide you in claim submissions and questions you may have regarding topics discussed today.*

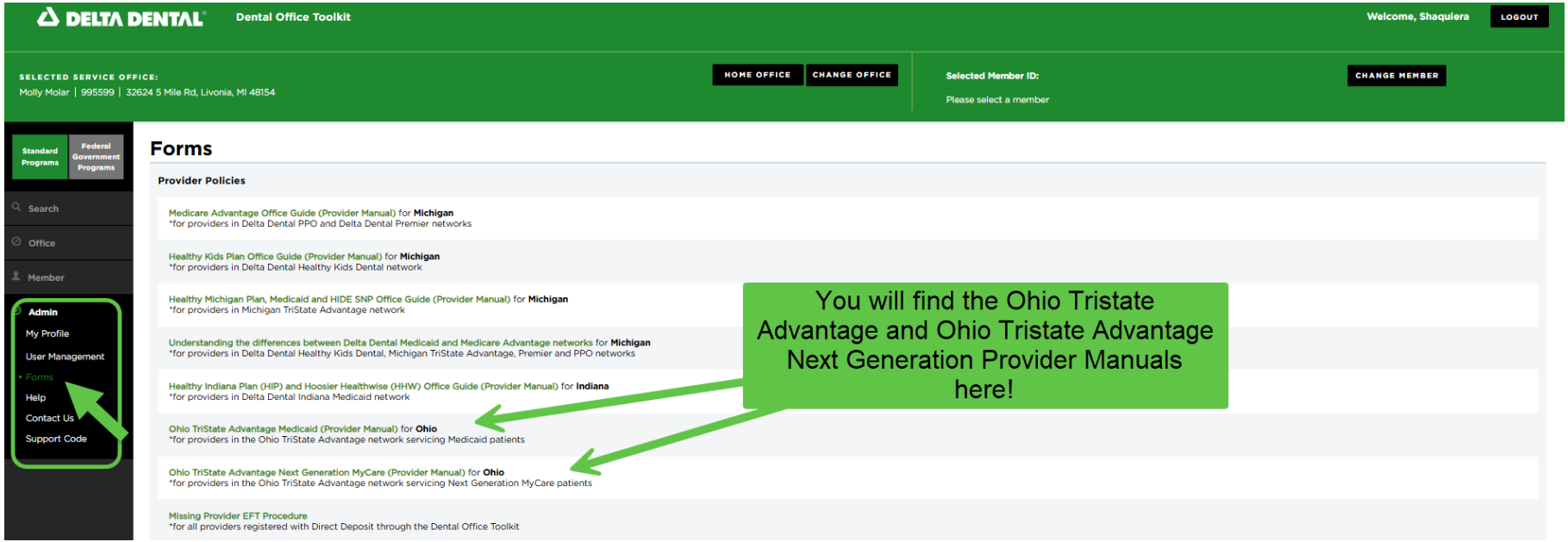
# Helpful links

- Provider forms
  - Non-Covered Services Form
  - Medicare Advantage and Medicaid Claim Adjustment Form
- Clinical criteria
  - deltadentaloh.com/dentists/tools-resources/clinical-criteria
- Peer-to-peer discussion
  - deltadentaloh.com/dentists/tools-resources/peer-peer-discussion




Presented by Kera Tennyson, Government Programs Customer Service Supervisor (Sept. 24, 2026)

# Dental Office Toolkit




Presented by Kera Tennyson, Government Programs Customer Service Supervisor (Sept. 24, 2026)



# Thank you for joining us today!

- I'll be happy to answer any questions from today's training.
- If you have additional questions after today's training, please reach out to your professional services representative.
- We're here to help! You can reach Government Programs Customer Service at 800-488-0134.

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# Pre-submitted questions



- What is the frequency and age limit for Code D1354?
- Why is D2991 being denied when it’s a covered service?
- How do I view a patient's history?
- Are there value-based care payments/incentive payments?
- How do I appeal a prior authorization and/or reasons for denial?
- What are SRP requirements?
- Does fluoride varnish require a prior authorization?
- How does orthodontic treatment get approved for patients?
- What are required documents for submitting claims?

# Thank you for your attendance and participation.

## STAY TUNED FOR THE LAST TRAINING OF 2026



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