PREMIER ACCESS

ACCESS DENTAL

Policy and Procedure			
Policy Name:	**Optional Treatment – Medicaid Programs**	Policy ID:	CL.007.02
Approved By:	Dental Director (signature on file)	Effective Date:	1/1/2013
States:	California	Revision Date:	N/A
Application:	California Medicaid Programs		

This policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".

Purpose

To define the process related to optional treatment plans contracted providers may offer to Premier Access Medicaid members and to establish clear procedures in terms of claims handling, quality management and implementation.

Policy

Medically necessary dental services for children (beneficiaries ages 0 to 21) are not generally optional services within a Medicaid program. If a dental provider recommends a noncovered medically necessary service for a beneficiary under the age of 21, procedures related to EPSDT Supplemental Services will apply in accordance with **Policy QM.013.01, EPSDT Supplemental Services.**

Dental providers may recommend medically necessary dental services for adults that are not covered by the program, due to the limited coverage for individuals 21 years or older.

Dental Providers may not require optional services as a condition of completing the covered treatment plan.

Material upgrades for covered services are NOT a billable optional service.

Only non-covered services can be charged and members must sign appropriate informed consent forms for services not covered prior to the treatment being performed.

Procedure

1. When optional treatment is offered, the provider must fully inform the member in writing of the following:
   - the recommended covered treatment
   - the advantages and disadvantages of both the covered and the optional treatment
   - all applicable fees
2. The member or guardian must verify his/her full understanding and sign a consent form for the treatment.
3. The member is responsible for any applicable copayments, and:
   - if the provider has a contracted fee for the covered procedure and there is no contracted fee for the optional procedure, the provider may charge the member the difference between the contracted fee for the covered procedure and the provider's usual and customary fee for the optional procedure; or
   - if the provider does not have contracted fees for the covered procedure or optional procedure (e.g. capitated provider), the provider may charge the member the difference between his/her usual and customary fees for the covered and optional procedures.

   "Contracted fee" refers to the provider's contracted fee schedule for the program in which the member is enrolled.

The member will not be responsible for any amounts in excess of those described above. The Plan will make an allowance for optional treatment based on the provider's contract and associated fee for the covered procedure, if applicable.

4. The materials used in a covered service are determined by the dental provider. No fees may be charged to the member for materials upgrades on a covered service. For example:
   a. Fillings are covered. If the provider offers composite fillings in the treatment plan, there is no charge to the member for materials upgrade.
   b. Crowns are covered. There are no permitted charges to the member for materials upgrades (e.g., no charge for metal upgrades (noble, high noble, etc.) or for laboratory crown upgrades)
   c. Antimicrobial and biologic materials are included in the covered periodontal procedure and may not be billed separately. There are no separate charges to the member for irrigation of any antimicrobial agents during root planing & scaling or other periodontal procedures. There are no upgraded antimicrobial solutions that may be charged to the member as optional.
   d. Benefits for many covered procedures are inclusive of additional procedures that are necessary to complete the treatment. For example, crown lengthening is not covered as a separate procedure – but if necessary is included within the covered restoration services.
5. If coverage and/or copayment(s) for an alternative procedure are included in the member's program, the procedure is not considered optional treatment.
6. Compliance with these procedures will be monitored during the claims review process and through member grievances/appeals.
7. If a provider does not offer a covered service which is considered the standard form of treatment typically provided under accepted dental practice standards, the alternate service must be provided to the member at the same copayment of the covered, standard form of treatment. In this case, the alternate service is not considered optional treatment. The member cannot be charged for any amount in excess of the covered service. This includes, but is not limited to, posterior composites when a provider does not offer amalgam restorations and resin crowns when a provider does not offer stainless steel crowns.
8. If a provider does not follow the standards defined in this policy and procedure, a corrective action plan may be implemented and monitored. Providers who do not comply with the corrective action plan may be subject to Plan sanctions including, but not limited to, probation or termination.

References

California Denti-Cal Manual of Criteria, April 2, 2012

See also related policy:

Policy CL.013.01, EPSDT Supplemental Services

Revision History

Date:	Description
01/01/2013	Written policy developed.