



Argus Dental Plan, Inc.

Provider Manual

Please refer to your Participation Agreement for plans in which you contract.

Argus Dental Plan, Inc.
4010 West State Street
Tampa, FL 33609
www.argusdental.com

This document contains proprietary and confidential information and may not be disclosed to others without written permission.



Contact Information

Department Faxes:

Appeals: 813-283-4259

Claims: 813-400-1783

Compliance /FWA/SIU: 813-283-2411

Credentialing: 813-400-1781

Grievances: 813-283-2457

Pretreat – Emergency: 813-283-2412

Pretreat –Standard: 813-283-2441

Provider Relations: 813-400-1782

Quality: 813-283-2405

Department Emails:

Compliance: compliance@argusdental.com -

Credentialing: credentialing@argusdental.com

Management Information Systems:
mis@argusdental.com

Pre – Authorization: pre-authorization@argusdental.com

Provider Relations: pr@argusdental.com

Quality: quality@argusdental.com

Sales & Marketing: sales.marketing@argusdental.com

Department Phone Numbers

813-831-4522 Compliance

877-864-0625 Customer Service – Toll

813-864-0625 Customer Service – Local



The Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognizes your rights while you are receiving dental care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of you the patient. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities are as follows:

- ✓ A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- ✓ A patient has the right to a prompt and reasonable response to questions and requests.
- ✓ A patient has the right to know who is providing dental services and who is responsible for his or her care.
- ✓ A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- ✓ A patient has the right to know what rules and regulations apply to his or her conduct.
- ✓ A patient has the right to be given by the dental care provider, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- ✓ A patient has the right to refuse any treatment, except as otherwise provided by law.
- ✓ A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- ✓ A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for dental care.
- ✓ A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- ✓ A patient has the right to impartial access to dental treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- ✓ A patient has the right to treatment for any emergency dental condition that will deteriorate from failure to receive treatment.
- ✓ A patient has the right to know if dental treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- ✓ A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance process of the dental care provider or dental care facility which served the patient and to the appropriate state licensing agency.
- ✓ A patient is responsible for providing to his or her dental care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his or her health.
- ✓ A patient is responsible for reporting unexpected changes in his or her condition to the dental care provider.
- ✓ A patient is responsible for reporting to his or her dental care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- ✓ A patient is responsible for following the treatment plan recommended by his or her dental care provider.



- ✓ A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the dental care provider or dental care facility.
- ✓ A patient is responsible for his or her actions if he or she refuses treatment or does not follow the dental care provider's instructions.
- ✓ A patient is responsible for assuring that the financial obligations of his or her dental care are fulfilled as promptly as possible.
- ✓ A patient is responsible for following dental care facility rules and regulations affecting patient conduct

Statement of Provider Rights and Responsibilities

Disclaimer:

Argus Dental herein referred as 'Plan' - shall disseminate bulletins as needed to incorporate any needed changes to this document.

The Plan strives to provide the most accurate, up-to-date and reliable information within this document, however the Plan reserves the right to update this document as needed.

Providers shall have the right to:

- 1) Communicate with their patients regarding dental treatment options.
- 2) Recommend a course of appropriate treatment for the patient.
- 3) File an appeal or complaint pursuant to the procedures of Plan.
- 4) Supply accurate, relevant, factual information to the patient or designee in connection with an appeal or complaint.
- 5) Dispute policies, procedures, or decisions made by Plan.
- 6) If a recommended course of treatment is not covered, e.g., not approved by Plan, the participating Provider must notify the member in writing and obtain a signature of waiver if the Provider intends to charge the member for such a non-compensable service.
- 7) Upon request, providers shall be informed of their credentialing application status. .
- 8) Participating Providers are responsible for verifying that members are eligible prior to services being rendered, and to determine if recipients have other dental coverage.



TABLE OF CONTENTS

| | |
|--|---------|
| Plan Eligibility and Member ID Card..... | p.7 |
| Specialist Referral..... | p.8-12 |
| Emergency Referral..... | p.12 |
| Claim Submission | p.13-15 |
| Coordination of Benefits | p.15-17 |
| Grievance and Appeals..... | p.17-18 |
| Utilization Management Program..... | p.19 |
| Quality Improvement Program | p.20 |
| Credentialing..... | p.21 |



The Patient Record.....p.21-25
Compliance..... p.25
Patient Recall System & Compliance Verificationp.25-26
Community Practice p.26
Discipline of Providers..... p.27
Radiology Requirementsp.27-29
Clinical Criteriap.30-37
Cultural Competency Program p.37
Reimbursement of Services Rendered p.38
Website links to online HIPAA Resources.....p.38-39

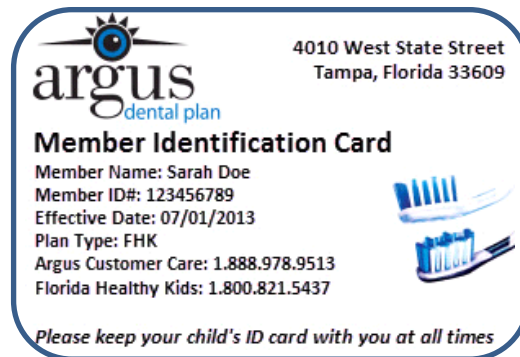


Plan Eligibility

Any person enrolled in the Plan program is eligible for benefits under the certificate.

Member Identification Card

Members will receive a plan ID card. Participating providers are responsible for verifying that members are eligible prior to the services being rendered and to determine if recipients have other dental coverage.



Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

Argus Dental's Eligibility Systems

The Plan offers three options to providers needing to obtain eligibility information. Those options are an Interactive Voice Response (IVR), faxback line and web portal system.

Interactive Voice Response (IVR)

Upon calling the Argus Dental toll-free number 888.978.9513, providers are presented with three options for assistance. After dialing the toll free number, option 1 guides participating providers to the Argus Dental portal system. Option 2 directs providers to the Argus Dental faxback line. Providers can press option 3 to discuss matters with an Argus Dental agent.



IVR Faxback Eligibility System

Upon calling the Argus Dental toll-free number 888.978.9513, providers are presented with three options for assistance. After dialing the toll-free number, option 1 guides participating providers to the Argus Dental portal system. Option 2 directs providers to the Argus Dental faxback line. Providers can press option 3 to discuss matters with an Argus Dental agent.

Access eligibility information via Internet:

Participating providers can access the Argus Dental portal system by logging onto <http://argusdental.com/portal.htm> by registering with their tax identification number and NPI. The portal system grants participating providers access to eligibility along with information pertaining to claims and pre-determinations. The Argus Dental portal system also allows participating providers to submit claims and pre-determinations directly to Argus Dental.

The portal system currently allows Providers to verify a member's eligibility as well as submit claims directly to the Plan.

1. Go to : <http://argusdental.com/portal.htm>
2. Press the Register button
3. Select that you are a 'Provider' accept our Statement of Understanding
4. Please enter your Name, TIN, NPI and phone number.
5. Please enter your username, password, email and security question/answer
6. From here you will be granted access to view patient eligibility, claim information, and even upload claims if you wish!
7. Questions can be sent to mis@argusdental.com

We will require your TIN, NPI and phone number along with the provider's name and and/or practice name. From here, we can grant you access to your members eligibility and claim information.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If you are having difficulty accessing either the IVR or website, please contact the member services at 1.888.978.9513. They will be able to assist you in utilizing either system.

Website: Provider Section

Providers can access the Argus Dental website provider section to important plan information and required documents.



Specialist Referral Process

The Plan requires a primary care dentist to contact the Dental's Case Manager if the primary care dentist determines that the member needs to be referred to a specialist. The primary care dentist shall provide the reason for the referral and any pertinent member information required in order for the specialist to see the member.

Specialists include:

- **Endodontist**
- **Orthodontist**
- **Oral Surgeon**
- **Periodontist**
- **Prosthodontist**

Specialist Referral Process and Form

Primary Care dentist will provide most of the dental treatment that Members need but when a Primary Care dentist determines that the dental services a Member needs is outside the scope of their capabilities, the dentist will submit a specialist referral to Argus on the Member's behalf.

Argus will determine if the treatment outlined in the referral is necessary depending on the documentation provided by the primary care dentist and the authorization guidelines. Once it is determined that the treatment is necessary, an Argus case coordinator will locate and contact an in-network Specialist and inform the office of the pending member's name and referral purpose. The Argus case coordinator will then contact the Member and advise them of the Specialist to contact for the referred procedures.

The specialist referral form can be found on p. xx in the back of the manual. You may also download online at www.argusdental.com/providers/fhk/ Password: dental (lowercase)

Pediatric Dentists

The Plan requires a referral to a pediatric dentist, only if the pediatric dentist is acting as a specialist, and is referred by the patient's primary care dentist.

Specialty Referral for Treatment – Statewide Providers Only

The Plan categorizes all general dentists and pediatric dentists as primary care providers. However, if a general dentist refers a patient to a pediatric dentist then a pediatric dentist is subject to a referral. It is



the primary care dentist responsibility to contact the Plan for the referral approval. General dentists and pediatric dentists must follow the following referral guidelines for other specialty treatment:

Orthodontics – New Cases

New orthodontic consultations and/or treatments require a referral to a participating Orthodontist by a General, or Pediatric Dentist.

Orthodontics – Continuation of Care

Orthodontic continuation of care cases where the provider can show documentation of an approved prior authorization that has not expired are not subject to a referral.

Specialty Referral for Treatment

Orthodontist

If a member requires treatment that is beyond the scope of the General dentist or Pediatric dentist, the member may be referred to a participating Orthodontist. All plans require referrals from a General dentist or Pediatric dentist to an Orthodontist. All Orthodontic referrals from a General dentist or Pediatric dentist require approval by the Plan.

For a referral to be processed, the General dentist and Pediatric dentist must submit the following:

- ✓ The Plan Specialty Referral Form.
- ✓ Panoramic or Full Mouth Series of radiographs.
- ✓ Narrative with the classification of occlusion.
- ✓ Measurement of overbite and overjet.

The following condition must exist in order to refer a member to a participating orthodontist:

- 1) Orthodontic services are limited to those circumstances where the member's condition creates impairment to their overall physical development, as defined in the Plan's schedule of benefits. and as defined in the Florida Medicaid Dental Coverage and Limitations Handbook

Once the referral is approved, the Plan will direct the member for a full orthodontic evaluation to a participating orthodontist. The Orthodontist will submit the recommendation, with all supporting documentation in order to gain prior authorization for treatment. The required documentation includes the following:

- ✓ Initial Orthodontist Assessment Form (IAF).
- ✓ Narrative or Rationale including diagnosis/treatment plan (On a case-by-case basis).
- ✓ Lateral cephalometric radiograph
- ✓ Study models or equivalent appropriate photographs.



Appropriate photographic requirements include:

- ✓ Facial photographs (right and left profiles in addition to a straight-on facial view)
- ✓ Frontal view, in occlusion, straight-on view
- ✓ Frontal view, in occlusion, from a low angle
- ✓ Right buccal view, in occlusion
- ✓ Left buccal view, in occlusion
- ✓ Maxillary Occlusal view
- ✓ Mandibular Occlusal view

In addition to or in lieu of the above photographic requirement, the Plan will accept quality photographs of study models with the following parameters:

- ✓ Occlusal view of the maxillary arch
- ✓ Occlusal view of the mandibular arch
- ✓ Right buccal view, in occlusion
- ✓ Left buccal view, in occlusion
- ✓ Facial views, straight on and low angle, in occlusion
- ✓ Posterior view of models in occlusion

Reimbursement for the pre-orthodontic treatment visit, procedure code, includes diagnostic casts or equivalent or appropriate photographs, radiographs (panoramic and cephalometric), and the diagnosis and treatment plan. These services are not reimbursed separately.

The Plan reimburses for code only if a request for prior authorization, along with diagnostic record components, has been submitted for review.

Orthodontic services will not be covered for the following conditions:

- ✓ Treatment primarily for cosmetic purposes; or
- ✓ Split phase treatment, with exception of cleft palate cases
- ✓ Cases that do not meet the point scoring guidelines from the Plan schedule of benefits. (The case must be considered dysfunctional and have a minimum of 26 points on the IAF form)

Interceptive orthodontic treatment under the Plan program will include only treatment for anterior or posterior crossbite and may be considered treatment in full and reimbursed once in a lifetime. The provider must submit a prior authorization request for all orthodontic procedures requesting x-bite therapy and full treatment if appropriate. The most cost-effective treatment plan may be approved.

Cleft and orthographic surgery cases are excluded from the "treatment in full policy" and are considered on a case-by-case basis.



The Plan will make the final determination for orthodontic treatment upon receipt of all the work-up materials.

Periodontist

Requests for referral for Periodontal Treatment require the following documentation:

- ✓ Diagnosis to include Periodontal Disease Classification.
- ✓ Mounted Full Mouth Series of Radiographs.
- ✓ Periodontal Charting.
- ✓ Intra-oral pictures when submitting for codes 4210 and 4211.
- ✓ Narrative

Oral Surgeons

The following conditions must exist in order for General dentist or a Pediatric dentist to refer a member to a participating Oral Surgeon:

- ✓ Tooth broken down below the bone level
- ✓ Severely Dilacerated Roots
- ✓ Roots or Root Apex in the sinus
- ✓ Third Molar Impactions
- ✓ For other conditions beyond the scope of a General or Pediatric dentist

Routine, uncomplicated extractions, removal of soft tissue impactions and minor surgical procedures are considered basic services and the responsibility of the general dentist. Only when it is beyond the scope of the general dentist, may the member be referred to a plan participating Oral Surgeon.

The Plan will not reimburse for any surgical extraction of third molars which are asymptomatic or do not exhibit any evidence of pathology or which were extracted for prophylactic reasons only.

The following are criteria required for the approval of third molar extractions.

- ✓ Recurrent Pericoronitis
- ✓ Non-restorable Carious Lesion
- ✓ Dentigerous Cyst
- ✓ Internal or External Resorption
- ✓ Periodontal Disease in connection with an adjacent third molar
- ✓ Any potential future damage to the adjacent tooth
- ✓ Pathology involving a third molar



In the event that any procedures are not consistent with our guidelines, the Plan reserves the right to deny the referral.

Emergency Referral Requests

The Plan has established an “Emergency” request fax line to expedite the receipt and processing of all emergency requests and to assure that emergency care is not delayed. The number to this fax line is 813.283.2412. When submitting a (non-hospital) “emergency” request for referral, please assure that the patient’s emergency condition and treatment rendered meet the definition of emergency and that the palliative care rendered is clearly stated on the request form. By definition and statutory requirement, all emergency services and care are required to be rendered immediately, within the same day. If this is not the case, please do not fax non-emergent requests to the Plan, indicating they are emergent, in order to obtain a more expedient response.

Appeal Process

The Plan providers have a right to file an appeal for a referral, as well as a denied prior authorization, claim, or other denial made by a the Plan Dental consultant. A submittal for an appeal in writing with a narrative and supporting documentation to the to the appeals fax line or by US mail.

Review & Claim Submission Procedures (Claim Filing Options) and Encounter Data

The Plan administers a review of certain procedures required to ensure that the procedures meet the requirements of dental standards of care and, federal and state laws and regulations. The plan performs a pre-treatment review and submits an authorization, denial or alternative benefit to the provider prior to starting or completing the treatment.

A pre-treatment review requires specific documentation such as radiographs, narratives and/or periodontal charting to establish dental necessity or justification for the procedure. The Plan schedule of benefits outlines all procedures that require a pre-treatment review, and the required documentation.

Upon submission of the completed authorized procedures, it is expected that the authorization number be documented by the provider, in field 2 or 35 of the ADA approved claim form. Authorizations are valid for 90 days from the original authorization date. If a procedure is billed without an approval, or the authorization is expired; the claim will be denied.

If for any reason authorized treatment cannot be completed within 90 days, a new pre-treatment review including all documentation must be re-submitted for review. A new authorization, denial, or alternate benefit will be provided in a timely manner.

The Plan receives dental claims in the following formats:



- ✓ Electronic claims via the Plan's web portal
- ✓ Electronic submission via your clearinghouse
- ✓ HIPAA Compliant 837D File
- ✓ Paper claims

The plan utilizes claims submissions and information to collect encounter data.

Electronic Attachments

The plan accepts dental radiographs electronically via FastAttach™ for review requests. The Plan, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating Providers the opportunity to submit attachments to claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontal charts, intraoral pictures, narratives and EOBs. It is compatible with most claims clearinghouse or practice management systems.

Submitting X-Rays for Prior Authorization or Claims that Require Prepayment Review

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended
- Submission of duplicate radiographs: Radiographs will not be returned, please so not send original

All radiographs should include member's name, identification number and office name to ensure proper handling.

If you have questions on submitting prior authorizations or claims or accessing the website, please contact the Plan's Management Information Systems Department (MIS).

Electronic Claim Submission via Clearinghouse

In some markets, Dentists may submit their claims to Argus Dental via Emdeon utilizing an 837D file.

You can contact your software vendor and make certain that they have a relationship with Emdeon and have Argus Dental listed as a payer. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to Emdeon. Argus Dental's payer ID is ARGUS.

NPI Requirements for Submission of Electronic Claims

- ✓ When submitting claims to the Plan you must submit all forms of NPI and TIN properly in their



entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's and TIN. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.

- ✓ If you are presently submitting claims to the Plan through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D 5010 format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

Paper Claim Submission

Claims must be submitted on an ADA approved claim form or other forms approved in advance by the Plan. All information included on the claim must be legible.

The member's name, identification number and date of birth must be listed on all claims submitted. If the member identification number is missing or miscoded on the claim form, the patient cannot be identified. These situations may result in delay in claim processing.

The paper claim must contain:

- Legible provider signature
- Provider and office location information clearly identified
- Dentist signature alone is insufficient for identification of the provider
- Typed dentist (practice) name or the Plan's Provider identification number

The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.

The date of service must be provided on the claim form for each service line submitted.

Approved ADA dental codes as published in the current CDT book or as defined in the schedule of benefits.

List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.



Claims should be mailed to the following address:

Argus Dental Plan
Attn: Claims
4010 W. State Street
Tampa, FL 33609

Coordination of Benefits (COB)

When the Plan is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, the Plan will consider the claim paid in full and no further payment will be made on the claim.

Filing Limits

Each provider contract specifies a specific timeframe after the date of service for when a claim must be submitted to the Plan. Any claim submitted beyond the timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing", the provider cannot bill the member. If the Plan is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

Receipt and Audit of Claims

In accordance with regulatory requirements, the Plan performs routine and focused audits, to evidence the Plan's commitment to compliance with all applicable guidelines, law and regulation.

Each Plan Dental Provider office receives an "explanation of benefit" report with their remittance. This report documents all patient information submitted on the claim with allowable fee, by date of service for each service rendered.

Regulatory Requirements

The Plan adheres to all state and federal regulatory requirements, including all guidance of the Centers for Medicare and Medicaid rules and regulations; and performs all services in accordance with such requirements; including but not limited to the HIPAA Final Rule Omnibus, Affordable Care Act and False Claims Act. The Plan's participation providers adhere to any such applicable standards, described in these or any regulatory requirements.

Health Insurance Portability and Accountability Act (HIPAA)



As a dental healthcare provider, your office is required to comply with all aspects and activities of the HIPAA regulations and any revisions to HIPAA, including but not limited to the HIPAA Omnibus Final Rule that have gone/will go into effect as indicated in the final publications of the various HIPAA rules.

The Plan has implemented various operational policies and procedures also compliant with the Privacy Standards. The Plan is compliant with Administrative Simplification and Security Standards. One aspect of our compliance plan is to work cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, provider contracts reflect the appropriate HIPAA compliance language. Providers are supplied various tools by the Plan to facilitate HIPAA compliance; details of which may be obtained by contacting compliance@argusdental.com.

The contractual updates include the following in regard to record handling and HIPAA requirements:

- ✓ Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.
- ✓ Safeguarding of all information about members according to applicable state and federal laws and regulations. All material and information, in particular information relating to members or potential members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- ✓ Neither the Plan nor Provider shall share confidential information with a member's employer absent the member's consent for such disclosure.

Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with the Plan in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and the Plan agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, the Plan will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.



Note: Copies of the Plan's HIPAA policies are available upon request by contacting the Compliance department at compliance@argusdental.com.

HIPAA 834D Companion Guide

To receive a copy of the most recent Companion Guide please contact our MIS Department via e-mail or phone.

Member & Provider Inquiries, Complaints, Grievances & Appeals

The Plan adheres to State, Federal, and Plan requirements related to processing inquiries, complaints, and grievances. Enrollees have the right to request continuation of benefits while utilizing the grievance system. Unless otherwise required by Agency and the Plan process such inquiries, complaints, grievances and appeals consistent with the following:

Inquiry: An inquiry is the first contact with the Plan (verbal or written) expressing dissatisfaction from the member, an attorney on behalf of a member, or a government agency.

Complaint: A complaint is any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights, health plan administration, claims practices, or provision of services that relates to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system. A complaint is the lowest level of challenge and provides the health plan an opportunity to resolve a problem without its becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.

Grievance: An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or health plan employee or failure to respect the enrollee's rights.

Appeal – A formal request from an enrollee to seek a review of an action taken

Complaints/Grievance Staff:

The Plan's Complaints/Grievance Coordinator receives member and provider inquiries, complaints, grievances and appeals. The Complaints/Grievance Coordinator has office hours from Monday through Friday, 8:00am to 5:00pm. The Coordinator investigates the issues, compiles the findings, requests



patient records (if applicable), sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals are notified of the resolution (i.e. Plan, member, and Provider as applicable). The complaint is closed and maintained on file for tracking and trending purposes.

The Complaints/Grievances Coordinator receives member and provider grievances. The Coordinator requests appropriate documentation, forwards the documentation to the dental consultant for review and determination. The decision to uphold or overturn the initial decision is communicated to the appropriate individuals.

Contracted providers have a right to file an appeal for denied claims (which include prepayment review process), prior authorizations and/or referral determinations. This can be done by submitting a request for appeal in writing with a narrative and supporting documentation via mail or fax.

Policy and Procedures:

Copies of the Plan's policies and procedures can be requested by contacting Provider Services at 888.978.9513, ext. 5.

Utilization Management Program

Evaluation

The Plan's Utilization Management Programs evaluate claims submissions in such areas as:

- ✓ Diagnostic and preventive treatment;
- ✓ Patient treatment planning and sequencing;
- ✓ Types of treatment;
- ✓ Treatment outcomes; and
- ✓ Treatment cost effectiveness.

Fraud, Waste and Abuse

The Plan is committed to detecting, reporting and preventing potential fraud, waste and abuse. Fraud, Waste and Abuse are defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.



Waste - Over-utilization of services (not caused by negligent actions) or the misuse of resources.

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care may be referred to the appropriate state regulatory agency.

Member Fraud: If a Provider suspects a member of ID fraud, drug-seeking behavior, or any other fraudulent behavior, this should be reported to the Plan's Compliance Department. .

Quality Improvement Program

The Plan administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) and AAAHC standards. The NCQA and AAAHC standards are adhered to; as the standards apply to dental managed care. The Quality Improvement Program includes but is not limited to:

- ✓ Provider credentialing and re-credentialing
- ✓ Member satisfaction surveys
- ✓ Provider satisfaction surveys
- ✓ Random Chart Audits
- ✓ Complaint Monitoring and Trending
- ✓ Peer Review Process.
- ✓ Utilization Management and practice patterns.
- ✓ Initial Site Reviews and Dental Record Reviews.
- ✓ Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time, access to care, etc.)

A copy of the Plan's Quality Improvement Program is available upon request by contacting the Provider Services Department.

The Plan has the sole right to determine which dentists (DDS or DMD); it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of Participating Providers. The Plan considers each Provider's potential contribution to the objective of providing effective and efficient dental services to members of the Plan.



The Plan's credentialing process adheres to National Committee for Quality Assurance (NCQA) and AAAHC standards as the guidelines apply to dentistry.

Nothing in this Credentialing Plan limits the Plan's sole discretion to accept and discipline Participating Providers. No portion of this Credentialing Plan limits the Plan's right to permit restricted participation by a dental office or the Plan's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement, and in accordance with the regulatory requirements and accreditation standards.

The Plan has the final decision-making power regarding network participation. The Plan will notify the applicable regulatory bodies and/or health plan clients of all disciplinary actions enacted upon Participating Providers, as applicable.

Appeal of Credentialing Committee Recommendations

If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

The applicant must request a reconsideration/appeal in writing and the request must be received by the Plan within 30 days of the date the Committee gave notice of its decision to the applicant.

Discipline of Providers

- Procedures for Discipline and Termination
- Re-credentialing
- Network Providers are re-credentialed at least every 36 months.

Note: The aforementioned policies are available upon request by faxing the Credentialing Department.

The Patient Record

Organization

1. The record must have areas for documentation of the following information:
 - a. Registration data including a complete health history.
 - b. Medical alert predominantly displayed inside chart jacket.
 - c. Initial examination data.
 - d. Radiographs.
 - e. Periodontal and Occlusal status.



- f. Treatment plan/Alternative treatment plan.
 - g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
 - h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).
2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information.
 - a. Health history
 - b. Medical alert
 - c. Examination/recall data
 - d. Periodontal status
 - e. Treatment plan
3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.
4. The design of the record must ensure that all components must readily identify the patient, (i.e., patient name, and identification number on each page clearly marked).
5. The organization of the record system must require that individual records be assigned to each patient, allowing records to be easily identified.

Content-The patient record must contain the following:

1. Adequate documentation of registration information which requires entry of these items:
 - a. Patient's first and last name.
 - b. Date of birth.
 - c. Sex.
 - d. Address.
 - e. Telephone number.
 - f. Name and contact number of person in case of emergency.
2. An adequate health history that requires documentation of these items:
 - a. Current medical treatment.
 - b. Significant past illnesses.
 - c. Current medications.
 - d. Drug allergies.
 - e. Hematologic disorders.
 - f. Cardiovascular disorders.
 - g. Respiratory disorders.
 - h. Endocrine disorders.



- i. Communicable diseases.
 - j. Neurologic disorders.
 - k. Signature and date by patient.
 - l. Signature and date by reviewing dentist.
 - m. History of alcohol and/or tobacco usage including smokeless tobacco.
3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
 - a. Significant changes in health status.
 - b. Current medical treatment.
 - c. Current medications.
 - d. Dental problems/concerns.
 - e. Signature and date by reviewing dentist.
4. A conspicuously placed medical alert inside the chart jacket that documents highly significant conditions from health history. These items are:
 - a. Health problems which contraindicate certain types of dental treatment.
 - b. Health problems that require precautions or pre-medication prior to dental treatment.
 - c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
 - d. Drug sensitivities.
 - e. Infectious diseases that may endanger personnel or other patients.
5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:
 - a. Blood pressure. (Recommended)
 - b. Head/neck examination.
 - c. Soft tissue examination.
 - d. Periodontal assessment.
 - e. Occlusal classification.
 - f. Dentition charting.
6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:
 - a. Blood pressure. (Recommended)
 - b. Head/neck examination.



- c. Soft tissue examination.
- d. Periodontal assessment.
- e. Dentition charting.

7. Radiographs which are:

- a. Identified by patient name.
- b. Dated.
- c. Designated by patient's left and right side.
- d. Mounted (if intraoral films).

8. An indication of the patient's clinical problems/diagnosis.

9 Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

- a. Procedure
- b. Localization (area of mouth, tooth number, surface).

10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

- a. Periodontal pocket depth.
- b. Furcation involvement.
- c. Mobility.
- d. Recession.
- e. Adequacy of attached gingiva
- f. Missing teeth.

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

- a. Gingival status
- b. Amount of plaque
- c. Amount of calculus
- d. Education provided to the patient
- e. Patient receptiveness/compliance
- f. Recall interval
- g. Date

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:

- a. Provider to whom consultation is directed.



- b. B Information/services requested.
 - c. Consultant's response.
13. Adequate documentation of treatment rendered which requires entry of these items:
- a. Date of service/procedure.
 - b. Description of service, procedure and observation.
 - c. Type and dosage of anesthetics and medications given or prescribed.
 - d. Localization of procedure/observation. (Tooth #, quadrant etc.)
 - e. Signature of the Provider who rendered the service.
14. Adequate documentation of the specialty care performed by another dentist that includes:
- a. Patient examination.
 - b. Treatment plan.
 - c. Treatment status.

Compliance

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

Patient Recall System Requirements

Recall System Requirement

Each participating Plan dental office is required to maintain and document a formal system for patient recall. The system can either utilize written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any health plan member that has sought dental treatment.

If a written process is utilized, the following language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."



Dental offices indicate that patients sometimes fail to show up for appointments. The Plan offers the following suggestions to decrease the “no show” rate.

- Contact the member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

Office Compliance Verification Procedures

- In conjunction with its office claim audits. Quality Improvement Program, the Plan will measure compliance with the requirement to maintain a patient recall system. The Plan’s Dental Dentists are expected to meet minimum standards with regards to appointment availability.
- Emergency care must be available 24 hours, 7 days a week.
- Urgent care must be available within one day.
- Sick care must be available within one week.
- Routine care must be available within one month.
- Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.
-

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment.

In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or “budgets” the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there is usually no patient co- payment, these dollars represent all the reimbursement available to the dentist. These “budgeted” dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

Community Practice Patterns

To do this, the Plan has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist’s treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the “community practice patterns” of local dentists and their peers. With this in mind, the Plan’s Utilization Management Programs are designed to ensure the fair and appropriate distribution of



healthcare dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these patterns. The Plan's Utilization Management Program acknowledges that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

Evaluation

The Plan's Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment;
- Patient treatment planning and sequencing;
- Types of treatment;
- Treatment outcomes; and
- Treatment cost effectiveness.

Results

Therefore, with the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance Dental Program dollars to dentists, the Plan's Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information, dentists will implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement.

Appeal of Credentialing Committee Recommendations.

If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation if presented within the timeframes covered within the P&P's. P&P's

The applicant must request a reconsideration/appeal in writing and the request must be received within 30 days of the date the Committee gave notice of its decision to the applicant.

Discipline of Providers



Procedures for Discipline and Termination are in accordance with the regulatory requirements and AAAHC & NCQA standards, as applicable. The Plan re-credentials Network Providers every 36 months in accordance with regulatory requirements and AAAHC & NCQA standards as applicable.

Note: The aforementioned policies are available upon request by contacting the Compliance department.

Radiology Requirements

Note: Please refer to benefit tables for radiograph benefit limitations

The Plan utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration.

- A. Radiographic Examination of the New Patient
- 1. Child – Primary Dentition

The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

- 2. Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

- 3. Adolescent – Permanent Dentition Prior to the eruption of the third molars

The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new adolescent patient.

Radiographic Examination of the Recall Patient

- 1. Patients with clinical caries or other high – risk factors for caries
- a. Child – Primary and Transitional Dentition

The Panel recommends that posterior bitewings be performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

- b. Adolescent



The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

Patients with no clinical caries and no other high risk factors for caries

a. Child – Primary Dentition

The Panel recommends that posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

Adolescent

The Panel recommends that posterior bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

a. Child – Primary Dentition

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

b. Child – Transitional Dentition

The Panel recommends an individualized periapical/occlusal series OR a panoramic radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. Adolescent

The Panel recommends that for the adolescent (age 16-19 years of age) recall patient, a single set of periapicals of the wisdom teeth OR a panoramic radiograph.

Criteria for Radiographs

American Dental Association (ADA) and American Association of Pediatric Dentists (AAPD) guidelines promote, that the number and type of radiographs should be based on the risk level of the patient and whether or not the provider can visualize the entire tooth. The following link describes current ADA and AAPD guidelines for radiographs.

http://www.ada.org/sections/professionalResources/pdfs/topics_radiography_chart.pdf



It is a fairly common occurrence for providers to perform a panoramic film instead of a full mouth series. Panoramic films alone are not considered sufficient for the diagnosis of decay, and must be accompanied by a set of bitewing X-rays if they are to be used as an aid for full diagnostic purposes. In cases where a provider is combining a panoramic film and bitewings, the benefit will equal that of a full mouth series. This recoding of services aligns with the concept of medical necessity (reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide) and, according to the ADA, is a result of requests from the dental community.

GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS

The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age and pregnant women.

American Dental Association, US Food & Drug Administration. The Selection of Patients for Dental Radiograph Examination. Available on www.ada.org

http://www.ada.org/sections/professionalResources/pdfs/topics_radiography_chart.pdf

Health Guidelines – (Ages 0-18 Years)

NOTE: Please refer to benefit tables for benefits and limitations.

Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003) Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines)

Clinical Criteria

The criteria outlined in the Plan's Provider Office Reference Manual (ORM) are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for review, such as radiographs, periodontal charting, treatment plans, or descriptive narratives.

These criteria were formulated from information gathered from practicing dentists, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as



guidelines for review and payment decisions and are not intended to be all-inclusive or absolute. Additional narrative information is appreciated when there may be a special situation.

The Plan's hope is that the enclosed criteria will provide a better understanding of the decision-making process for reviews. The goal of incorporating generally accepted criteria that will be consistent with the ADA, State and Health Plan requirements, and dental standards of care. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. The Plan shares your commitment and belief to provide quality care to patients and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not and you should check the Plan's schedule of benefits. In addition, there may be additional program specific criteria regarding treatment. Therefore it is essential you review the schedule of benefits prior to providing any treatment.

Criteria for Dental Extractions Not all procedures require review. Documentation needed for review procedure:

- ✓ Appropriate radiographs showing clearly the adjacent teeth should be submitted for review: bitewings, periapicals or panorex.
- ✓ Narrative stating necessity
- ✓ Treatment rendered under emergency conditions, when review is not possible, will still require appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- ✓ The removal of primary teeth whose exfoliation is imminent does not meet criteria. Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered subject to consultant review.
- ✓ Appropriate radiographs and a narrative stating the necessity should be submitted for review.

Criteria for Cast Crowns

Documentation needed for review of procedure:

- ✓ Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for review: bitewings, periapicals or panorex.

Criteria



- ✓ In general, criteria for crowns will be met only for permanent teeth needing multi- surface restorations where other restorative materials have a poor prognosis.
- ✓ Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- ✓ Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- ✓ Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria

- ✓ Request should include a dated post-endodontic radiograph.
- ✓ Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- ✓ The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or dentures in the opposite arch or be an abutment for a partial denture.

- ✓ The patient must be free from active and advanced periodontal disease.
- ✓ The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth.
- ✓ Cast Crowns on permanent teeth are expected to last, at a minimum, five years. Approval for
- ✓ Crowns will not meet criteria if:
- ✓ A more cost effective means of restoration is possible that provides quality care and meets the standard of care.
- ✓ Tooth has subosseous and/or furcation caries.
- ✓ Tooth has advanced periodontal disease.
- ✓ Tooth is a primary tooth.
- ✓ Crowns are being planned to alter vertical dimension.

Criteria for Endodontics

Not all procedures require review. Documentation needed for review of procedure:

- ✓ Sufficient and appropriate radiographs showing clearly the adjacent teeth and a pre- operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.



- ✓ Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- ✓ Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- ✓ Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- ✓ Root canal treatment limited to permanent teeth or retained primary teeth with no succedaneous permanent teeth.

Approval for Root Canal therapy will not meet criteria if:

- ✓ Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- ✓ The general oral condition does not justify root canal therapy due to loss of arch integrity.
- ✓ Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- ✓ Tooth does not demonstrate 50% bone support.
- ✓ Root canal therapy is in anticipation of placement of an overdenture.
- ✓

Other Considerations

- ✓ Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.
- ✓ In cases where the root canal filling does not meet the Plan's treatment standards, the Plan can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the Plan reviews the circumstances.

Criteria for Stainless Steel Crowns

- 1) Reference the Plan's schedule of benefits to determine if review is required .Where review is



required for primary or permanent teeth, the following criteria and documentation apply:

Documentation needed for review of procedure:

- ✓ Appropriate radiographs or digital photographic images showing clearly the adjacent teeth, including submittal for review:
- ✓ bitewings, periapicals or panorex.
- ✓ Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review prior to payment.
- ✓ In general, criteria for stainless steel crowns will be met only for teeth needing multi- surface restorations where amalgams and other materials have a poor prognosis.
- ✓ Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- ✓ Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- ✓ Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- ✓ Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

An approval for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- ✓ Request should include a dated post-endodontic radiograph.
- ✓ Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- ✓ The filling must be properly condensed/obdurated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- ✓ The patient must be free from active and advanced periodontal disease.
- ✓ The permanent tooth must be at least 50% supported in bone.

Stainless steel crowns on permanent teeth are expected to last five years. Approval of treatment using stainless steel crowns will not meet criteria if:

- ✓ A more cost effective means of restoration is possible that provides quality care and meets the standard of care.
- ✓ Tooth has subosseous and/or furcation caries.



- ✓ Tooth has advanced periodontal disease.
- ✓ Tooth is a primary tooth with exfoliation imminent.
- ✓ Crowns are being planned to alter vertical dimension.

Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for review of procedure:

- ✓ Treatment plan.
- ✓ Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for review: bitewings, periapicals or panorex.

Criteria

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- ✓ A denture is determined to be an initial placement under the plan.
- ✓ Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- ✓ Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- ✓ Partial dentures will not be covered for a single tooth unless it is an anterior tooth
- ✓ Partial dentures are not covered if there are at least 8 teeth in occlusion.
- ✓ As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- ✓ In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), the treating dentist must determine that the existing denture is unserviceable, and cannot be made serviceable to qualify for replacement.

In general, a partial denture will be approved for benefits for if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full sized teeth.

Approval for removable prosthesis will not meet criteria:

- ✓ That is determined by the dentist to be unserviceable and cannot be made serviceable. If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- ✓ If there are untreated cavities or active periodontal disease in the abutment teeth.



- ✓ If abutment teeth are less than 50% supported in bone.
- ✓ If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
- ✓ If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- ✓ If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- ✓ If there is a pre-existing prosthesis, it must be at unserviceable and cannot be made serviceable as determined by the dentist to qualify for replacement.
- ✓ Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After 6 months of denture placement
- ✓ Adjustments will be reimbursed after 6 months of placement. Repairs will be reimbursed at two repairs per denture per year, within 6 months of placement.
- ✓ All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- ✓ When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for review of procedure:

- ✓ Treatment plan (authorized if necessary).
- ✓ Narrative describing medical necessity for general anesthesia or IV sedation.
- ✓ Treatment rendered under emergency conditions, when review is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

A request for general anesthesia or IV sedation (see the plan's schedule of benefits for limitations) is covered subject to a review following the criteria below.

Extensive or complex oral surgical procedures such as:

- ✓ Impacted wisdom teeth.



- ✓ Surgical root recovery from maxillary antrum.
- ✓ Surgical exposure of impacted or unerupted cuspids.
- ✓ Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- ✓ Medical condition(s) which require monitoring (e.g. Cardiac problems, severe hypertension).
- ✓ Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down syndrome) which would render patient non-compliant.
- ✓ Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- ✓ Patients 3 years old and younger with extensive procedures to be performed.

Criteria for Periodontal Treatment

Documentation needed for review of procedure:

- ✓ Radiographs – periapicals or bitewings preferred.
- ✓ Complete periodontal charting.
- ✓ Treatment plan.

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

Criteria

- ✓ A minimum of four (4) teeth affected in the quadrant.
- ✓ Periodontal charting indicating abnormal pocket depths in multiple sites.

Additionally at least one of the following must be present:

1. Radiographic evidence of root surface calculus.
2. Radiographic evidence of noticeable loss of bone support.

Cultural Competency Program



The Plan incorporates measures to promote cultural sensitivity/awareness in the delivery of member services as well as dental healthcare services. Services to members are delivered in a manner sensitive to the member's cultural background and his/her religious beliefs, values and traditions. It is the policy of the Plan to provide all information in a culturally competent manner that assists all individuals, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds or physical or mental disability issues in obtaining dental health care services. The Plan incorporates measures to track bias/discrimination issues that hinder or prevent to be administered in accordance with the American with Disabilities Act, and other applicable Federal and State laws, to its members and the Plan's employees and report appropriate occurrences to the Complaint and Grievance Department or the Human Resources Department.

The Plan ensures that its staff is trained in cultural awareness to provide a competent system of service, which acknowledges and incorporates the importance of culture, language, and the values and traditions of members.

The Plan ensures that its staff is trained in cultural awareness to provide a competent system of service, which acknowledges and incorporates the importance of culture, language, and the values and traditions of all the Plan's employees and the members served by the Plan.

The Plan supports Providers in efforts to work in a cross-cultural environment and to ensure the adaptation of services to meet members cultural and linguistic needs.

A copy of the Plan's Cultural Competency Plan is available at no charge upon request by contacting the Compliance Department.

Reimbursement of Services Rendered

Reimbursement will only occur for services that are clinically necessary for dental care and do not duplicate another provider's service. "Medically necessary" is defined as services that meet the following conditions:

- a. necessary to protect life, prevent significant illness or significant disability or alleviate severe pain
- b. individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
- c. consistent with generally accepted professional dental standards as determined by the Florida Healthy Kid's program, and not be experimental or investigational
- d. reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide

In addition, the services must meet the following criteria:



- ✓ The services cannot be experimental or investigational; and
- ✓ The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved care, goods, or services do not, in itself, make such care, goods or services clinically necessary for quality dental care, or a covered service.

LINKS TO ONLINE HIPAA RESOURCES

The following is a list of online resources that may be helpful.

- ✓ Accredited Standards Committee (ASC X12)
 - ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org
- ✓ American Dental Association (ADA)
 - The Dental Content Committee develops and maintains standards for the dental claims form and dental procedures codes. www.ada.org
- ✓ Association for Electronic Health Care Transactions (AFEHCT)
 - A healthcare association dedicated to promoting the interchange of electronic healthcare information. www.afehct.org
- ✓ Centers for Medicare and Medicaid Services (CMS)
 - CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at www.cms.gov/hipaa/hipaa2/.
 - This site is the resource for Medicaid HIPAA information related to the Administrative
- ✓ Simplification provision. www.cms.gov/medicaid/hipaa/admsim
- ✓ Designated Standard Maintenance Organizations (DSMO)
 - This site is a resource for information about the standard setting organizations, and transaction change request system. www.hipaa-dsmo.org
- ✓ Office for Civil Rights (OCR)
 - OCR is the office within Health and Human Services responsible for enforcing the
- ✓ Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa
- ✓ United States Department of Health and Human Services (DHHS)



- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admsimp
- ✓ Washington Publishing Company (WPC)
 - WPC is a resource for HIPAA-required transaction implementation guides and code sets. The
- ✓ WPC website is www.wpc-edi.com/HIPAA
- ✓ Workgroup for Electronic Data Interchange (WEDI)
 - WEDI is a workgroup dedicated to improving health care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org