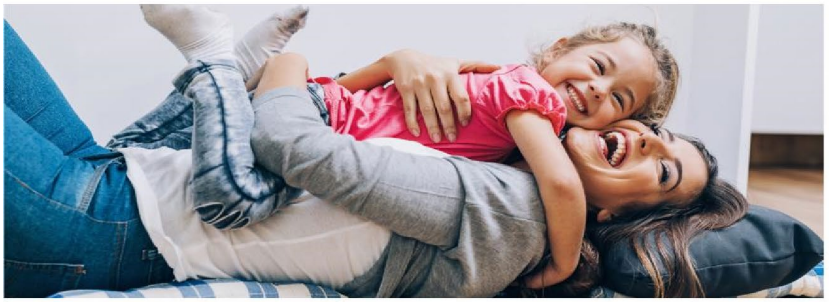





Access Dental Plan Dental Provider Manual
Sacramento Geographic Managed Care (GHP)
and
Los Angeles Pre-Paid Health Plan (LAPHP)
of California

access dental

Welcome

Dear Doctor,

Access Dental Plan welcomes you and your staff to our network of participating dentists and dental specialists. We are pleased that you have chosen to join our network and to provide oral health services to our members.

With nearly 40 years in the business, we know that serving the Medicaid population is not always easy. Patients may be just learning how to develop a practice of regularly seeing their dentist, and the administrative burden is perceived by many to be high.

While our influence over fees and patients is limited, as your Medicaid dental administrator, we can strive to make the administrative burden a little bit easier by:

- Communicating with you clearly and succinctly about our policies, practices, and resources
- Giving you direct access to oral health professionals on our team to help answer many of your clinical and procedural questions—on the phone, by email, and in your office
- Keeping our secure web portal up to date with the latest information about which American Dental Association (ADA) Current Dental Terminology (CDT) codes are covered by this plan

This manual outlines many of the policies and procedures that govern how we manage this plan. The Contact Information section on page 6 of this manual offers you phone numbers, email addresses, and web tools to help you navigate the plan.

If you require assistance or information that is not included within this document, please contact our Provider Services Department. This office is typically staffed Monday through Friday from 8:00 a.m. until 6:00 p.m. (PST), excluding observed holidays.

Again, we welcome you and your staff to the growing network of participating Access Dental Plan providers, and we look forward to a successful relationship with you and your practice.

Sincerely,

Dr. Jason Mann, DMD

Vice President, Dental Services

Table of Contents

Contact Information

Customer Service Geographic Managed Care (GMC) Medi-Cal Program P.O. Box 38312 Phoenix, AZ 85069 **877-821-3234**	**Customer Service** Los Angeles Prepaid Health Plan (LAPHP) Medi-Cal Program P.O. Box 38312 Phoenix, AZ 85069 **888-414-4110**
Provider Services California Dental Providers **800-640-4466** **ProviderRelations@premierlife.com**	Access Dental Plan Claims Department P.O. Box 38312 Phoenix, AZ 85069 · Attn: Dental Appeals · Attn: Dental Claims · Attn: Dental Corrected Claims · Attn: Dental Post-Review · Attn: Dental Preauthorization **800-448-4733** **AccessReferral@premierlife.com**
Dental Director for California Access Dental Plan Dr. Roshani Mehta, DDS, MBA **Quality_PPI@avesis.com**	**Grievances** Access Dental Grievance Department PO Box: 38312 Phoenix, AZ 85069 **800-448-4733**

We make every effort to maintain the accuracy of information contained in this manual. If you see any typographical errors, please let us know. Call **800-640-4466**. Access Dental Plan is not liable for any damages, directly or indirectly, that may occur from the result of a typo.

General Information

Access Dental Plan (the Plan) has been providing fully insured dental and vision services since 1978. Providing outstanding customer service is a top priority, and our core values of accountability, empowerment, excellence, and integrity help us achieve high member and client satisfaction. Recognizing that every client is unique, Access Dental Plan has built a network of dentists and dental specialists to support the constantly growing needs of the medical assistance (Medicaid) and indigent populations. We believe that a successful dental program is one where the members receive the best possible care, and the participating network dentist and dental specialists are satisfied with the support that they receive from us.

This Provider Manual is a compilation of all the information necessary to successfully manage the treatment and administration for Access Dental Members.

We are here to support you in both your doctor-patient relations and your administrative needs; if you have questions, concerns or suggestions, please contact us.

Provider Services operates Monday through Friday from 8:00 a.m. until 6:00 p.m. (PST), excluding the following observed holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Presidents' Day
- Memorial Day
- Juneteenth Day
- Independence Day
- Labor Day
- Thanksgiving Day
- The day after Thanksgiving
- Christmas Eve (afternoon only)
- Christmas Day

All offices will be notified 45 business days prior to the effective date of any material changes or revisions to this manual unless the change is required by law or regulation. An update/revision will be sent to the office and will be accompanied by a cover sheet to indicate the subject matter being addressed, the page(s) to be replaced or added, and the effective date of the change. To assist providers with the administration of benefits to members, information in this manual will be updated on the Access Dental Plan website at **www.premierlife.com**. It is the responsibility of the provider to stay current with these updates. If they are printed from the website, please be sure to discard the older pages and replace them with the revised pages.

Provider Rights and Responsibilities

As a Primary Care Dental Provider, you have the right and responsibility to:

- Provide or coordinate all dental care for the member in accordance with generally accepted dental practices and standards prevailing in the professional community at the time of treatment
- Provide 24-hour emergency service, seven days a week with information to obtain urgent or emergency care after regular business hours (Arrange for coverage by another Provider when necessary (vacation, illness, etc.)
- Reschedule any appointments promptly in a manner that is appropriate for the Member's health care needs, ensuring continuity of care consistent with good professional practice.
- Not differentiate by days or time of day when professional services are rendered to Members
- Obtain prior authorization, when required, for any specialty referral or supplemental payment
- Comply with accessibility parameters as set by the Plan
- Ensure that dental records are protected and confidential in accordance with all Federal and State laws and the California Dental Practice Act.
- Complete and return quarterly Provider Survey within 10 days of mailing
- Maintain dental records for 10 years from the close of the State fiscal year in which the date of service occurred, unless a longer period is required by law, or until such time as an audit or inspection is resolved, whichever is longer, and make dental records available during regular business hours
- Provide documentation within 5 days of receiving an acknowledgment letter from the Plan, or earlier if required by the Plan, regarding a Patient complaint
- Provide a complete copy of dental records including x-rays upon Member and/or Plan request
- Provide updated re-credential information upon request by the Plan
- Provide monthly encounter information for all covered services
- Participate in Quality Management Program and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements
- Not use aggressive sales techniques to sell optional (non-covered) services or inadequately document the consent of the Member for accepting optional services
- Inform the Members of availability of free language assistance services for any linguistic need

These are a few of the responsibilities of an Access Dental Plan contracted Dentist. There may be more information you need to meet your responsibilities included in this Manual. If you have any questions, please contact Provider Services at **(800) 640-4466**.

As a Dental Care Specialist Provider, you have the right and responsibility to:

- Provide specialty care in a timely manner to Members when prior authorization has been obtained
- Work closely with Primary Care Dentists (PCD) to enhance continuity of Patient care
- Send a notification to the PCD upon completion of treatment

- Collect any applicable Patient co-payment. [Note: Medi-Cal Members do not pay any co-payments for services]
- Submit a narrative of findings to the Plan
- Participate in Quality Management Program (QMP) and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements
- Maintain dental records for 10 years from the close of the State fiscal year in which the date of service occurred, unless a longer period is required by law, or until such time as an audit or inspection is resolved, whichever is longer, and make dental records available during regular business hours
- Ensure that dental records are protected and confidential in accordance with all Federal and State laws and the California Dental Practice Act
- Inform the Members of availability of free language assistance services for any linguistic need
- Provide documentation within 5 days of receiving an acknowledgement letter from the Plan, or earlier if required by the Plan, regarding a Patient complaint
- Provide a complete copy of dental records including x-rays upon request from the Member or from the Plan
- Provide 24-hour emergency service, seven days a week with information to obtain urgent or emergency care after regular business hours (Arrange for coverage by another Provider when necessary (vacation, illness, etc.))
- Reschedule any appointments promptly in a manner that is appropriate for the member's health care needs, ensuring continuity of care consistent with good professional practice
- Not differentiate by days or time of day when professional services are rendered to Members.

These are a few of the responsibilities of an Access Dental Plan Contracted Dentist. There may be more information you need to meet your responsibilities included in this Manual. If you have any questions, please contact Provider Services at **800-640-4466**.

Advance Directives

While we never expect that a patient will have an event during an office visit, there is always the possibility a medical emergency can occur. To ensure you are informed of your patient's desires, you should ask your patients for a copy of their advance directive during their patient onboarding process. An advance directive can include a living will or durable power of attorney for health care.

- You should retain a copy of the patient's advance directive in their medical record.
- You should note in the patient's chart if the member informs you that s/he has moral and/or religious beliefs that would stop him/her from making an advance directive.

Member Rights and Responsibilities

Members have the right to:

- Communicate openly and freely with Access Dental Plan and their dentists and other oral health providers without fear of retribution

- Expect privacy according to HIPAA (Health Insurance Portability and Accountability Act), California Confidentiality of Medical Information Act (CMIA) and other state or federal guidelines
- Be treated with respect, courtesy, and dignity
- Be treated the same as all other patients in the practice
- Be treated without discrimination based on race, religion, color, sex, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other protected category
- Be informed of their oral health status and examination findings
- Participate in choosing treatment options
- Receive information on treatment options in a manner that they can understand, including receiving materials translated into their primary language, upon request
- Know whether treatment is medically necessary
- Know whether the treatment is experimental and give his/her consent
- Refuse any treatment, except as provided by law
- Be provided with a phone number in case of an emergency
- Obtain non-covered services only when a disclosure form is signed by all parties
- Submit a complaint against a provider, without fear of retribution
- Be informed of any appeals filed on their behalf
- Change providers
- File grievance issues with Access Dental Plan
- Access their records to review and/or change

Members shall, to the best of their ability:

- Choose providers who participate in the Access Dental Plan network
- Be honest with the providers
- Provide accurate information to the providers
- Understand the medicines they take and know what they are, what they are for, and how to take them properly, and to provide their doctor with a correct list of medications at each visit
- Provide complete information about past or present complaints/illnesses, hospitalizations, surgical procedures, and allergies
- Respect the rights, property, and environment of all providers, employees, and other patients
- Behave in a respectful manner and not be disruptive to the office
- Understand the status of their oral health
- Choose a mutually agreed upon treatment plan with options they believe are in the best interest of their oral health
- Have the opportunity to ask about a fee associated with any non-covered service before the service is rendered

- Use best efforts to not miss or be late for an appointment
- Cancel scheduled appointment in advance, if unable to make it
- Provide emergency contact information
- Follow home care instructions
- Call the dentist of record in the event of an emergency
- Report suspected, fraud, waste, and abuse
- Inform caregivers about any changes to Advance Directives

Standards of Participation

Access Dental Plan requires that all providers participating in our programs meet any applicable state and federal laws and regulations. The following specifications must be met by all providers for participation with Access Dental Plan:

- Current licensure by the appropriate licensing board for your specialty
- Contracting and credentialing with Access Dental Plan
- NPI number issued through the National Plan and Provider Enumeration System (NPPES)

Standards of Care

Providers are required to practice within the scope of dental practice as established by the State Board of Dentistry and State Board of Medical Licensure, as applicable. Providers are also expected to be aware of any applicable state and federal laws that impact the role as an employer, a business owner, and a healthcare professional.

A dentist or dental specialist is expected to use all relevant training, knowledge, and expertise to provide the best care for the member.

Standards for Member Medical Records

Each member must have an individual record that is maintained at the dental office. The record should meet the requirements defined in the Recordkeeping section of this manual. The records must be available for review by an Access Dental Plan staff member during any facility review. If computerized, the records shall be non-changeable. However, the system shall permit adding to the original record. All files must be properly backed up for protection, in accordance with any applicable HIPAA requirements. The provider shall confirm that all records conform to applicable industry standards.

All services, tests, and procedures billed to Access Dental Plan must be substantiated in the member's medical record. Services that are not documented or where the documentation is incomplete are not reimbursable. When those services, tests, and procedures are identified post-payment, the payment will be reversed.

Recordkeeping

Your office shall maintain confidential and complete member medical records and personal information as required by applicable state and federal laws and regulations. Access Dental Plan requires that member records and radiographs be maintained for at least 10 years from the close of the State fiscal year in

which the date of service occurred, unless a longer period is required by law, or until such time as an audit or inspection is resolved, whichever is longer.

Your records must be written in standard English, legible, and maintained in a current, comprehensive, and organized manner. Information that must be a part of the patient record includes:

- Administration documentation
    - Patient's identification number on all pages
    - Signed HIPAA confidentiality statement
    - Signed consent to permit Access Dental Plan to access medical records upon request
    - Claims and billing records
    - The name and telephone number of the member's PCP
    - Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
- Medical documentation
    - The original handwritten personal signature, initials, or electronic signature of practitioner performing the service, and initiated by the dentist, if s/he did not perform the service
    - Current health history
    - Complete medical history
    - Current prescription and non-prescription medications, including quantities and dosages
    - Medication allergies and sensitivities, or reference "No Known Allergies" (NKA) to medications prominently on the record
    - Any disorders and/or diseases
    - Initial examination data
    - Tobacco, alcohol, and substance abuse history for patients aged 14 and older
    - A physical assessment, including member's current complaint, if relevant
    - Diagnosis that is reasonably based on the history and/or examination
    - Documentation that problems from previous visits were addressed
    - Treatment plan consistent with the diagnosis, signed by the provider and adult member, parent/guardian, or minor member
    - Progress notes
    - Date for return or follow-up visit
    - All radiographs taken during the member's previous dental visits (dated and labelled)
    - Copies of all authorizations or referrals
    - Copies or notations regarding any drugs prescribed
    - Signed informed consent form

In addition, the following significant conditions must be prominently noted in the chart:

- A health problem that requires pre-medication prior to treatment

- Current medications being taken that may contraindicate the use of other medications
- Infectious diseases that may endanger others

Amendments to protected health information shall be governed by the applicable HIPAA provisions of 45 CFR 164.

Confidentiality of Records

The confidentiality of member medical and billing records and personal information shall be maintained in accordance with all applicable federal and state law. You and your office shall not use any information received while providing services to members except as necessary for the proper discharge of your obligations as an Access Dental Plan network provider. You and your office agree to comply with all the applicable state and federal requirements for privacy and security of health information, including, but not limited to, those set forth in HIPAA, the American Recovery and Reinvestment Act of 2009, and the CMIA.

Records Audit

Department of Managed Health Care ("DMHC") and Department of Health Care Services ("DHCS") require all licensed plans to monitor and assist Providers through on-site visits to Provider offices. The Plan performs such site visits regularly. In most instances, the Dental Director and/or Dental Consultant (Auditor) visit the Provider offices annually according to established enrollment thresholds. The frequency of the site visits may be higher for certain programs, such as Medi-Cal Managed Care Dental Programs. The Plan views the site visits of the Provider offices to assist Providers in complying with regulations related to the operations of dental offices.

DMHC and/or DHCS and other government agencies have the right to inspect Providers' premises, facilities, equipment, books, records, contracts, computer, and other electronic systems.

Standards for Member Contact Information and Outreach

Each office shall maintain accurate contact information for each member and shall have appropriate contact numbers for parent(s) or legal guardian, if the member is under the age of majority.

The CMS comprehensive and preventive child health program for individuals under the age of 21 is called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). EPSDT requires that every Access Dental Plan network provider has documented member outreach policy and procedures to help ensure that members receive oral health services on a regular schedule. CMS specifically requires the following:

- For members of record (under age 21): Providers must attempt to make contact at least two times per year.
- For adult members of record (age 21 and over): Providers must attempt to make contact at least one time per year.

The outreach attempts must be documented in the member's medical record. Access Dental Plan may request to see a record of the attempts during site visits.

Standards for Member Appointments

Each new member must have thorough medical and dental health histories completed before any treatment begins. Each new member must have a complete clinical examination (including documentation of existing oral conditions) and oral cancer screening. Each member must have appropriate radiographs for diagnosis and treatment based upon age and dentition. Each member must have a written treatment plan in the member record that clearly explains all necessary treatments.

Missed Appointments

CMS does not allow a provider to bill for failed appointments. Doing so constitutes potential fraud.

Communication with your patients if they miss an appointment is a useful tool for building trust. We encourage providers to develop an office policy that applies to all patients equally—government-supported, commercial, and private pay—regarding (a) outreach following a missed appointment and (b) termination of a member following multiple missed appointments. Dismissal of a Medicaid patient from your practice may require the approval of the Plan or DHCS. We encourage providers to follow up with members who miss an appointment.

Standards for Infection Control

Access Dental Plan requires all Providers to comply with the standard precautions and infection control measures as outlined and mandated by the Dental Board of California under California Code of Regulations (CCR) Title 16, Section 1005 and the California Division of Occupational Safety and Health (Cal-OSHA) under Title 8, Section 5193. The Plan expects all Providers to comply with these regulations.

The dental office shall follow all appropriate federal and state guidelines, including any from OSHA and the CDC that impact clinical dental practice. The office shall perform appropriate sterilization procedures on all instruments and dental hand pieces.

Appropriate disinfection procedures for all surfaces in the treatment areas shall be performed following each patient visit. Masks, gloves and gowns must be worn while treating any member. Protective eyewear should be available for all dental healthcare personnel and patients. Members shall always be protected from all chemical and biological hazards.

Failure to use appropriate infection control procedure may result in the immediate suspension of the provider. The suspension shall remain in place from the time of notice of suspension until the provider has satisfactorily demonstrated compliance with infection control procedures to an Access Dental Plan dental consultant or state Dental Director.

Standards for Radiation Protection

All healthcare personnel required to use radiograph technology must be trained on the proper use of this technology prior to its use. The dental office shall have radiograph machines that have been checked by the appropriate state authorities and were confirmed to be within the standards set by statute or regulation. Members shall be given proper shielding for all radiographs, and the processing shall be done according to manufacturer’s specifications. For digital radiographs, the computer system shall have the appropriate storage and back-up protection. Radiation badges to monitor the levels of radiation in the dental office shall also be worn by all personnel, if required by state law.

Standards for Treatment Planning

All treatment plans must be recorded and presented to the member and, if the member is a minor lacking the legal capacity to consent to said treatment plan alone, to the parent or authorized representative. The member must be given the opportunity to accept or reject the treatment recommendations, and the member’s response must be recorded in the member’s record.

Access Dental Plan Provider Network

Access Dental Plan seeks to support a geographically diverse, high-quality dental network made up of oral health providers who:

- Are fully and actively licensed and certified
- Are appropriately insured
- Provide excellent care to all members

To accomplish these objectives, the Credentialing Committee is responsible for the development and implementation of a thorough and objective credentialing process. Providers accepted into the Access Dental Plan network must undergo a thorough investigation to establish that they have the necessary skills and capabilities to deliver quality care. Access Dental Plan also believes that it is important to periodically confirm that these providers continue to possess these capabilities through a re-credentialing process.

Support for the Access Dental Plan provider network is provided by our clinical staff, including the Vice President, Dental Services and California Dental Director for Access Dental.

Quality

To ensure that the highest quality services are consistently provided to our members and that providers continue to perform only those services that are necessary for the welfare of the members, Access Dental Plan maintains an approach to quality that includes three components:

- Quality standards
- Quality assurance
- Utilization review

We welcome participation from you and other network providers who seek to review and/or contribute to either of these efforts.

Participating network providers are required to agree, respond to, and/or otherwise comply with Access Dental Plans' Quality Improvement Program as it relates to quality assurance, utilization review, and member grievances. Network providers may also be subject to the quality assurance, utilization review, and grievance programs of the health plan for which Access Dental Plan provides benefit administration.

Quality Management Program

Access Dental Plan's primary quality assurance goals are to provide members access to high-quality dental services that meet industry standards of care and to perform all necessary administrative services associated with the dental programs. Access Dental Plan operates a Quality Management Program (QMP) to facilitate these goals as they pertain to quality-related issues.

The Access Dental Plan QMP includes the following components to monitor the quality of care rendered through our dental programs:

- New provider credentialing
- Provider re-credentialing
- Ongoing monitoring
- Provider site reviews
- Maintenance of the collection of provider credentialing documents that comply with NCQA credentialing standards
- Member complaint resolution
- Member satisfaction surveys

- Provider complaint resolution
- Provider satisfaction surveys
- Provider corrective action
- Service delivery studies (i.e., office reviews, performance report cards, etc.)
- Utilization review/utilization management
- Review of staff/internal corrective action plans (CAPs)
- QMP Evaluation

These efforts are complemented by the development of quality initiative programs and plans to constantly increase and improve the quality of our services.

Access Dental Plan has also established indicators regarding the clinical aspects of care delivered by our participating network providers. These include:

- Quality of care
- Access and availability
- Utilization management
- Complaints, appeals, and grievances statistics
- Customer/member services

The QMP is reviewed and updated annually by the Access Dental Plan Quality Oversight Committee. The Committee is composed of senior staff of Access Dental Plan and clinical staff, including the Vice President of Dental Services and California Dental Director for Access Dental. Members of each state's Dental Advisory Board are also permitted to participate.

Role of the Dental Director

The Access Dental Plan Dental Director is your local contact as a dental professional. Your Dental Director represents you and other participating network dentists and specialists in our role as administrator of the Access Dental Plan dental programs in the state. This includes participating in the local dental association and its component societies.

Your Dental Director is available for discussion and consultation concerning issues of importance to you and other participating network dentists and dental specialists.

Dental Home

As defined by the American Academy of Pediatric Dentistry (AAPD):

The Dental home is an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than one year of age and includes referral to dental specialists when appropriate.

The AAPD recommends your child should see a pediatric dentist when the first tooth appears, or no later than his/her first birthday. Parents or caregivers establish a dental home that would provide a complete oral examination, risk assessment, prevention services and comprehensive care appropriate to the needs of the child.

Children who have a dental home are more likely to receive appropriate preventive and routine oral health care. Referral by the primary care physician or health provider has been recommended, based on risk assessment, as early as the first tooth erupts, and no later than 12 months of age. Furthermore, subsequent periodicity of reappointment is based upon risk assessment. This provides time-critical opportunities to implement preventive health practices and reduce the child's risk of preventable dental/oral disease.

Access Dental Plan supports the AAPD in its efforts and recommends that providers follow the AAPD guidelines.

Office Accessibility

Access Dental is required under California law to ensure that members have timely access to care. Services shall be provided to members in a timely manner in accordance with applicable law and professionally recognized standards of dental practice and consistent with the Member's individual needs. Access Dental will randomly telephone your facility to inquire about wait times; these calls may be anonymous.

Participating dentists are required to provide covered services to Members during normal working hours, and during such other hours as may be necessary to keep patient appointment schedules on a current basis.

Provider Relations will educate providers on Access Dental appointment accessibility standards and ensure compliance in accordance with 28 CCR 1300.67.2.2 as specified below. Access Dental will monitor compliance with appointment standards outlined below and will have a corrective action plan when appointment standards are not met.

- Initial Appointment – within 4 weeks
- Routine Appointment (non-emergency) – within 4 weeks
- Preventive Dental Care Appointment – within 4 weeks
- Specialist Appointment (Adult Members 21 and over) – within 30 business days from authorized request
- Specialist Appointment (Members under 21) – within 30 calendar days from authorized request
- Emergency Appointment – within 24 hours from the request for appointment

When it is necessary for a Provider or a member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice.

Waiting time for a scheduled appointment ***must not exceed thirty (30) minutes***. (Provider offices must maintain records indicating when a member arrives for an appointment and when the Provider sees the Member.)

Note from Access Dental Plan: You will receive an Accessibility Survey on a regular basis to obtain information on appointment availability, waiting time, the availability of interpreter services, acceptance of new Members, staffing changes, and other information necessary to fulfil the Plan's reporting requirements to DMHC and DHCS. You are required to complete each survey and return it in a timely manner.

Contact Access Dental Plan: In the event you need to contact Access Dental to obtain assistance if a member is unable to obtain a timely referral to an appropriate provider, please contact Provider Services at 800-640-4466 or ProviderRelations@premierlife.com. In the event a member wants to contact Access Dental for assistance in obtaining a timely referral to an appropriate provider, please direct the member to Access Dental's Customer Services as follows: GMC members to 877-821-3234 and LAPHP members to 888-414-4110.

Contact DMHC: In the event you or a member wish to contact the Department of Managed Health Care to file a complaint if the member is unable to obtain a timely referral to an appropriate provider, DMHC's toll-free telephone number is 1-888-466-2219 and DMHC has a TDD line (1-877-688-9891) for the hearing and speech impaired. The DMHC's internet website is www.dmhc.ca.gov.

After-Hours Accessibility

On weekends, after hours, or during holidays, you and your office must have a means of being contacted by members or their authorized representatives (like a parent/guardian). This contact may be an answering service, phone machine, or voice mail directing the member to contact a cell or other phone or another method of reaching a person. Whichever means you choose, it must be checked regularly by your or your designee during hours when your office is closed, to ensure members have access to you or your office in the event of an emergency.

Emergency Care

An emergency dental condition is a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of dentistry could reasonably expect the absence of immediate dental attention to result in:

- Placing the patient's health (or in the case of pregnant woman, the health of the woman or unborn child) in serious jeopardy, such as:
    - High risk-to-life or seriously disabling conditions such as cellulitis, oral hemorrhage, and trauma.
    - Low risk-to-life or minimally disabling conditions such as painful low-grade oral infections, near pulpal exposures, or fractured teeth.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or part.

Emergency services are those covered services that are furnished by a Provider that is qualified to furnish those services needed to evaluate or stabilize an emergency dental condition. Emergency services do *not* include:

- Preventive services including prophylaxis, fluoride, and routine examinations
- Routine restorations, including crowns (Resin/porcelain/ceramic, PFM, SSC)
- Prosthodontic Procedures including dentures, partial dentures, and denture relines and repair
- Extraction of asymptomatic teeth, including third molars

All Access Dental Plan provider offices are responsible for the effective response to and treatment of dental emergencies of patients on record. Furthermore, Access Dental Plan requires that sufficient access be available to ensure that members can receive necessary emergency services in the office rather than in a hospital emergency room.

Access Dental Plan shall permit treatment of all dental services necessary to address a dental emergency for a member without prior authorization. However, elective dental services not necessary for relieving pain and/or preventing immediate damage to dentition default to the standard prior authorization process.

To confirm whether the situation is a true emergency, the dentist must speak with the member or member's authorized representative to assess the member's problem and take the necessary actions. If it is determined by the provider and the member that it is a true dental emergency, then a provider may either:

- render services in the dental office to treat the emergency, or
- assist the patient in obtaining proper dental care from another dentist or specialist or a hospital emergency room, if the condition warrants emergency room treatment

In accordance with the Provider Agreement, in the case of a dental emergency or urgent dental condition, you shall make every effort to see the member immediately and within 24 hours.

If the member calls with an emergency, during non-business hours, your office must have an answering service or alternate number to reach the on-call provider.

Waiver of Prior Authorization for Emergencies

Access Dental Plan recognizes that prior authorization is not required for emergency services. In this situation, following the delivery of treatment, please submit a completed 2019 ADA claim form with all supporting and required documentation including:

- Narrative explaining the emergency and treatment rendered
- Radiograph(s) of tooth/teeth and any area of treatment
- Hospital records, if admitted to hospital
- Anesthesia records if general anesthesia was administered

Access Dental Plan dental consultant licensed in your state will review the claims and accompanying documentation. Claims received without required documentation will be denied, and the member will not be liable for payment. If the claim is found not to be a qualified emergency, the payment may be reduced or denied.

Referrals

There may be times when a member's care may be better served by another dental provider. This typically happens when specialist care is needed or when timeliness is a factor.

To refer a patient to another provider, the member's Primary Care Dentist must complete the referral form and return it to Access Dental Plan Referral Department by mail or fax and an escalation request may be emailed. The form is like the prior authorization form, with the addition of information about the names of the referring and referred providers.

When we receive the referral form, we record the information in our claims management system. If we do not see a claim processed against the referral within 45 days, we may reach out to the member by mail to remind them of the need for treatment by the provider to whom they have been referred.

All Specialty referrals must meet criteria for dental necessity and be a covered benefit under the applicable program.

Specialist Treatment

A member who requires a referral to a dental specialist must be referred directly from their Primary Care Dentist to any specialist in the Access Dental Plan network. The Provider Services Department is available to assist you with locating a specialist that participates in the Access Dental Plan network.

Transfer of Care

In the event a member's care needs to be transferred to another primary care dentist or specialist, it is the responsibility of the dentist or specialist to provide a copy of diagnostic quality radiographs to the successor dentist or specialist.

If a successor dentist cannot get the required radiographs from the dentist from whom care is being transferred within 10 business days, the successor dentist should contact Access Dental Plan Provider Services. We will notify the originating dentist or specialist in writing within 15 calendar days that the successor dentist or specialist did not receive diagnostic quality radiographs. In this notice, we will notify the member's originating dentist that Access Dental Plan will charge them for radiographs that the successor dentist or specialist must retake for appropriate care if:

- The originating dentist or specialist has provided radiographs that were not of diagnostic quality as determined by Access Dental Plan clinical staff

  OR

- Radiographs were not submitted to the successor dentist or specialist within 10 business days following a request for the radiographs

If the successor dentist or specialist deems that radiographs do not need to be repeated, a narrative must be included to explain the dental conditions found upon examination.

Continuity of Care

Continuity of care refers to those circumstances when a dental procedure requires more than one office visit, and the member changes insurance providers between procedure visits. This typically applies in the case of orthodontic treatment.

Please refer to the addendum to the document for details on the state or plan requirements regarding continuity of care for orthodontic treatment. Continuity of care standards do not apply in the case of a treatment plan being transitioned between providers. In this case, transfer of care standards would apply.

For detailed information regarding continuation of care, please visit:
https://www.dhcs.ca.gov/services/Documents/MDSD/2017%20DAPLs/APL_Transition_of_Care_Errata_(003).pdf

Locum Tenens

Locum tenens arrangements are made between the providers whereas one provider will temporarily replace another provider for a period due to medical emergencies. Locum tenens should not be used to temporarily replace a non-credentialed or disciplined provider until they are restored to the network.

Locum Tenens Form

The Locum Tenens form can be found at the end of this manual, see Forms and Documents section.

A completed Locum Tenens form from the practice owner must be submitted to Access Dental Plan in advance of the use of a locum tenens provider. If locum tenens is used due to the incapacitation or death of a participating provider, then the letter must be signed by the executor of the estate. The locum tenens is good for 60 continuous calendar days within a 12-month period.

The locum tenens provider may not render services until the locum tenens relationship is approved by Access Dental Plan. To secure approval, we first affirm that the locum tenens provider has a valid NPI number and a valid state Medicaid number. Next, a member of our credentialing department will run two searches to determine whether there are any sanctions against the provider. Once these reports clear,

the form is sent to a dental director for approval. From there, the locum tenens request goes to the credentialing committee for review and approval.

When approved, the participating Access Dental Plan provider can submit claims to receive payment for the covered benefits for services provided by the locum tenens provider. The locum tenens provider must hold a valid professional license within their practicing state. The existing provider's malpractice insurance is used to cover the locum tenens provider.

Indiscriminate billing under one provider's name or number without regard to the specific circumstances of rendering of the services is specifically prohibited and is grounds for recoupment or claim denial. Abuse of the locum tenens relationship may result in discipline of the billing provider up to and including termination of the provider's agreement. The common practice of one provider covering for another will not be construed as a violation of this section when the covering provider is on call and provides emergency or unscheduled services for a period not to exceed 60 continuous calendar days during a 12-month period.

Clinical Coordination

Oral health care is an essential component of overall health. In many cases, the provision of good oral health care may require coordination between dentists and their patient's primary care physicians or facilities. It is important that your members' medical records include any detail about health conditions that may impact their oral health, along with the names and contact information for your members' primary physician and/or facility. This information will help you communicate with your members' treatment teams in the event of a medical issue that impacts their oral health and hygiene. You might also have occasion to reach to a member's primary care team if your care identifies potential medical concerns that might be better addressed outside of the dental office.

Case Management

All complex and special needs cases are to be referred to the Plan's Case Management Coordinator; case management provides valuable services to Members and Providers with complex cases.

Complex cases are those cases where the dental condition is compromised by a medical condition, and care needs to be coordinated between medical and dental providers. Special needs cases are those members with physical and/or mental handicaps who are in need of dental care from Providers who have experience working with these patients.

Nonpharmacological pain management involves the treatment of pain without the use of drugs. To control and lessen pain, this type of treatment can make use of strategies to change thoughts and focus more effectively. Providers should use evidenced-based nonpharmacological pain management techniques in their practice. Nonpharmacological pain management techniques include:

Behavior‐modification techniques

- Voice control.
- Tell, show, do.
- Signaling
- Positive reinforcement.
- Relaxation training.
- Breathing relaxation.
- Distraction.
- Modeling

Dental anxiety or phobia

- deep breathing.

- meditation.
- distraction (such as listening to music or the use of devices)
- guided imagery.
- progressive muscle relaxation.
- agreeing with dentist on a signal to stop during the treatment for a break (such as raising your left pointer finger or hand)

Other Treatment

- Laser therapy
- Appliances (ex: mouthguards)

Pregnant Women

Under CMS rules, women who are pregnant and lack insurance coverage, may be eligible for limited coverage under Medicaid. This coverage typically begins on the date pregnancy is verified and ends the date of delivery. Coverage typically includes routine dental benefits for their age category (under 21 or over 21). This includes 60 days of postpartum care. Services for pregnant beneficiaries who are 21 years of age or older are payable if the procedure is listed under Federally Required Adult Dental Services (FRADS) or Allowable Procedure Codes for Pregnant Women.

Patients with Special Needs

Certain patients with special needs require additional consideration for clinical treatment. Some patients with special needs may be able to be treated in a dental office, while others may require treatment in a facility where anesthesia can be administered. If you have a member with special needs who cannot be treated in your office, please reach out to a pediatric dentist or a dentist who routinely treats patients with special needs to discuss potential transfer of care.

If your office can treat patients with special needs, please be sure to document the names and contact information for people who are authorized to give permission for treatment for the member, if relevant.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment)

EPSDT is medical assistance's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary healthcare service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the state's plan to the rest of the medical assistance population. For members under 21 years of age, a service is "medically necessary" if the service meets standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. Medically necessary dental services shall include diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illness and conditions discovered by screening services, whether or not such services are a covered benefit. The EPSDT program consists of two mutually supportive, operational components:

- Assuring the availability and accessibility of required healthcare resources
- Helping medical assistance recipients and their parents or guardians effectively use these resources

These components enable medical assistance agencies to:

- Manage a comprehensive child health program of prevention and treatment

- Seek out eligible patients and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently
- Assess the child's health needs through initial and periodic examinations and evaluations
- Assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment costlier

If a provider is unable to conduct the necessary EPSDT screens for members under age 21, they are responsible for making a referral. All relevant medical information, including the results of the EPSDT screens, is to be incorporated into the member's primary medical record.

Caries Risk Assessment

A Risk Assessment Form has been created to establish a standardized caries risk assessment and management protocols for network dental Providers. It is intended to assist the dentist in clinical decision-making regarding diagnostic, fluoride, dietary, and restorative treatment based upon caries risk level and patient compliance for infants, children, and adolescents.

Sentinel Events and Adverse Incidents

If a sentinel event (an unexpected, non-traumatic occurrence that causes a member's death) or an adverse incident (serious incident, therapeutic misadventure, iatrogenic injuries, or other adverse occurrences directly associated with care or service provided) occurs, you must report this to Access Dental Plan immediately using the Provider Services number provided herein.

Credentialing and Re-Credentialing

All providers participating in the Access Dental Plan provider network must have met basic eligibility criteria established by Access Dental Plan and in accordance with DHCS. Prior to receiving the countersigned agreements and your provider identification numbers, the provider's application and credentials will be reviewed by the Centralized Credentialing Committee. All CA terminations/denials are initiated by one of the CA dental directors and seconded by another member of the committee. To maintain participation in the Access Dental Plan provider network, all providers are required to re-credential at least every 36 months.

Credentialing Requirements

Dentists are enrolled in our provider network if they:

- Continuously meet the Access Dental Plan credentialing standards based upon the National Committee for Quality Assurance (NCQA) guidelines, as applicable
- Hold an active, unrestricted professional license to provide dental services authorized within the scope of their specialty
- Maintain professional liability coverage in the amount of $1,000,000 per occurrence and 3,000,000 aggregate
- Agree to adhere to the administrative procedures of Access Dental Plan

The dental provider types subject to Access Dental Plan credentialing and re-credentialing include:

- Doctor of Dental Surgery (DDS)
- Doctor of Dental Medicine (DMD)
- Medical Doctor (MD)

Credentialing Details

To be considered for admission to the Access Dental Plan network, we require that the following documents be submitted to our office.

For each individual dentist or facility who shall receive payment for services rendered to members, the following contracting paperwork is required:

- Completed and signed Access Dental Plan Provider Agreement
- Signed W-9 (any version prior to 2018 will not be accepted)
- ADA survey regarding the accessibility of your office for members with special needs or hearing impairments, in addition to details on your practice's ability to treat developmentally disabled patients.
- Copy of IRS approval of Tax Identification Number letter

For each dentist in the office who will be rendering services to members, the following credentialing paperwork is required:

- Completed and signed Centralized Provider Application or state-specific application, as appropriate, including work history
- Release and Authorization form if using an application other than the Centralized Provider Application
- Copy of current state license
- Copy of current DEA or State CDS certificate, if applicable
- Evidence of current professional liability insurance ($1 million/$3 million minimum limits required for all CMS providers) or business insurance for dispensing providers without professional liability coverage, except where participating in a state Patient Compensation Fund, in which case the certificate of insurance must indicate required underlying insurance limits and fund participation
- Documentation explaining any affirmative answers from the attestation page
- NPI number
- Disclosure of criminal convictions by an employee of the provider if related to federal healthcare programs
- History of liability claims against the provider
- History of sanctions from participating in Medicare and/or Medicaid/MediCal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the Access Dental Plan's provider network
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards
- History of any suspension or curtailment of clinical privileges

- Satisfaction of any applicable continuing education requirements
- Work history
- If participating in Medicaid program(s), the provider's Medicaid identification number(s)

Upon receipt of an initial network application, the Access Dental Plan Credentialing Department will mail the provider a letter confirming receipt of the application.

In the submission, all gaps in work history greater than 6-months must be explained, all attestation questions must be completed, a Credentials Release of Verification must be included, and all affirmative responses must include a written explanation.

After the primary source verifications are completed, the provider's credentialing file is presented to the Access Dental Plan Credentialing Committee for review. Access Dental Plan will provide written notification to the provider within 60 calendar days of decision.

Both the credentialing and re-credentialing processes include the review of the exclusions list produced by the Office of Inspector General (OIG), Government Services Administration, and other state and federal bodies. Providers appearing on one of these lists MAY NOT participate in any government program (i.e., Medicaid and Medicare).

If a provider is excluded from our network, a copy of the report will be placed in the provider's file.

Incomplete Submissions

Within five business days of receipt of an incomplete initial application, we will contact your office by phone, fax, or email to discuss and request the missing information. This request will include the name and contact information for the Credentialing Specialist making the request.

Review of the application is suspended until all information is received. If the information is not received within 30-calendar days, the application will be placed in a closed file status and a letter will be sent to the applicant advising them of this action.

Correcting Information in Your Network Enrollment Package

If the information is received from the Credentials Verification Organization (CVO) or through other source verification that is materially different from that supplied by the provider in the application, the provider will be notified within five business days and given an opportunity to review and modify the information. We will continuously attempt to secure the requested information. If the information is not received within 30-calendar days, the application will be placed in a closed file status and a letter will be sent to the applicant advising them of this action.

Re-Credentialing Details

The re-credentialing process is initiated 6-months in advance of the provider's re-credentialing due date. The Provider must complete the re-credentialing application and provide proof of current professional liability coverage in addition to meeting the following:

- Satisfy the Access Dental Plan credentialing requirements met during the time of initial credentialing
- Remain in good standing with federal and state regulatory bodies

If the Provider fails to comply with the request to complete re-credentialing, the provider will be subject to termination from all Access Dental Plan networks.

Credentialing Timelines

Applications for credentialing and re-credentialing must be processed and either approved or denied within the timeframe specified by the state authority from the date of receipt of all required information. Providers who are accepted into the Access Dental Plan network during initial credentialing will receive confirmation letters within 15 business days from their acceptance date.

Credentialing Denials

If a provider's application for re-credentialing is denied, the Credentialing Committee will notify the provider in writing within 15 business days from the date of the committee meeting. Included in the letter shall be the reason for the denial along with information on how the provider may appeal the Credentialing Committee's decision.

A provider may be denied acceptance into the network for two reasons:

- Doctor has not supplied all the required information and signatures
- Doctor has not met established criteria

The provider's denial letter will note the specific reasons for the denial.

Re-Credentialing Denial Appeals Process

When a denial of an application for re-credentialing is sent to a provider, it will include notification that the provider may appeal the denial.

The written appeal must contain an explanation of why the provider meets the requirement or, if the provider does not meet the requirement, what steps they have taken to address meeting the requirement. If the provider does not meet the requirement, they must demonstrate how quality of care will still be ensured.

The provider has the right to review any information submitted in support of the credentialing information except for information that is protected by peer review or law. All requests to review information must be made in writing and directed to the Appeals mailbox. The provider will be notified of this right in the denial or termination letter. Copies of the information will be sent within 30 days of a written request signed by the provider. The provider has the right to correct erroneous information with the primary source from which it was obtained. The provider must notify Access Dental Plan in writing that the erroneous information has been corrected within 30 days of receipt of the denial or termination letter and may request that their appeal be suspended until the corrected information is received. The provider shall be notified of this right in the denial or termination letter. The primary source may require the provider to work with them directly to correct the misinformation.

A response to the provider must be sent within 30 days of receiving the appeal. It may request additional information, uphold the denial, or grant an exception. Any action on the appeal and the date are noted on the file. Any decision to accept the provider must be made within the credentialing time frames established, or the provider must resubmit the application.

Delegated Credentialing

Typically, Access Dental Plan performs the primary credentialing functions, but on occasion, we delegate all or portions of credentialing to another group or entity. At a minimum, a delegated entity must meet the requirements for credentialing and re-credentialing outlined in the full Access Dental Plan credentialing policies and procedures in addition to the relevant requirements of NCQA and our health plan partners.

Before accepting a group for delegated credentialing, we perform a pre-delegation review to ensure that group complies with Access Dental Plan credentialing criteria. The review includes:

- A complete Delegated Credentialing Intake Form
- Verification that the group does not sub-delegate any credentialing or re-credentialing functions
- Proof that the group's credentialing policies are reviewed annually and updated as necessary
- Proof of the group's NCQA, URAC, or Joint Commission Credentials Verification Organization Accreditation or Certification
- Successful completion of a pre-delegation audit by Access Dental Plan

Once approved by the Access Dental Plan Credentialing Committee, the delegated credentialing group can perform the following credentialing activities for Access Dental Plan:

- Collection of the applicable provider application, including original signature and attestation
- Completion of primary source verification of the following data elements:
- Unrestricted state licensure, including all states provider holds a valid license
- Valid anesthesia permit, if applicable
- Current DEA or CDS certificate
- Education and training
- Work history, all gaps explained
- Valid malpractice insurance
- Clean malpractice history for past 10 years
- No record of appearing on the social security death master file
- Confirmation national practitioner identifier (NPI-1) and taxonomy code are compatible
- No federal and state sanctions or exclusions

The group that has been accepted as a credentialing delegate performs no other credentialing activities for Access Dental Plan outside of this list.

Post-Credentialing

Participating providers agree to bill Access Dental Plan for only those services rendered by them personally, or under their direct supervision by salaried employees or assistants duly certified pursuant to state law. Direct supervision includes, at a minimum, periodic review of the patient's records and immediate availability of the provider to confer with the salaried employee performing the service regarding a member's condition. This does not mean that the enrolled provider must be present in the same room; however, the enrolled provider must be present at the site where services are rendered, at the time they are performed (e.g., office suite, hospital, or clinic).

Note: Under no circumstances may a provider bill for services rendered by another provider. Services performed by non-credentialed providers in a group practice are not covered. Services performed by locum tenens will be covered when Access Dental Plan is notified by the provider of the locum tenens situation.

Provider Data Maintenance

Upon acceptance into the network, authorized data entry personnel enter all your application and relevant practice information into the appropriate system(s). Documents associated with the application will be maintained in your file with the most current information on top; this data shall be retained securely. In lieu of retaining your paperwork, scanned images may be saved to your folder on the secure, internal Access Dental Plan network. All records shall be retained for a minimum of 10 years following termination of the provider from the network.

Practice & Facility Information Form

To download a copy of the Practice & Facility Information form:

- Go to: **www.premierlife.com**
- Select Providers from the blue navigation bar
- Select **Forms and Materials**
- Search for the Practice & Facility Information form from the list

Documentation stored on file includes:

- Completed Provider Agreement
- Completed provider application
- Credentialing Committee approval form
- Credentials Verification Organization (CVO) report form, if applicable
- Verification documents
- Copies of provider's credentials and certificate(s)
- Certificate of Insurance and any reports regarding claims against the provider
- Information regarding any sanctions or suits against the provider
- Disclosure of ownership form, if applicable

Updating Information

You agree to notify Access Dental Plan in advance in writing should any changes in participation status occur before rendering any services. These changes might include a new address, new contact information, additional practice location, provider retirement, provider death, change of employment of practice, or change in payee.

Any change to the Tax Identification Number or payee information must be submitted on a new, signed and dated W-9 and Provider Agreement.

Each change in participation status must be reported to the Access Dental Plan Provider Network Department at least 30 business days before the effective date of the change. Access Dental Plan will accept a signed letter on office letterhead explaining the change in participation or a completed Practice Update form with a corresponding W-9, if applicable.

Participation in Medicare or a medical assistance program requires a confirmation of provider data at least quarterly. Failure to comply with our confirmation process may result in suspension or termination from the Access Dental Plan provider network.

Verifying Eligibility

The confirmation of eligibility is an important step for every appointment. Access Dental Plan updates the eligibility files at least monthly. Verification of benefits or eligibility is not a guarantee of payment. Actual

payment is based on the terms and conditions of the plan in force once the claim is adjudicated. There are several ways to verify eligibility:

Access Dental Plan Secure Website

Go to www.premierlife.com

Enter your username and password to log into the secure provider portal

Click “Eligibility Search” from the home screen or select “Member Search” within the Eligibility tab on the blue navigation bar

Enter any of the following information:

- Member’s ID in the Member Number field
- Member’s first name, last name, and date of birth into the First Name, Last Name, and Date of Birth fields
- Member’s social security number and date of birth into the SSN and Date of Birth fields
- Receive a real-time response

Setting Up Your Provider Username and Password

To register your new account:

- Visit www.premierlife.com
- Select Providers from the blue navigation bar
- Register Here button
- Select Provider, enter office tax ID and zip code

Interactive Voice Response (IVR)

Please have your provider PIN available and call:

- Sacramento GMC – 877-821-3234
- Los Angeles PHP – 888-414-4110

Access Dental Plan Provider Services

- Call Access Dental Plan Provider Services using the phone number listed in the Quick Reference Guide
- Provide your NPI; if we are unable to validate your NPI, be prepared to enter your taxpayer identification number (TIN)
- Provide the members identification number

Provider and Practice Support Tools

The strength of our service depends on the strength of the support we provide to you and your office. The two primary ways we support your office are:

- Delivering a secure web portal for managing administrative tasks and sharing important information
- Providing educational resources and programming to you and your office staff

Provider Portal

The Access Dental Plan provider portal is a secure tool for information entry and retrieval allowing for communication between your office and internal Access Dental Plan operations departments. With the portal, you and your staff can:

- Communicate through alerts/announcements, archived messages, and electronic mail
- Search member eligibility
- Search remittance advice and explanation of benefits information
- Access all documents associated with Access Dental Plan business

Forms available through the portal include:

- Access Dental Plan Practice & Facility Information Form
- ePayment Enrollment and Authorization Form
- Specialist Referral Form
- Fraud, Waste & Abuse
- Cultural Competency Attestation

Provider Educational Programming

The goals of the Access Dental Plan provider education program are to furnish program information to contracted providers to support member access to dental care services, and to support the Access Dental Plan Quality Assurance Program.

Our provider educational programming starts with the welcome call and welcome visit we conduct with each new provider office. During our welcome visit, we orient the providers and their office staff to the use of the secure portal, offer education on key processes like claims submission and eligibility verification, and help the office bookmark the location of important forms. We might also walk through the office facility to identify resources the office may need to effectively service our members.

Learning Through the Access Dental Plan Provider Portal

To access learning resources on the provider portal:

- Log into the secure provider portal at **www.premierlife.com**
- From this screen, you have access to various forms, regulations, and trainings; select a dynamic box to access the associated document

We also regularly deliver education and information on topics such as utilization management and utilization review protocols, understanding the covered benefits available to members through their health plan, preventing or mitigating claims submission issues, quality data and quality processes, revisions to company policies and procedures, cultural competency, and preventing and reporting fraud, waste, and abuse.

Educational programming may be delivered in myriad ways, including:

- Provider newsletter
- Online education programming through the secure provider portal on the Access Dental Plan website
- Regional provider education meetings, as necessary in the office or over the phone

Claims, Billing and Payment

Eligibility verification is not a guarantee of payment. Benefits are determined at the time that the claim is processed.

Clean Claims

A clean claim contains the following:

- Patient's plan ID number
- Patient's name, date of birth, and gender
- Patient's address (street or P.O. box, city, zip)
- Subscriber's name
- Patient's relationship to subscriber
- Subscriber's address, if different from patient (street or P.O. box, city, zip)
- Subscriber's policy number, if different from patient
- Subscriber's birthdate and gender, if different from patient
- Disclosure of any other health benefit plans and their corresponding EOB for the date(s) of service submitted.
- Patient's or authorized person's signature or notation that the signature is on file with the provider
- Subscriber's or authorized person's signature or notation that the signature is on file with the provider, if different from the patient
- Date(s) of service
- Place of service codes
- CDT code for the service, including arch, tooth number, quadrant, and tooth surface, as applicable
- ICD10 code, if applicable
- Diagnosis by specific service
- Charge for each listed service
- Number of units
- Rendering provider's NPI, federal taxpayer ID number, and license numbers
- Total charge(s)
- Signature of provider who rendered service, including indication of professional license (e.g. DMD, DDS, etc.)
- Name and address of office or facility where services were rendered
- Provider's billing name and address, billing NPI and license numbers for billing provider, if required
- The claim must be accompanied by all necessary documentation.

Note: Missing or incorrect information may cause either a delay or non-payment of a claim.

Note: Claims being investigated for fraud, waste, and abuse or pending medical necessity review are not considered clean claims.

Timely Filing Deadlines

Timely filing guidelines will be strictly adhered to. Claims received after the filing deadline will be denied. There are no exceptions. The following deadlines will be adhered to unless specified per state/federal guidelines:

Action	Timeline to File Claim
Provider to file a claim	6 months or 180 days from the date of service
Provider to appeal a claim	365 calendar days from the explanation of payment
Provider to correct a claim	180 days from the date of service
Coordination of Benefits	90 calendar days from explanation of payment from the primary payer

Claim Submission

All clean claims submitted will be processed and, when appropriate, paid according to the applicable fee schedule. Each claim must include the appropriate line item with your charges and applicable codes.

Claims must be received within 180 days from the date of service. Submit a clean claim form or file electronically after services and materials have been provided. Missing or incorrect information will cause delays in the processing of your claim.

Claims can be submitted through an approved clearinghouse, mail or fax. However, claims can only be faxed when x-rays are **not** required.

- Through a clearinghouse that can convert paper claims into HIPAA-compliant EDI (electronic data interchange) format:
    - Change Healthcare (formerly Emdeon Dental)
      Payer ID 91185
      https://www.changehealthcare.com/
      866-371-9066
- By sending a completed paper ADA claim form to:

  Access Dental Plan
  Attention: Dental Claims
  P.O. Box 38312
  Phoenix, AZ 85069
- Fax to: 916-646-9000

Claims Review Process

In reviewing claims, Access Dental Plan will typically check to ensure the services for which you are requesting payment are:

Medically Necessary Services: Medically necessary dental services must be appropriate and consistent with the standard of care for dental practices. Medically necessary dental services include all covered services, as identified in the Medi-Cal Dental Manual of Criteria, that are reasonable and necessary to

protect life; prevent significant illness or significant disability; or alleviate severe pain through the diagnosis or treatment of disease, illness or injury as set forth in 22 CCR 51303(a). Medically necessary dental services also include those services related to the ability for a member to achieve age-appropriate growth and development, and to attain, maintain, or regain functional capacity.

For a Medi-Cal beneficiary under the age of 21, "medical necessity" is expanded to include the standards set forth in 22 CCR 51340 and 51340.1 and Section 1396d(r)(5) of Title 42 of the United States Code, and to include diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illness and conditions discovered by screening services, whether or not such services are a covered benefit.

Provided by you or by an employee under your supervision: Participating providers agree to bill Access Dental Plan for only those services rendered by them personally, or under their direct supervision by salaried employees or assistants duly certified pursuant to state law.

There may be times when a claim is denied. This may happen because:

- Access Dental Plan did not receive the claim
- The claim was returned to you to complete missing or incorrect information
- The claim is being investigated for fraud, waste, or abuse
- Eligibility was not verified
- The claim was submitted after the filing deadline

Please do not wait more than 30 calendar days after claim submission before notifying Access Dental Plan of a claim that has not been adjudicated.

Checking Claim Status

Providers may check status of a submitted claim at **www.premierlife.com**. Providers are encouraged to follow up on claims submissions within 30 calendar days after claim submission. If the claim has not been received, providers should contact Access Dental Plan.

Note: Members cannot be balance-billed in any circumstance.

Claims Payment

Access Dental Plan is committed to processing all clean claims within 30 working days as defined by state or federal regulations. Dental services provided to members are reimbursed at the rates set forth in the provider's contract.

Corrected or Voided Claims

Providers have a right to correct claim information that may have been submitted incorrectly. A corrected claim must be resubmitted within 180 calendar days of the original submission. Corrected claims may be submitted on the secure provider portal on our website or by mail. The corrected claim should be submitted on a 2019 ADA claim form with the corrected information and the words "CORRECTED CLAIM" at the top of the form.

Checking Claim Status

To check the status of a dental claim on our secure provider portal, please use the guide. To find it, do the following:

- Log into the secure provider portal at **www.premierlife.com**
- Select Providers from the blue navigation bar
- Member Info, Claims

Submitting a Corrected Claim

Write CORRECTED CLAIM at the top of the form and submit your correction in one of two ways:

- Through our secure portal at **www.premierlife.com**
- By mail to:
  Access Dental Plan
  Attn: Corrected Claims
  P.O. Box 38312
  Phoenix, AZ 85069

IMPORTANT: Access Dental Plan reserves the right to deny payment of a claim if the provider fails to apply third-party payments, to file necessary claims, or to cooperate in matters necessary to secure payment by the third party.

Receiving Payment

Claims payments are issued by paper check or Change Healthcare (Emdeon) ePayment.

Explanation of Payment (EOP)

An EOP is issued with every check payment. Each EOP includes all the processed claims associated with the payment being made. It will also include any claim that has previously been submitted and where an adjustment has been made, if applicable. In addition, the EOP can be viewed within one business day of payment on the secure provider portal at **www.premierlife.com.**

Overpayment

There may be times when you or your practice are overpaid for a service provided to a member. You must report and repay all overpayments to Access Dental Plan within 60 days of becoming aware of an overpayment from Access Dental Plan. If Access Dental Plan identifies the overpayment, however, you must repay the overpayment within 30 working days of receipt of a written or electronic notice from Access Dental Plan of the overpayment, unless you contest the overpayment recoupment notification within 30 working days in writing and identify the portion of the overpayment being contested and the specific reasons for contesting the overpayment. If you do not submit payment for uncontested recoupment within 30 working days of Access Dental Plan mailing the recoupment notice, Access Dental Plan reserves the right to recoupment or offset from current or future amounts due from Access Dental Plan to you.

You can return overpayment to Access Dental Plan by sending a check or money order. The check must be made out to Access Dental Plan and mailed to PO Box 38312 Phoenix, AZ 85069. The check or money order must be accompanied by all COB documentation.

Member Billing

A member shall not be billed for covered services. Should a member wish to receive a non-covered service, the provider, prior to rendering said non-covered service, must obtain and maintain in the member's file. A signed Non-Covered Services Disclosure form, indicating the member understands that the service or procedure will not be covered by this insurance and that s/he will be liable for payment.

Any charges to members shall not exceed your office's usual and customary fee for that dental service.

If the member will be subject to collection action upon failure to make the required payment, the terms of said action must be kept in the member's treatment record.

Failure to comply with this procedure will subject you or your office to sanctions up to and including termination from the Access Dental Plan network.

Coordination of Benefits

Access Dental Plan follows guidelines established by the National Association of Insurance Commissioners (NAIC) for determining primary and secondary coverage. These guidelines state that Medicaid should always be the payer of last resort.

If a member seen in your office has additional insurance coverage, all claims must be filed with the other insurance company prior to filing any claim to Access Dental Plan.

If the primary payer pays less than the fee listed on the applicable fee schedule for a procedure, a secondary claim can be sent to Access Dental Plan for the balance. The EOB from the primary payer must be included with the secondary claim submission. If the EOB is not received with the claim, the claim will be denied.

If the claim is considered clean, the remaining charges will be reimbursed up to the maximum allowed for that procedure as noted on the fee schedule.

If it is later determined that a member has other insurance coverage and a claim was processed without the primary EOB, the office will receive an overpayment request letter. This letter will require that the overpayment is satisfied by check or Access Dental Plan will recoup the overpayment from a future claim payment.

Note: Access Dental Plan must receive the claim within 90 days of the date of the primary payer's remittance advice.

Utilization Management (UM)

The goals and objectives of the Access Dental Plan UM program include:

- Analysis, review, and integration of national, state, and HMO/health plan client goals and initiatives
- Provision of proactive and superior service to all customers
- Provision of information to providers, health plan clients, and members regarding their benefits
- Review of methodologies to streamline the authorization process
- Assurance of adherence to existing health plan standards and existing HIPAA, HITECH, CMIA, and other rules and guidelines

The UM program is reviewed annually by the Quality Oversight Committee. This process sets and/or affirms the standards and benchmarks for reviewing the utilization patterns of our participating network providers.

The UM Committee reviews claims submission patterns, requests for prior authorization, medical records, and utilization patterns. If potential aberrant billing practices are detected or if other potentially negative processes are uncovered, Access Dental Plan' personnel will speak or meet with a provider to address the problem and help develop a program to resolve the issue. Corrective action plans may be developed for individual provider offices, as required. When the results indicate a potentially negative situation such as up-coding on a routine basis, an audit process may be initiated. The process may include chart audits and could result in: a) the provider receiving the necessary education to adjust the practice pattern to be within acceptable norms; b) placement of the provider(s) on post-service, prepayment review to confirm appropriate billing; c) placement of the provider(s) on a pre-authorization corrective action plan to ensure proposed services are appropriate; and/or d) recoupment of the overpayment related to the aberrant billing practice(s).

Statistical Provider Review

Access Dental Plan compiles and reviews total services rendered by all dental providers serving members in the state to provide data regarding the demand for dental services and appropriateness of care. Each code will be analyzed against the number of total dental members in the plan that are being treated. The result will be an average frequency of services per 100 recipients treated in the Access Dental Plan dental program for the state. Providers per member cost will be calculated for the quarter. An average state-wide per-member cost income will be the result.

The following items formulate the basis of the review:

- Average Service Comparison: Access Dental Plan will prepare a summary of the statistical results by CDT code for each provider compared with the state average. We will perform this analysis only if the provider has treated a sufficient number of plan members in that quarter. Providers that qualify must fall within a reasonable range of the state average. Those providers falling outside of the range will be reviewed for over- or under-treatment patterns.
- Relative Service Comparison: Certain dental services are typically performed with or after other services. Access Dental Plan will review a series of related dental services for appropriate care. Some examples include:
    - A root canal on a tooth, followed by the placement of a crown
    - A fluoride treatment for a child being performed at the same appointment as his/her prophylaxis

These related services would be compared to the averages and to other similarly utilized providers to detect any over- or under-utilization.

Total Per-Member Cost: Access Dental Plan shall calculate the per-member cost for all participating network dentists and dental specialists using the services rendered during the review period. The results shall be compared to all other providers and to previous review periods. Providers may request a summary of their per-member cost compared to the state average.

Accurate Claim Submission: During the statistical review, Access Dental Plan will look for any services that would be impossible due to a tooth being previously extracted or a service done on a tooth that would not require that service (i.e., placing an amalgam on a tooth that already had a stainless-steel crown).

Wait Time Review

In lieu of requiring providers to submit an average wait time report, Access Dental Plan will perform random and anonymous surveys of practices to inquire whether scheduling wait times are excessive. Wait time should not exceed 30 minutes for scheduled, routine or emergency appointments.

Providers found to have excessive wait times will be notified that they did not meet wait time standards. Their office will be randomly tested during the next survey cycle. If they do not meet wait time standards the second time, they will receive a call from Provider Relations. During this call, the Provider Relations Representative will work with the office to try to understand the root cause of the wait time issues so they can be addressed. If the provider's office fails a third wait time review survey, a Provider Relations Representative will visit the office to provide one-on-one education about the wait time standards and to try additional ideas for addressing the issue. At this time, Access Dental Plan will need to contact the health plan sponsor or state Medicaid agency.

If a member complains that wait times in a provider's office were excessive, Access Dental Plan is required to notify the provider about the complaint. Typically, this comes through our complaints and grievances process. Our provider relations team may be engaged to do one-on-one education with the provider officer.

Site Reviews

Site reviews will be performed by Access Dental Plan staff to confirm that providers are following mandated practices as established by OSHA, HIPAA, CMIA, and any relevant state or federal agencies that has rules and/or regulations that impact a provider's office. The key areas that are reviewed during an office review include:

- Office signs and visibility

- Handicapped patient access
- Cleanliness of office
- Appointments and accessibility
- Accessibility of medical emergency kit
- Members' records
- Patient privacy practices
- Infection control practices (e.g., spore testing)
- Equipment inspection
- Staff lists and credentials

A formal site review form is used to help ensure the consistency of the office review process. Offices are evaluated based on the results of the site review and will have the results communicated to them in writing within 30 business days of the review.

If the office fails to earn a satisfactory score, the review will be repeated in 90 to 120 business days or as otherwise designated from the initial review. Consequences for not achieving a satisfactory site review include being placed on a CAP, being placed on probation, or being terminated from the network in accordance with the termination clause in the Provider Agreement.

Covered Services

Access Dental Plan will cover services within the program guidelines when the treatment has appropriate diagnoses and when medically necessary. Coverage limitations and reimbursement guidelines are outlined in the Benefit Grid and Fee Schedule located on the provider portal.

Prior Authorization

Access Dental Plan uses a prior authorization review process to manage the utilization of services. Services that require prior authorization are defined in the dental benefit grid. Non-emergency services requiring prior authorization must be approved prior to initiating these services.

Prior authorization is not a guarantee of payment for service. Non-emergency treatment begun prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the member or Access Dental Plan.

A request for prior authorization must include:

- The 2019 ADA Claim form, with the request for prior authorization box checked
- Pre-treatment radiographs necessary for proper diagnosis and treatment

Medical Necessity

Access Dental Plan defines medical necessity by following the regulatory definition for the state in which we're administering a plan. We support our definition further through guidance from key industry leaders such as:

- American Dental Association (ADA)
- American Academy of Pediatric Dentistry (AAPD)
- American Association of Oral and Maxillofacial Surgeons (AAOMS)
- American Academy of Periodontology (AAP)
- American College of Prosthodontists (ACP)
- American Association of Orthodontists (AAO)

- Any other material required for proper diagnosis and treatment such as periodontal charts or ortho models
- Documentation of index criteria used to determine orthodontic necessity

The prior authorization request must also be accompanied by a narrative treatment plan. The treatment plan must include all the following:

- Pertinent dental history
- Pertinent medical history, if applicable
- Strategic importance of the tooth
- Condition of the remaining teeth
- Existence of all pathological conditions
- Preparatory services performed and completion date(s)
- Documentation of all missing teeth in the mouth
- Oral hygiene of the mouth
- All proposed dental work
- Identification of existing crowns, periodontal services, etc.
- Identification of the existence of full and/or partial denture(s), with the date of initial insertion
- Periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality, and prognosis
- Identification of abutment teeth by number
- Prior authorization requests for periodontal services must include a comprehensive periodontal evaluation.
- For those service programs where, dental services are limited to those provided in an in-patient hospital, hospital short procedure unit, or ambulatory surgical center, please include a statement identifying where the service will be provided.
- Should a procedure need to be initiated due to an emergency, you may submit the service(s) for post-treatment review, including a narrative of the nature of the emergency.

Prior authorization review requests may be submitted:

- On paper via postal service using the 2019 ADA claim form

  Access Dental Plan
  Attention: Dental Prior Authorization
  P.O. Box 38312
  Phoenix, AZ 85069

Providers will be notified if additional material is needed to make the determination or if the clinical reviewer has determined that the services requested are medically necessary.

Once all the necessary paperwork is received, licensed dental consultants review all requests to determine if:

- The service is medically necessary

- A less expensive service would meet the member's needs
- The service conforms to commonly accepted standards in the dental community

If requested services are determined to be medically necessary, your provider notification will include an authorization number.

Once the determination has been communicated, providers are responsible for advising the member of the review decision. Specific timeframes for determinations are dictated by the program in which the member participates.

Note: Prior authorization is not transferable to other members or other providers.

Post-Treatment Review

Post-treatment review is made available to providers who are unable to get the services reviewed and approved prior to performing the services. A narrative of why the service was unable to be reviewed prior to being performed should be submitted with the request.

The post-treatment review process shall not retrospectively deny coverage for services when prior approval has been given, unless the approval was based on fraudulent, materially inaccurate, or misrepresented information submitted by the provider, member, or member's authorized representative.

Diagnostic Codes

The procedures and diagnostic codes to which post-treatment review applies may be found in the MOC (Manual of Criteria) **https://www.dental.dhcs.ca.gov/Dental_Providers/Medi-Cal_Dental/MOC_SMA_Versions/**

The post-treatment review process is as follows:

- Following receipt of a claim for a procedure or diagnostic code that requires post-treatment review, Access Dental Plan will send a letter to the provider within two business days of receipt, requesting additional information in support of the medical necessity of the claim.
- Upon receipt of the requested information, we will review the file and make a determination based upon guidelines and screening criteria established for the procedure/service.
- If the post-treatment review is approved, the provider will then have to submit a standard claim to be paid.
- If the request does not meet the screening criteria or guidelines established for the procedure/service, the request will immediately be turned over to the Dental Advisory Board member or state dental director for review.
- If it is the decision of the state dental director or advisory board to deny the claim, written notification of the adverse determination shall be communicated to the provider and member within 30 calendar days. This notification shall include:
    - Date of the determination
    - Principal reason(s) for the determination
    - Source of the criteria used to make the determination
    - Notification that the provider and/or member can obtain a copy of the actual benefit provision or clinical protocol on which the adverse determination was based
    - Instructions for initiating an appeal of the adverse determination.
- Adverse determination notifications shall be signed by the state dental director and include contact information for Access Dental Plan.

- Notifications of adverse determinations, whether for pre- or post-service reviews, will include a statement that the decision is based on appropriate care and service guidelines and that there is no reward for issuing denials nor are incentives offered to encourage inappropriate utilization.
- Review personnel will be qualified to speak with providers to obtain diagnosis and/or treatment information and shall be supervised by the Vice President of Dental Services for Access Dental Plan.
- Personnel may use pre-established screening criteria that have been reviewed and approved for purposes of approving the requested treatment or materials. Screening criteria shall be periodically evaluated and updated by the Vice President of Dental Services for Access Dental Plan and Dental Advisory Board.

You are responsible for submitting all the necessary documentation for the review process. This includes:

- Completed 2019 ADA claim form
- Pre-treatment radiographs necessary for proper diagnosis and treatment
- Any other material required for proper diagnosis and treatment such as periodontal charts or ortho models
- Documentation of index criteria used to determine orthodontic necessity

Post-treatment review material may be submitted:

- Mail sent to:

  Access Dental Plan
  Attention: Dental Post-Treatment Review
  P.O. Box 38312
  Phoenix, AZ 85069

Access Dental Plan clinical staff will review these services after the treatment has been performed. If we do not receive this documentation, the claim will not be paid.

While Access Dental Plan will review some dental services after the treatment is completed, we will not delay payment during this review.

If an Access Dental Plan Dental Consultant determines that the treatment was inappropriate or excessive based upon the documentation received, the claim will not be paid. If there are relevant, extenuating circumstances, a narrative must be included with the claim.

Non-Covered Services

Non-Covered Services Disclosure Form

The Non-Covered Services Disclosure form is located at the end of this manual, see Forms and Documents.

Should a member ask you or your office to render services that are not covered benefits, the member must consent in writing to the services and the cost of the services prior to receiving said services. The consent must be in writing and include:

- The member's willingness to accept non-covered procedures or treatments
- The member's acknowledgement that they received notice that the procedure is not a covered benefit
- The member's acknowledgement that they have been informed of the cost of the non-covered procedure or treatment

- Assurance that there are no covered benefits available to the member

Where permissible by state law, the member will pay a discounted usual and customary rate as payment in full for said service or treatment.

If the member elects to receive any non-covered service, the member is financially responsible and should be billed the usual and customary fee as payment in full for the agreed upon procedure or treatment. If the member becomes subject to collection action upon failure to make the required payment, the terms of the action must be kept with the member's record.

Failure to comply with this procedure may subject you and your office to sanctions that may include termination.

Fraud, Waste, and Abuse

Fraud means an 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 applicable Federal or State law.

Waste means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit.

Abuse means provider practices that are inconsistent with sound fiscal, business, or dental practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for dental services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Access Dental Plan views fraud, waste, and abuse as a serious matter. Identifying and reporting fraud, waste, and abuse is everyone's responsibility—from doctors to employees to members.

Examples of Member Fraud, Waste, and/or Abuse:

- Inappropriately using services such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions
- Sharing ID cards
- Non-disclosed other health insurance coverage
- Alteration of prescription forms
- Obtaining unnecessary equipment and supplies
- Members receiving services or picking up prescriptions through identify theft
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Examples of Provider Fraud, Waste, and/or Abuse:

- Prescribing drugs, equipment, or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower reimbursement rates
- Billing for tests or services not provided
- Intentionally using improper dental coding to receive a higher reimbursement
- Purchasing drugs from outside the United States

- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not verifying Member ID resulting in claims submission for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical/dental qualification
- Using member lists for the purpose for submitting fraudulent claims
- Payments stemming from kickbacks or Stark Violations
- Retaining overpayments made in error by Access Dental Plan
- Preventing Members from accessing covered services resulting in underutilization of services offered
- Services rendered by a provider that has not been credentialed

Access Dental Plan is committed to preventing, detecting, and reporting possible fraud, waste, and abuse. We expect that all our staff and providers understand and adhere to the Access Dental Plan Anti-Fraud Program. Compliance is everyone's responsibility.

Reporting Suspected Fraud, Waste, and Abuse

Access Dental Plan and its staff are committed to preventing, detecting, and reporting possible fraud, waste, and abuse, adhering to the Access Dental Plan Anti-Fraud Program. All Access Dental Plan personnel receive annual training regarding the detecting of fraud, waste, and abuse, and staff involved with claims processing, claims payment, and utilization review receive more in-depth training. All our providers and their office staff are also expected to be alert to possible fraud, waste, and abuse and report any suspicious activity to Access Dental Plan. The Access Dental Plan fraud hotline number is 855-704-0435. You may leave a message on the hotline's voice mail anonymously, as the hotline is not answered in real time. Or you may leave your contact information so that we may provide you with updates on the investigation. Upon receipt of a report of suspected fraud, waste, or abuse, Access Dental Plan will work with relevant plan fraud units and the applicable state/federal fraud, waste, and abuse authorities to investigate.

There are several other ways you can report suspicions of fraud, waste, and abuse:

- The California Department of Health Care Services
    - Call **916-445-1248** or submit a form online at **www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx**
- The U.S. Department of Health and Human Services, Office of Inspector General OIG Hotline Operations
    - Call **800-447-8477** Monday through Friday from 8:30 a.m. until 3:30 p.m. EST or remain anonymous and call after hours and leave a voicemail
- Access Dental Plan Compliance Department
    - Mail a report to: Chief Compliance Officer, Access Dental Plan/Premier Access, P.O. Box 38313, Phoenix, AZ 85069
    - Call the Access Dental Plan Fraud Hotline at **855-704-0435**
- EthicsPoint, an independent third party that will obtain anonymous reports

- Call **833-613-2445** or visit **avesis.ethicspoint.com** to “Make a Report”

Federal Laws and Statutes Affecting Providers

The Federal False Claims Act allows everyday people to bring “whistleblower” lawsuits on behalf of the government-knows as “qui tam” suits-against businesses or other individuals that defraud the government through programs, agencies, or contracts. Using the False Claims Act, you can help reduce fraud against the federal government. The False Claims Act, also called the “Lincoln Law” imposes liability on persons and companies who defraud governmental programs.

Providers should also be aware of the anti-kickback statute (42 U.S.C. Sec. 1320a-7b) and the physician self-referral law (42 U.S.C. Sec. 1395nn). Violations of these rules could result in claims not being paid, monetary penalties, exclusion from participating in medical assistance, and Medicare Advantage programs or imprisonment.

CMS requires that Access Dental Plan and providers who treat medical assistance and/or Medicare Advantage members check two federal exclusions databases and a state database for the state in which the provider is rendering service prior to the start of an employee or consultant’s employment and monthly thereafter. The federal databases are Office of the Inspector General (OIG), List of Excluded Individuals and Entities (LEIE), the Government Services Administration, and System for Award Management (SAM).

Most states maintain exclusions that must also be screened prior to employment and monthly thereafter.

As a participating network provider, you are required to ensure that no staff providing services to medical assistance members appears on any of these lists. If you identify yourself or a staff member on one of these lists, you must report the event to the Chief Compliance Officer at Access Dental Plan within two days by calling our Fraud Hotline at **855-704-0435** or emailing **compliance@Avesis.com.**

Anti-Fraud Training

All Access Dental Plan personnel receive annual training about detecting fraud, waste, and abuse; however, staff involved with claims processing and payment and utilization review receive more in-depth training on this topic.

Required CMS MLN Training

To gain access to the required training course:

- Log into the provider portal at **www.premierlife.com**
- Select **Forms and Materials**
- Search for the Fraud, Waste & Abuse Compliance Training link from the list

The Centers for Medicare & Medicaid Services (CMS) requires that annual fraud, waste, and abuse training is completed by all employees (providers and staff) in a practice that treats Medicaid and/or Medicare Advantage members. Additionally, any non-employee providers (independent contractors) associated with the practice must complete the training. For your convenience, Access Dental Plan has placed a link to the fraud, waste and abuse compliance training available from the CMS Medicare Learning Network (MLN) in the secure provider portal of our website. Access Dental Plan does not require that training is completed through us if similar training has been completed through another source. Once training has been completed, either through the Access Dental Plan portal or through another venue, you and your providers will be required to read and attest to the following statement or a substantially similar statement:

The employees in my practice and I have completed the annual Fraud, Waste, and Abuse training during this current year. I understand that non-employee providers must complete the training and attestation separately.

If this training is completed through our secure provider portal, the online attestation indicating fulfillment of this annual requirement must be filled out. The provider's NPI number must be included as part of your attestation. If we do not have this on record, it could result in:

- Contract termination
- Criminal penalties
- Exclusion from participation in all federal healthcare programs
- Civil monetary penalties

Leaving the Network

Both you and Access Dental Plan have the right to terminate your network agreement at any time, provided written notice is supplied within the timelines set by your provider contract.

Voluntary Termination

If you or your office no longer wishes to see our members, you must notify us in writing and agree to comply with the continuity of care policy for the plan for which you provide services. Generally, you may close your practice to our members effective the first of the following month, provided you gave us written notice at least five business days before the end of the month.

Involuntary Termination

Access Dental Plan may terminate your agreement at any time for immediate cause, which includes, but is not limited to:

- The failure of a provider to maintain or obtain a license to practice medicine in the state where services are provided
- The failure of a provider to obtain and/or maintain hospital privileges at a hospital or contracted ambulatory healthcare facility, if applicable
- The cancellation of a provider's coverage or insurability under his/her professional liability insurance
- A provider's conviction of a felony
- Unprofessional conduct by or on behalf of a provider as defined by the laws of the state where services are rendered
- A filing of bankruptcy (whether voluntary or involuntary) by a provider, declaration of insolvency by a provider, or the appointment of a receiver or conservator of a provider's assets

If conditions arise that cause Access Dental Plan to issue a notice of termination, in most cases the provider shall be given the opportunity to mediate the issue within time frames set forth in the contract. If the provider fails to implement a satisfactory cure within the required time frame, his/her network participation will be terminated.

There may be instances where a provider's agreement with Access Dental Plan may be terminated immediately. Conditions that may lead to this action include, but are not limited to, situations where:

- A provider breaches a material term of his/her agreement or the provider manual, including, without limitation, the representations and warranties or responsibilities defined in these documents and in such a way that the problem cannot be mediated
- The provider poses an imminent danger to Access Dental Plan members or the public health, safety, and welfare
- The provider is charged with a felony or a crime of moral turpitude
- The provider is convicted of an offense related to Medicare or Medicaid
- The provider is terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List
- The provider fails to satisfy the credentialing or re-credentialing program requirements
- The provider ceases participation in Access Dental Plan network through non-renewal of the credentialing application or denial of approval for participation

Participating providers shall be automatically unenrolled from the Access Dental Plan network upon their death or retirement or if their license expires, lapses, or is inactivated by the applicable state licensing board.

Termination Appeals

Providers terminated for a quality issue have appeal rights. The notice of termination will provide the appeal rights and method and timeframe for requesting an appeal.

Upon receipt of written notification of appeal stating the grounds for the appeal, Access Dental Plan will convene a hearing panel to review the appropriate information. The decision will be either confirmed or overturned. If the original decision is overturned, the contracting entity and/or participating provider will be reinstated. If the original decision is confirmed, the contracting entity and/or participating provider shall continue to have the right to dispute resolution as outlined in their contract.

A provider may reapply for inclusion in the network. Providers will only be allowed one reapplication to the network each twelve-month period.

Suspension

Access Dental Plan may, in its sole and absolute discretion, suspend a provider and/or dental office's participation in the network if any of the following were to occur:

- Billing or claims submission issues occurring with such frequency that Access Dental Plan, in its sole and absolute discretion, determines the provider and/or office should be suspended pending further investigation and the resolution of said issues
- Breach of contract by the provider or office, until what caused the breach has been cured
- Other concerns that Access Dental Plan in its sole discretion believes may have a negative impact to member health and safety

Provider Complaints, Claim and Other Disputes

Access Dental Plan has designated personnel who are available to receive phone calls or encrypted emails regarding complaints or appeals. If you make a complaint or appeal, all the specifics surrounding it will be thoroughly investigated and documented. Investigation and resolution shall be made using applicable statutory, regulatory, and contractual provisions. Often issues can be resolved before it rises to the level of a formal complaint or appeal by working with your provider relations representative to understand the concern. Please feel free to contact your provider relations representative or our provider services team who are standing by to assist you with any questions or concerns you may have. Of course, you may always file a complaint or appeal.

Submitting Complaints and Appeals

Make complaints and appeals in writing to:

Access Dental / Premier Access
Grievance Department
P.O. Box 38312
Phoenix, AZ 85069

Providers are permitted to consolidate their complaints or appeals of multiple claims involving the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.

Provider Complaints

A complaint is an expression of dissatisfaction (verbally or written). A grievance is the same as a complaint. A provider complaint includes but is not limited to: challenging, appealing, or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or a contract dispute or dispute a request for reimbursement of an overpayment of a claim.

A provider may file a complaint by calling or writing Access Dental Plan. Should you require assistance, Access Dental Plans' customer service and provider services departments can assist you. The complaint must include the reason for the issue or concern and any supporting documentation.

Access Dental Plan will review the complaint, and if, based upon the information provided, it is determined that the service or material should be reimbursed, the claim will be paid. If Access Dental Plan determines that the claim should not be paid, the claim will be referred for peer level review for final determination. Complaints can be made in writing to:

Access Dental
Attn: Dental Director
P. O. Box 38312
Phoenix, AZ 85069
Email: GrievanceDept@premierlife.com

Claim Disputes and Reconsideration

All claim dispute reviews are handled in accordance with the Access Dental Plan Complaints, Appeals, and Grievances (CAG) policies and procedures (available at www.premierlife.com). All provider claim disputes must be submitted within 365 calendar days of receiving a remittance advice/explanation of payment. The provider will be notified by mail of the decision.

You may consolidate your complaints or appeals of multiple claims involving the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.

Information regarding the ways you can appeal adverse determinations will be included with each EOP.

Note: If the Access Dental Plan appeals process has been exhausted regarding denied or partially denied claims, a provider may pursue the administrative review process or select binding arbitration as set forth in the Provider Agreement. Information regarding how to appeal adverse determinations will be included with the Notice of Action that is sent.

Other Disputes

A non-claims grievance may include, but is not limited to:

- The quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the member's rights, regardless of whether remedial action is requested
- A dispute over an extension of time proposed by the Plan to make an authorized decision

A Grievance Form is included in the EOC or COI booklet disseminated to all new Members and in the Provider Manual. Grievance Forms must also be made available in Provider offices and online.

To fully investigate and resolve an appeal or complaint that you may file, please include all documentation necessary for the conclusion. Necessary documentation may include any of the following:

- Dental records
- Billing records
- Patient registration records
- Test Results
- Digital copies of x-rays (Dental)
- Other, any documents necessary to support the appeal/complaint.

Member Inquiries, Grievances, and Appeals

Upon enrollment, the Plan informs the members of their right to file grievances or appeals. With written consent from the member or the member's legal representative, a provider may file a grievance on behalf of the member and/or serve as the member's advocate.

If the provider acts in this capacity, he/she should be aware of the member grievance and appeal processes, including the time frames for filing. Grievance procedures must comply with applicable state and/or CMS rules. Please refer to **www.premierlife.com** or to the Member Notice of Rights included in this Provider Manual for more information about member grievances, appeals, and State Hearing procedures.

Cultural Competency and Language Services

As a company dedicated to providing clients with superior service, Access Dental Plan fully recognizes the importance of serving members in a culturally and linguistically appropriate manner. We know from direct experience that:

- Some members have limited proficiency with the English language, including some members whose native language is English but who are not fully literate
- Some members have disabilities and/or cognitive impairments that impede their communicating with us and using health care services
- Some members come from cultures that view health-related behaviors and healthcare differently

The Premier Access Cultural Competency Program

Details on the components of Premier Access' cultural competency program may be found on our website.

Visit **www.premierlife.com**

- Select Providers from the blue navigation bar
- Select Forms and Materials
- Search for Cultural Competency Training

Cultural competency is more than a philosophy. It is also a legal requirement for the delivery of services. To this end, Access Dental Plan complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other protected category. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other protected category. To help facilitate the fair and equal treatment of all members, Access Dental:

- Provides aid and services to people with disabilities to communicate effectively with us and your practice, such as:
    - Qualified sign language interpreters
    - Information written in other formats (Braille, large print, audio, accessible electronic formats, other formats)
- Provides language services to people whose primary language is not English such as:
    - Qualified interpreters
    - Information written in other languages

Access Dental Plan is committed to ensuring that network providers, as well as our policies and infrastructure, meet the diverse needs of all members, especially those who face these challenges. Cultural competency is a key component of Access Dental Plan' continuous quality improvement efforts.

Cultural competency includes:

- Identifying members who may have cultural or linguistic barriers so that alternative communication methods can be made available
- Using culturally sensitive and appropriate educational materials

- Ensuring that resources are available to overcome the language barriers and communication barriers that exist in the member population
- Recognizing the culturally diverse needs of the population
- Teaching staff to value the diversity of both their co-workers inside the organization and the population served, and to behave accordingly

If a member seen in your practice needs linguistic support, please contact our customer service line to make arrangements. These cultural and linguistic services will be provided to the member at no cost.

Foreign Language Translation Services/Special Needs Assistance

Access Dental Plan employs customer service representatives who are fluent in Spanish. The representatives may be reached through the Spanish language queue at our toll-free number. Additionally, Access Dental Plan contracts with a company that provides language assistance services in approximately 250 languages for members with limited English proficiency. Access Dental Plan pays all costs for this service.

In compliance with the Affordable Care Act, Section 1557, the Access Dental Plan website has information for members who need language assistance.

In addition, Section 1557 of the Affordable Care Act requires you to post signage in the top 15 languages used in your state indicating the availability of language assistance. These languages may change each year so be sure to check the Access Dental Plan provider portal annually to ensure you have the correct list.

Translation vs. Interpretation

While often confused, translation services are separate from interpretation services.

Translation refers to the process of changing the written word from one language or dialect to another.

Interpretation refers to the real-time process of transmitting spoken word from one language or dialect to another.

Access Dental Plan will work with our Providers and Members to provide any vital documents in the member's preferred language, as well as telephone or face-to-face interpreting services. These services are available to Access Dental Members free of charge and can be arranged through the Access Dental Plan's Customer Services Department.

Access Dental Plan maintains a Language Assistance Program to assist Members with limited English language proficiency in order that they may better communicate and participate more fully in their dental health care.

You may access the interpreting services by calling the Telephone Service Center toll-free at **800-423-0507**, Monday through Friday, between 8 a.m. and 5 p.m., and selecting option 2 when prompted.

Friends or family members must not be asked to serve as interpreters on dental matters, instead, we encourage Members to use the qualified interpreters provided through this service by calling the Telephone Service Center toll-free at **800-322-6384**, Monday through Friday, between 8 a.m. and 5 p.m. and following the prompts:

- English, press 1
- Spanish, press 2
- Mandarin, press 3
- Vietnamese, press 4

- Russian, press 5
- Farsi, press 6
- Korean, press 7
- Cantonese, press 8
- Arabic, press 9
- Armenian, press 10
- For a language not listed, press 11

Please note: To avoid delays and allow time to obtain language interpreter services during an appointment, providers are encouraged to identify if a Medi-Cal patient needs language assistance when they schedule an appointment.

If you have bilingual providers or office staff available to speak to Members, they may do so only to the extent necessary to facilitate administrative customer service functions. (Provide updated bilingual language capabilities by staff with Access Dental Plan on a quarterly basis.) Compliance with the Language Assistance Program policies will be confirmed during quality assurance audits.

Providers can also download the Provider Office Language Assistance Tagline at **https://smilecalifornia.org/wp-content/uploads/2020/03/interpretation_services_sign.pdf** *and display it in their dental office. This at-a-glance, one-page sheet is written in threshold languages and lets your Medi-Cal patients know they should indicate if interpreter services are needed.*

Your Provider Agreement includes information regarding the Language Assistance Program and your responsibilities with regard to its administration.

Deaf or Hard of Hearing Patients

Members who are deaf or hard of hearing may require devices or services to aid them in communicating effectively with their providers.

Access Dental Plan's customer service representatives have the ability to communicate with members who are deaf or hard of hearing using relay devices. When a member calls using a relay service, our team will ask the member if s/he would like a certified interpreter—such as a computer assisted real-time reporter, oral interpreter, cued speech interpreter, or sign-language interpreter—to be present during the provider visit. Customer Service maintains a list of phone numbers and locations of interpreter services by county.

If the use of an interpreter is not requested by the member, Customer Service will ask the member to specify a preferred type of auxiliary aid or service.

To support the linguistic accessibility of your office to any patient who is deaf or hard of hearing, please consider the following suggestions:

- Provide a quiet background for the patient
- Reduce echoes to enhance sound quality
- Add lights to enhance visibility
- Install flashing lights that work in conjunction with auditory safety alarms
- Clearly identify all buildings, floors, offices, and room numbers

Free Access to TRS

Dial **711** to be automatically connected to a TRS operator at no charge.

- Include telecommunications relay services (TRS) to communicate by phone with a member with a hearing or speech disability

If the member requires an interpreter onsite during or following the examination, contact Customer Service to make the necessary arrangements.

Functional Illiteracy

A person with functional illiteracy is someone with basic education but whose reading and writing skills are inadequate for everyday needs. Health illiteracy is the degree to which individuals lack the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.1 This becomes important to a provider when a member is unable to accurately complete registration and medical/dental history forms.

Signs a member seen in your practice may be functionally illiterate or have lower than proficient health literacy include difficulty:

- Circling the date of a medical appointment on a follow-up appointment form
- Completing required forms accurately
- Following basic, printed follow-up or procedure preparation requirements
- Reiterating printed information about personal oral health conditions

Strategies your office might consider implementing to help all patients successfully access the written materials available through your office include:

- Orally reviewing printed medical history or other forms with patients to ensure accuracy and completeness of the information
- Complementing the distribution of printed material with oral explanations of treatment preparation or follow-up instructions
- Offering to complement written appointment reminders with phone call reminders

Cultural Competency Training

DHCS and CMS guidelines require that all providers servicing Medicaid patients complete a cultural competency training each year. Information about your completion of this training is required by law to be included in our provider directory.

You will be asked to fill out an attestation indicating that this training has been completed.

For your convenience, Access Dental Plan has placed a link to the cultural competency training on the secure provider portal of our website. You do not have to complete this through Access Dental Plan if similar training has been completed through another source.

Required Annual Cultural Competency Training

To gain access to the required training course:

- Select Providers from the blue navigation bar
- Select Forms and Materials
- Search for Cultural Competency Training

1 U.S. Department of Health and Human Services. 2000. Healthy People 2010. Washington, DC: U.S. Government Printing Office. Originally developed for Ratzan SC, Parker RM. 2000. Introduction. In National Library of Medicine Current Bibliographies in Medicine: Health Literacy. Selden CR, Zorn M, Ratzan SC, Parker RM, Editors. NLM Pub. No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

Once training has been completed, either through the Access Dental Plan portal or through another venue, read and attest to the following statement:

My employees and I have completed the annual Cultural Competency training during this current year. I understand that non-employee providers who interact with patients must complete the training and attestation separately.

If you complete this training through our secure provider portal, please use the online attestation indicating fulfillment of this annual requirement. Your NPI number must be included as part of your attestation.

If we do not have this on record, it could result in:

- Contract termination
- Criminal penalties
- Exclusion from participation in all federal healthcare programs
- Civil monetary penalties

Cultural Competency Grievances

If you believe Access Dental has failed to adequately provide cultural or linguistic support to a member in your care, you can file a grievance with us. This may be done by phone, mail, fax, or email, as described in the Grievances section in this manual.

However, if you need help filing a cultural competency grievance, the Chief Compliance Officer is available to help you. You may reach the Chief Compliance Officer by:

Fax: **602-638-5976**
Mail: Compliance
10400 N. 25th Street, Suite 200
Phoenix, AZ 85021-1696

Email: compliance@avesis.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **800-368–1019** or **800-537–7697** (TDD).

Clinical Criteria

Providers are asked to be aware of the parameters of care established by the ADA, American Association of Oral and Maxillofacial Surgeons (AAOMS), American Academy of Periodontology (AAP), American Association of Orthodontists (AAO), American Academy of Pediatric Dentistry (AAPD), American Association of Endodontists (AAE), and the American Association of Dental Consultants (AADC) regarding evidence-based dentistry. Access Dental looks to these parameters and other criteria as indicative of appropriate care for services rendered to patients.

Sources for Information about Evidence-based Dentistry

ADA: http://www.ada.org/en
AAOMS: http://www.aaoms.org/
AAP: https://www.perio.org/
AAO: https://www.aaoinfo.org/
AADC: https://www.aadc.org/

Claims for services rendered and requests for prior authorization are evaluated for medical necessity using generally accepted diagnostic materials and standards. This may include radiographs, photographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the state legislature or other state or federal agency will define the requirements for dental procedures and medical necessity. Access Dental understands that local community standards of care may vary from region to region. We use generally accepted criteria that are consistent with the concept of local community standards and the current national community standards.

Medically necessary dental services must be appropriate and consistent with the standard of care for dental practices. Any omission of services has the potential to adversely affect the member's condition. The nature of the diagnosis and the severity of the symptoms must not be provided solely for the convenience of the dental professional or facility or other entity. There must be no other effective and more conservative or substantially less costly treatment available.

For procedures requiring prior authorization, the procedure is medically necessary to prevent or minimize the recurrence and progression of oral disease. Prior authorization may still be requested for comprehensive extensive treatment plans even when it is not necessary to clearly assist any patient financial responsibilities prior to treatment being provided.

These criteria and policies are designed as guidelines for dental service authorization and payment decisions. They are not intended to be all-inclusive or absolute. It is essential that you review and understand a member's covered benefits before providing any treatment.

Periodicity Schedules

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance Counseling of the American Academy of Pediatric Dentistry (AAPD) states:

Since each child is unique, the recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The AAPD emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references. Refer to the text in the Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents for supporting information and references.

The Periodicity Schedule for your state can be found on the American Academy of Pediatric Dentistry (AAPD) website.

Preventive Care

Access Dental typically follows the standards of care and periodicity schedules for preventive treatment set by the American Dental Association and the American Academy of Pediatric Dentistry.

1) Dental Prophylaxis and Fluoride Treatment (D1110-D1208):

    a) Dental prophylaxis (D1110 and D1120) is defined as the preventive dental procedure of coronal scaling and polishing which includes the complete removal of calculus, soft deposits, plaque, stains and smoothing of unattached tooth surfaces.

    b) Fluoride treatment (D1206 and D1208) is a benefit only for prescription strength fluoride products.

c) Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride.

d) The application of fluoride is only a benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.

e) Fluoride procedures (D1206 and D1208) are a benefit once in a four-month period without prior authorization up to the age of six.

f) Fluoride procedures (D1206 and D1208) are a benefit once in a six-month period without prior authorization from the age of six to under the age of 21.

g) Prophylaxis procedures (D1120) are a benefit once in a six-month period under the age of 21.

h) Prophylaxis and fluoride procedures (D1110, D1206 and D1208) are a benefit once in a 12-month period without prior authorization for age 21 or older.

i) Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Diagnostic Care—Radiographs

Access Dental typically follows the standards of care and periodicity schedules for the use of radiographs as set by the American Dental Association.

1) Radiographs (D0210-D0340):

a) According to accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis shall be taken.

b) Original radiographs shall be a part of the patient's clinical record and shall be retained by the provider at all times.

c) Radiographs shall be made available for review upon the request of the Department of Health Services or its fiscal intermediary.

d) Pursuant to Title 22, CCR, Section 51051, dental radiographic laboratories shall not be considered providers under the Medi-Cal Dental Program.

e) Radiographs shall be considered current as follows:

i) radiographs for treatment of primary teeth within the last eight months.

ii) radiographs for treatment of permanent teeth (as well as over-retained primary teeth where the permanent tooth is congenitally missing or impacted) within the last 14 months.

iii) radiographs to establish arch integrity within the last 36 months. Arch radiographs are not required for patients under the age of 21.

f) All radiographs or paper copies of radiographs shall be of diagnostic quality, properly mounted, labeled with the date the radiograph was taken, the provider's name, the provider's billing number, the patient's name, and with the tooth/quadrant/area (as applicable) clearly indicated.

g) Multiple radiographs of four or more shall be mounted. Three or fewer radiographs properly identified (as stated in “e” above) in a coin envelope are acceptable when submitted for prior authorization and/or payment.

h) Paper copies of multiple radiographs shall be combined on no more than four sheets of paper.

i) All treatment and post treatment radiographs are included in the fee for the associated procedure and are not payable separately.

j) A panoramic radiograph alone is considered non-diagnostic for prior authorization and/or payment of restorative, endodontic, periodontic, removable partial and fixed prosthodontic procedures.

k) When arch integrity radiographic images are required for a procedure and exposure to radiation should be minimized due to a medical condition, only a periapical radiograph shall be required. Submitted written documentation shall include a statement of the medical condition such as the following:

i) pregnancy,

ii) recent application of therapeutic doses of ionizing radiation to the head and neck areas,

iii) hypoplastic or aplastic anemia.

l) Prior authorization for procedures other than fixed partial dentures, removable prosthetics and implants is not required when a patient’s inability to respond to commands or directions would necessitate sedation or anesthesia in order to accomplish radiographic procedures. However, required radiographs shall be obtained during treatment and shall be submitted for consideration for payment.

2) Photographs (D0350):

a) Photographs are a part of the patient’s clinical record and the provider shall retain original photographs at all times.

b) Photographs shall be made available for review upon the request of the Department of Health Care Services or its fiscal intermediary.

c) Paper copies of multiple photographs shall be combined on no more than four sheets of paper.

3) Prior authorization is not required for examinations, radiographs, or photographs.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Restorative Care

Access Dental typically follows the standards of care for restorative treatment that are typical for the region in which the service is being delivered.

1) Amalgam and Resin-Based Composite Restorations (D2140-D2394):

a) Restorative services shall be a benefit when medically necessary, when carious activity or fractures have extended through the dentinoenamel junction (DEJ) and when the tooth demonstrates a reasonable longevity.

b) Amalgam and resin-based composite restoration procedures do not require submission of pre-operative radiographs for payment except when requested by the program.

c) The submitted radiographs shall clearly demonstrate that the destruction of the tooth is due to such conditions as decay, fracture, endodontic access or missing or defective restorations. Payment for restorative procedures shall be modified or denied when the medical necessity is not evident.

d) Should the submitted radiographs fail to demonstrate the medical necessity for the restoration, intraoral photographs shall also be submitted as further documentation.

e) When radiographs are medically contraindicated due to recent application of therapeutic doses of ionizing radiation to the head and neck areas, the reason for the contraindication shall be fully documented by the patient's attending physician and submitted for payment. If this condition exists, intraoral photographs shall also be submitted to demonstrate the medical necessity for the restoration.

f) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

g) Restorative services are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

h) Restorations for primary teeth near exfoliation are not a benefit.

i) The five valid tooth surface classifications are mesial, distal, occlusal/incisal, lingual and facial (including buccal and labial).

j) All surfaces on a single tooth restored with the same restorative material shall be considered connected, for payment purposes, if performed on the same date of service.

k) Payment is made for a tooth surface only once for the same date of service regardless of the number or combination of restorative materials placed on that surface.

l) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, bonding agents, lining agents, occlusal adjustments (D9951), polishing, local anesthesia and any other associated procedures are included in the fee for a completed restorative service.

m) The original provider is responsible for any replacement restorations necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits). Radiographs (and photographs, as applicable) shall be submitted for payment to demonstrate the need for replacement.

n) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription and submitted for payment

2. Prefabricated Crowns (D2930-D2933):

A. Primary Teeth:

a) Prefabricated crowns (D2930, D2932 and D2933) are a benefit only once in a 12-month period.

b) Primary teeth do not require prior authorization.

c) Prefabricated crowns do not require submission of pre-operative radiographs for payment except when requested by the program.

d) At least one of the following criteria shall be met for payment:

i) Decay, fracture or other damage involving three or more tooth surfaces,

ii) Decay, fracture or other damage involving one interproximal surface when the damage has extended extensively buccolingually or mesiodistally,

iii) the prefabricated crown is submitted for payment in conjunction with therapeutic pulpotomy or pulpal therapy (D3220, D3230 and D3240) or the tooth has had previous pulpal treatment.

e) Prefabricated crowns for primary teeth near exfoliation are not a benefit.

f) When prefabricated crowns are utilized to restore space maintainer abutment teeth, they shall meet Medi-Cal Dental Program criteria for prefabricated crowns and shall be submitted separately for payment from the space maintainer.

B. Permanent Teeth:

a) Prefabricated crowns (D2931, D2932 and D2933) are a benefit only once in a 36-month period.

b) Permanent teeth do not require prior authorization.

c) Prefabricated crowns do not require submission of pre-operative radiographs for payment except when requested by the program.

d) At least one of the following criteria shall be met for payment:

i) anterior teeth shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least the loss of one incisal angle,

ii) bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth which involves three or more tooth surfaces including at least one cusp,

iii) molars shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least two cusps,

iv) the prefabricated crown shall restore an endodontically treated bicuspid or molar tooth.

e) Arch integrity and the overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered based upon a supportable 36-month prognosis for the permanent tooth to be crowned.

f) Indirectly fabricated or prefabricated posts (D2952 and D2954) are benefits when medically necessary for the retention of prefabricated crowns on root canal treated permanent teeth.

g) Prefabricated crowns on root canal treated teeth shall be considered for payment only after satisfactory completion of root canal therapy. Post root canal treatment radiographs shall be submitted for payment of prefabricated crowns.

h) Prefabricated crowns are not a benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214).

C. Primary and Permanent Teeth:

a) Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

b) Prefabricated crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

c) Prefabricated crowns are not a benefit when a tooth can be restored with an amalgam or resin-based composite restoration.

d) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic build ups, pins (D2951), bonding agents, occlusal adjustments (D9951), local anesthesia (D9210) and any other associated procedures are included in the fee for a prefabricated crown.

e) The original provider is responsible for any replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits). Radiographs (and photographs, as applicable) shall be submitted for payment to demonstrate the need for replacement.

3. Laboratory Processed Crowns (D2710-D2792):

a) Laboratory processed crowns on permanent teeth (or over-retained primary teeth with no permanent successor) are a benefit only once in a 5-year period except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

b) Prior authorization with current periapical and arch radiographs is required. Arch films are not required for crown authorizations if the Medi-Cal Dental Program has paid for root canal treatment on the same tooth within the last six months. Only a periapical radiograph of the completed root canal treatment is required.

c) A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction and a crown is medically necessary to restore the tooth back to normal function. The following criteria shall be met for prior authorization:

i) Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:

a) the involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,

b) the loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,

c) an incisal angle is not involved but more than 50% of the anatomical crown is involved.

ii) Premolars that have not been endodontically treated shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp.

iii) Molars that have not been endodontically treated shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.

iv) Premolars and molars that have had adequate endodontic treatment.

d) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

e) Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

f) Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite.

g) When a tooth has been restored with amalgam or resin-based composite restoration within 36 months, by the same provider, written documentation shall be submitted with the TAR justifying the medical necessity for the crown request. A current periapical radiograph dated after the restoration is required to demonstrate the medical necessity along with arch radiographs.

h) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic build-ups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, occlusal adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed laboratory processed crown

i) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable 5-year prognosis for the teeth to be crowned.

j) Indirectly fabricated or prefabricated posts (D2952 and D2954) are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.

k) Partial payment will not be made for an undelivered laboratory processed crown. Payment shall be made only upon final cementation.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Endodontics

1) Endodontic General Policies (D3000-D3999)

a) Prior authorization with current periapical radiographs is required for patients ages 21 or older and not required for patients under the age of 21 for initial root canal therapy (D3310, D3320 and D3330), and root canal retreatment (D3346, D3347 and D3348). Prior authorization is required for all ages for partial pulpotomy for apexogenesis (D3222), apexification/recalcification (D3351) apicoectomy (D3410, D3421, D3425 and D3426) and periradicular surgery without apicoectomy (D3427) on permanent teeth.

b) Prior authorization for root canal therapy (D3310, D3320 and D3330) is not required when it is documented on a claim for payment that the permanent tooth has been accidentally avulsed or there has been a fracture of the crown exposing vital pulpal tissue. Preoperative radiographs (arch and periapicals) shall be submitted for payment.

c) Root canal therapy (D3310, D3320, D3330, D3346, D3347 and D3348) is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.

d) The prognosis of the affected tooth and other remaining teeth shall be evaluated in considering endodontic procedures for prior authorization and payment. Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to non-restorability or periodontal involvement).

e) Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.

f) Endodontic procedures are not a benefit for third molars, unless the third molar occupies the first or second molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

g) The fee for endodontic procedures includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals, medicated treatments, bacteriologic studies, pulp vitality tests, removal of root canal obstructions (such as posts, silver points, old root canal filling material, broken root canal files and broaches and calcifications), internal root repairs of perforation defects and routine postoperative care within 30 days.

h) Endodontic procedures shall be completed prior to payment. The date of service on the payment request shall reflect the final treatment date. A post treatment radiograph is not required for payment.

i) Satisfactory completion of endodontic procedures is required prior to requesting the final restoration.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Periodontics

Access Dental typically follows the standards of care of periodontic treatment as set by the American Dental Association and the American Academy of Periodontology.

1) Periodontal General Policies (D4000-D4999)

a) Periodontal procedures shall be a benefit for patients ages 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented on the TAR.

b) Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist) (D4920) and periodontal maintenance (D4910).

c) Current periapical radiographs of the involved areas and bitewing radiographs are required for periodontal scaling and root planing (D4341 and D4342) and osseous surgery (D4260 and D4261) for prior authorizations.

d) Photographs are required for gingivectomy or gingivoplasty (D4210 and D4211) for prior authorizations.

e) Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity and shall meet Medi-Cal Dental Program criteria for the requested procedure. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:

i) a full quadrant is considered to have four or more qualifying diseased teeth,

ii) a partial quadrant is considered to have one, two, or three diseased teeth,

iii) third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

f) Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.

g) Scaling and root planing (D4341 and D4342) are a benefit once per quadrant in a 24-month period. Patients shall exhibit connective tissue attachment loss and radiographic evidence of bone loss and/or subgingival calculus deposits on root surfaces.

h) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) are a benefit once per quadrant in a 36-month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.

i) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by-case basis.

j) Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing.

k) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.

l) Procedures involved in acquiring graft tissues (hard or soft) from extra-oral donor sites are considered part of the fee for osseous surgery (D4260 and D4261) and are not payable separately.

m) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) performed in conjunction with a laboratory crown, prefabricated crown, amalgam or resin-based composite restoration or endodontic therapy is included in the fee for the final restoration or endodontic therapy and is not payable separately.

n) The criteria for periodontal procedures shall apply to all dental provider billing types providing services within their scope of practice.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Prosthodontics—Removable

Prosthodontics (Removable) General Policies (D5000-D5899)

1) Complete and Partial Dentures (D5110-D5214, D5863, D5865):

a) Prior authorization is required for removable prostheses except for immediate dentures (D5130 and D5140) under certain circumstances. See the criteria for D5130 and D5140.

b) Prior authorization shall be considered for a new prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or reline.

c) Current radiographs of all remaining natural teeth and implants and a properly completed prosthetic Justification of Need for Prosthesis Form, DC054 (9/18) are required for prior authorization. A panoramic radiographic image shall be considered diagnostic for edentulous areas only.

d) Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when the full treatment has been completed. Any revision of a prior authorized treatment plan requires a new TAR.

e) New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist (see “g” below).

f) All endodontic, restorative and surgical procedures for teeth that impact the design of a removable partial denture (D5211, D5212, D5213 and D5214) shall be addressed before prior authorization is considered.

g) The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.

h) Providers shall use the laboratory order date as the date of service when submitting for payment of a prior authorized removable prosthesis. The laboratory order date is the date when the prosthesis is sent to the laboratory for final fabrication. Full payment shall not be requested until the prosthesis is delivered and is in use by the patient.

i) Partial payment of an undeliverable completed removable prosthesis shall be considered when the reason for non-delivery is adequately documented on the Notice of Authorization (NOA) and is accompanied by a laboratory invoice indicating the prosthesis was processed. The completed prosthesis shall be kept in the provider's office, in a deliverable condition, for a period of at least one year.

j) A removable prosthesis is a benefit only once in a five-year period. When adequately documented, the following exceptions shall apply:

i) Catastrophic loss beyond the control of the patient. Documentation must include a copy of the official public service agency report (fire or police), or

ii) A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure, or

iii) The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.

k) Prosthodontic services provided solely for cosmetic purposes are not a benefit.

l) Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.

m) Spare or backup dentures are not a benefit.

n) Evaluation of a denture on a maintenance basis is not a benefit.

o) The fee for any removable prosthesis, reline, tissue conditioning or repair includes all adjustments necessary for six months after the date of service by the same provider.

p) Immediate dentures should only be considered for a patient when one or more of the following conditions exist:

i) extensive or rampant caries are exhibited in the radiographs,

ii) severe periodontal involvement is indicated in the radiographs,

iii) numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient's health.

q) There is no insertion fee payable to an oral surgeon who seats an immediate denture.

r) Preventative, endodontic or restorative procedures are not a benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a benefit.

s) Partial dentures are not a benefit to replace missing third molars.

2. Relines and Tissue Conditioning (D5730-D5761, D5850 and D5851):

a) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), and overdentures (D5863 and D5865) and cast metal partial dentures (D5213 and D5214) that **required** extractions.

b) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit 12 months after the date of service for complete dentures (D5110 and D5120), overdentures (D5863 and D5865) and cast metal partial dentures (D5213 and D5214) that **did not require** extractions.

c) Laboratory relines (D5760 and D5761) are not a benefit for resin based partial dentures (D5211and D5212).

d) Laboratory relines (D5750, D5751, D5760 and D5761) are not a benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741).

e) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5863 and D5865), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that **required** extractions.

f) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5863 and D5865), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that **did not require** extractions.

g) Chairside relines (D5730, D5731, D5740 and D5741) are not a benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761).

h) Tissue conditioning (D5850 and D5851) is only a benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment.

i) Tissue conditioning (D5850 and D5851) is a benefit the same date of service as an immediate prosthesis that **required** extractions.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Maxillofacial Prosthetics

1) Maxillofacial Prosthetics General Policies (D5900-D5999)

a) Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

b) All maxillofacial prosthetic procedures require written documentation for payment or prior authorization. Refer to the individual procedures for specific requirements.

c) Prior authorization is required for the following procedures:

i) trismus appliance (D5937),

ii) palatal lift prosthesis, interim (D5958),

iii) fluoride gel carrier (D5986),

iv) surgical splint (D5988).

d) All maxillofacial prosthetic procedures include routine postoperative care, revisions and adjustments for 90 days after the date of delivery.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Implants

1) Implant Services General Policies (D6000-D6199)

a) Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Medi-Cal Dental Program for medical necessity for prior authorization. Exceptional medical conditions include, but are not limited to:

i) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.

ii) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.

iii) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).

iv) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

b) Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.

c) Single tooth implants are not a benefit of the Medi-Cal Dental Program.

d) Implant removal, by report (D6100) is a benefit. Refer to the procedure for specific requirements.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Fixed Prosthodontics

1) Fixed Prosthodontic General Policies (D6200-D6999)

a) Fixed partial dentures (bridgework) are considered beyond the scope of the Medi-Cal Dental Program. However, the fabrication of a fixed partial denture shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. **Most importantly, the patient shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered.**

b) Medical conditions, which preclude the use of a removable partial denture, include:

i) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,

ii) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,

iii) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

c) Documentation for medical conditions shall be submitted for prior authorization that includes a written, signed and dated statement from the patient's physician, on their professional letterhead,

describing the patient's medical condition and the reason why a removable partial denture would be injurious to the patient's health.

d) Documentation for obtaining employment shall be submitted for prior authorization that includes a written statement from the patient's case manager or eligibility worker stating why the nature of the employment precludes the use of a removable partial denture.

e) Fixed partial dentures are a benefit once in a five-year period only on permanent teeth when the above criteria are met.

f) Current periapical radiographs of the retainer (abutment) teeth and arch radiographs are required for prior authorization.

g) Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.

h) Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.

i) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pin retention-per tooth, in addition to restoration (D2951), bonding agents, lining agents, impressions, temporary crowns, occlusal adjustment-limited (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed fixed partial denture.

j) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization. Prior authorization shall be based upon a supportable five-year prognosis for the fixed partial denture retainer (abutment).

k) Fixed partial denture retainers (abutments) on root canal treated teeth shall be considered only after satisfactory completion of root canal therapy. Post root canal treatment periapical and arch radiographs shall be submitted for prior authorization of fixed partial dentures.

l) Partial payment will not be made for an undelivered fixed partial denture. Payment will be made only upon final cementation.

m) Fixed partial denture inlay/onlay retainers (abutments) (D6545 and D6634) are not a benefit.

n) Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Oral and Maxillofacial Surgery

1) Oral and Maxillofacial Surgery General Policies (D7000-D7999)

a) Diagnostic pre-operative radiographs are required for all hard tissue surgical procedures that are submitted for prior authorization and/or payment. Refer to the individual procedure for specific requirements.

b) Local anesthetic, sutures and routine postoperative care within 30 days following an extraction procedure (D7111-D7250) are considered part of, and included in, the fee for the procedure. All other oral and maxillofacial surgery procedures include routine postoperative care for 90 days.

c) The level of payment for multiple surgical procedures performed on the same date of service shall be modified to the most inclusive procedure.

1. Extractions (D7111-D7250):

a) The following conditions shall be considered medically necessary and shall be a benefit:

i) full bony impacted supernumerary teeth or mesiodens that interfere with the alignment of other teeth,

ii) teeth which are involved with a cyst, tumor or other neoplasm,

iii) unerupted teeth which are severely distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth,

iv) the extraction of all remaining teeth in preparation for a full prosthesis,

v) extraction of third molars that are causing repeated or chronic pericoronitis

vi) extraction of primary teeth required to minimize malocclusion or malalignment when there is adequate space to allow normal eruption of succedaneous teeth,

vii) perceptible radiologic pathology that fails to elicit symptoms,

viii) extractions that are required to complete orthodontic dental services excluding prophylactic removal of third molars,

ix) when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

b) The prophylactic extraction of third molars is not a benefit.

c) The fee for surgical extractions includes the removal of bone and/or sectioning of tooth, and elevation of mucoperiosteal flap, if indicated.

d) Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal.

e) The level of payment for surgical extractions shall be allowed or modified based on the degree of difficulty as evidenced by the diagnostic radiographs. When radiographs do not accurately depict the degree of difficulty, written documentation and/or photographs shall be considered.

2. Fractures (D7610-D7780):

a) The placement and removal of wires, bands or splints is included in the fee for the associated procedure.

b) Routine postoperative care within 90 days is included in the fee for the associated procedure.

c) When extensive multiple or bilateral procedures are performed at the same operative site, each procedure shall be valued as follows:

i) 100% (full value) for the first or major procedure, and

ii) 50% for the second procedure, and

iii) 25% for the third procedure, and

iv) 10% for the fourth procedure, and

v) 5% for the fifth procedure, and

vi) over five procedures, by report.

d) Assistant surgeons are paid 20% of the surgical fee allowed to the surgeon. Hospital call (D9420) is not payable to assistant surgeons.

3. Temporomandibular Joint Dysfunctions (D7810-D7899):

a) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.

b) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.

4. Repair Procedures (D7910-D7998):

a) Suture procedures (D7910, D7911 and D7912) are not a benefit for the closure of surgical incisions.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Orthodontics

1) Orthodontic General Policies (D8000-D8999)

A. Orthodontic Procedures (D8080, D8660, D8670 and D8680)

a) Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).

b) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.

c) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

d) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

e) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (09/18) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead. Refer to procedure D0470 for the criteria for the proper labelling and handling of diagnostic casts.

f) The automatic qualifying conditions are:

i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

iv) a crossbite of individual anterior teeth causing destruction of soft tissue,

v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

g) When a patient transfers from one orthodontist to another orthodontist, a new TAR for prior authorization shall be submitted:

i) when the patient has already qualified under the Medi-Cal Dental Program and has been receiving treatment, the remaining course of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (09/18) and photographs are not required for a transfer case that has already been approved, or

ii) when a patient has been receiving orthodontic treatment that has not been previously approved by the Medi-Cal Dental Program, pre-treatment diagnostic casts and current photographs are required. If pre-treatment diagnostic casts are not available, then current diagnostic casts shall be submitted. Prior authorization for the remaining course of the orthodontic treatment shall be allowed or denied based on the Medi-Cal Dental Program's evaluation of the diagnostic casts and photographs.

h) When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.

i) If the patient's orthodontic treatment extends beyond the month of their 21st birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment.

j) The Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form DC016 (09/18) shall be completed within the last three months prior to submitting for prior authorization for orthodontic services.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Anesthesia

1) Anesthesia (D9210-D9248)

a) Deep sedation / general anesthesia (D9222 and D9223) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

b) Intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.

c) Non-intravenous conscious sedation (D9248) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) by a route other than IV (oral, patch, intramuscular or subcutaneous) and appropriate monitoring.

d) Behavior modification and local anesthesia shall be attempted first before any type of sedation is considered. If this fails or is not possible due to the patient's medical condition, then sedation shall be considered. If sedation is indicated, then the least profound procedure shall be attempted first. The least profound procedure is inhalation of nitrous oxide/analgesia, anxiolysis (D9230) or non-intravenous conscious sedation (D9248), the next profound procedure is intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) and the most profound is deep sedation/general anesthesia (D9222 and D9223).

e) If the provider provides clear medical/dental documentation of **both** i) and ii) below then the patient shall be considered for prior authorization for deep sedation/general anesthesia (D9222 and D9223) or intravenous moderate (conscious) sedation/analgesia (D9239 and D9243). If the provider documents any **one** of iii) through vi) then the patient shall be considered for prior authorization for deep sedation/general anesthesia (D9222 and D9923) or intravenous moderate (conscious) sedation/analgesia (D9239 and D9243).

i) Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient. Written documentation from the referring/treating provider shall include a copy of the patient record indicating such a failure or why it was not feasible based on the medical needs of the patient.

ii) Use of inhalation of nitrous oxide/analgesia, anxiolysis (D9230) or non- intravenous conscious sedation (D9248) failed or was not feasible based on the medical needs of the patient. Written documentation from the referring/treating provider shall include a copy of the patient record indicating such a failure or why it was not feasible based on the medical needs of the patient.

iii) Use of effective communicative techniques and the ability for immobilization of the patient (patient is dangerous to self or staff) failed or was not feasible based on the medical needs of the patient. Written documentation from the referring/ treating provider shall include a copy of the patient record indicating such a failure or why it was not feasible based on the medical needs of the patient.

iv) Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation. Radiographs (and photographs, if applicable) shall be submitted demonstrating such proposed treatment and shall be included on the same Treatment Authorization Request (TAR).

v) Patient has acute situational anxiety due to immature cognitive functioning. Written documentation from the referring/treating provider shall include a copy of the patient record indicating such a condition.

vi) Patient is uncooperative due to certain physical or mental compromising conditions. Patient is either a Registered Consumer from the Department of Developmental Services or written documentation from the patient's physician (on their professional letterhead) indicates such a condition.

f) Patients with certain medical conditions such as, but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias and significant bleeding disorders (continuous anticoagulant therapy such as Coumadin therapy) shall be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis.

g) The administration of deep sedation/general anesthesia (D9222 and D9223), inhalation of nitrous oxide / analgesia, anxiolysis (D9230), intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) and therapeutic parenteral drug (D9610) is a benefit in

conjunction with payable associated procedures. Prior authorization or payment shall be denied if all associated procedures by the same provider are denied.

h) Only one anesthesia procedure is payable per date of service regardless of the methods of administration or drugs used. When one or more anesthesia procedures are performed only the most profound procedure will be allowed. The following anesthesia procedures are listed in order from most profound to least profound:

i) Procedure D9222/D9223 (Deep Sedation/General Anesthesia),

ii) Procedure D9239/D9243 (Intravenous Moderate (Conscious) Sedation/Analgesia),

iii) Procedure D9248 (Non-Intravenous Conscious Sedation),

iv) Procedure D9230 (Inhalation of Nitrous Oxide/Analgesia, Anxiolysis).

i) Providers who administer general anesthesia (D9222 and D9223) and/or intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) shall have valid anesthesia permits with the Dental Board of California.

j) Evaluation for anesthesia procedures is included in the fees for anesthesia and oral evaluation procedures.

k) The cost of analgesic and anesthetic agents and supplies are included in the fee for the analgesic/ anesthetic procedure.

l) Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.

m) Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

Refer to the Manual of Criteria for specific procedure instructions and program limitations.

Forms and Documents

Access Dental Plan Locum Tenens Form

Noncovered Services Disclosure Form

Specialty Care Referral Request

Grievance / Appeal Form

Member Notice of Rights

Orthodontic Continuation of Care Form

Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet

Member ID Card

Access Dental Plan Locum Tenens Form

Locum Tenens is a Latin phrase that means: Holding the Place. Locum Tenens arrangements are between providers whereas one provider will temporarily replace another provider for a period of time. After Access Dental receives notification of a Locum Tenens situation, the Participating Provider may submit a claim under his/her name and provider number and receive payment for covered benefits for services provided by the locum tenens provider.

Please complete below:	
Tax Identification Number:	
Provider Name and NPI:	
Locum Tenens Name and NPI:	
Contact Person:	
Contact Phone Number:	
Effective Date for Locum Tenens Relationship:	
Reason for Locum Tenens Relationship:	
Expected Termination Date for Locum Tenens Relationship:	

The following documentation **must** accompany this form:

1. A written notice from the owner of the facility to Access Dental in advance advising of the use of a locum tenens provider. If the use of the locum tenens is due to the incapacitation or death of the Participating Provider, then the letter must be signed by the executor of the estate.
2. Copy of the Locum Tenens provider's license
3. Proof of professional liability of one million dollars per occurrence/three million aggregate minimum

In accordance with the Provider Agreement, the Participating Provider may pay the locum tenens provider for his/her services on a per diem basis or similar fee for time basis.

The locum tenens provider may not provide services to members for a period of time in excess of sixty (60) continuous days within a twelve (12) month period.

Non-Covered Services Disclosure Form

To be completed by Physician Rendering Care

I am recommending that_____receive services
Member Name and Identification Number

that are not covered by the_____ Access Dental Covered Benefits Schedule. I am
Health Plan Name

willing to accept my Usual and Customary Fee as payment in full. The following procedure codes are recommended:

CODE	DESCRIPTION	FEES

The total amount due for service(s) to be rendered is $_____
_____

_____

Doctor's Signature *Date*

To be completed by Member

I_____, have been told that I require
Print Your Name

services or have requested services that are not covered by the_____ Access Dental
Health Plan Name

Covered Benefits Schedule.

Read the question and check either YES or NO	YES	NO
My doctor has assured me that there are no other covered benefits.		
I am willing to receive services not covered by my Health Plan		
I am aware that I am financially responsible for paying for these services.		
I am aware that my Health Plan is not paying for these services.		

I agree to pay $_____per month. If I fail to make this payment, I may be subject to collection action.

_____ _____

Member's Signature if over eighteen (18) or Parent / Guardian *Date*

Specialty Care Referral Request

☐ Specialty Care Referral (Mail to address below with x-ray & documents ☐ Emergency Referral (Call (800) 270-6743)

Plan Name	Phone	Fax	Mailing Address
Geographic Managed Care (GMC)	(800) 270-6743	(877) 648-7741	PO Box 38312, Phoenix, AZ 85069
Prepaid Health Plan (PHP)	(800) 270-6743	(877) 648-7741	PO Box 38312, Phoenix, AZ 85069
DHMO	(800) 270-6743	(877) 648-7741	PO Box 38312, Phoenix, AZ 85069

Member		**Provider**	
Member Name:	ID #:	Name:	ID #:
Patient Name:	DOB:	License #:	
Address:	Phone:	Address:	Phone:
City, State, Zip:		City, State, Zip:	

Treatment Request

#	CDT Code	Procedure Code Description	Tooth #		#	CDT Code	Procedure Code Description	Tooth #
1					4			
2					5			
3					6			

PLEASE COMPLETE ALL REQUESTED INFORMATION IN EACH SPECIALTY CATEGORY:

Endodontics (Must submit PA & BWX)	Prognosis (circle one): good / poor Reason for treatment (each tooth): Reason treatment is beyond the scope of your practice: Additional Information:
Oral Surgery (Must submit PA or Pano)	Reason for treatment (each tooth) : Reason treatment is beyond the scope of your practice: Additional Information:
Pediatric Dentistry	Reason for Referral: Reason treatment is beyond the scope of your practice (Please document behavioral problems occurring at initial exam): Date of 1st attempt: _____ Date of 2nd attempt: _____ Additional Information:
Periodontics (Must submit most current dated FMX & Periodontal charting)	Case Type (circle one): I II III IV Area(s) or Tooth #(s): _____ Dates of Root Planing: Date of perio maintenance following SRP's: _____ UR_____ LL _____ LR_____ LR _____ Additional Information:
Orthodontics (Must submit HLD form, Pano and Cast Models)	Notes:
Other	Notes:

I hereby certify that the above noted treatment request constitutes services that are beyond the scope of my practice and acknowledge that the final claim for payment is subject to clinical review.

Treating Dentist Signature:_____ Date: _____

Dental Plan Use Only: Approve Deny Insufficient Information Date : _____ Comments: _____

Dental Consultant Signature: _____ _____

Grievance / Appeal Form

Refer to page two of this form for information about grievances and appeals. If you need help with this form, please call us.

Mail completed form to:

Access Dental
Attn: Grievances/Appeals Dept.,
PO Box 38312
Phoenix, AZ 85069

Customer Service:

Monday through Friday, 8:00 a.m. to 6:00 p.m.
GMC: 877-821-3234
LAPHP: 888-414-4110

This form can also be emailed to:

GrievanceDept@premierlife.com or faxed to 602-638-5956

What program is this grievance/appeal request for?	☐ **GMC**	☐ **LAPHP**
Who is completing this form? Providers can file a grievance/appeal on behalf of a member, with the member's written consent, which must be attached.	☐ Member	☐ Provider
Is a quick decision needed? A quick decision is needed when there is possible harm to a member's life, health, or ability to function. These are expedited appeals. Expedited appeals can be filed by calling Customer Service. A form is not needed.	☐ Yes	☐ No
Has this already been filed by phone? When you file an appeal by phone, a written form is not required. If you filed by phone and need to submit additional documents, please submit a completed form with your documents.	☐ Yes	☐ No
Do you want to continue receiving services while we process your grievance/appeal? If the member continues services while we process the grievance/appeal, and the outcome is not in the member's favor, the member will be responsible for the cost of the disputed services received.	☐ Yes ☐ Does not apply	☐ No

Member ID Number: _____ Member Birthdate: _____ Telephone: _____

Member Last Name: _____ Member First Name: _____ MI: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Office Name: _____ Office Address: _____

Provider Name: _____ Office Phone Number: _____

Contact/Person filing on the member's behalf
(if applicable): _____ Contact Phone Number: _____

Signature: _____ Date: _____

Guidelines for Grievances and Appeals:

	Grievances	Appeals
What is it?	A grievance is a complaint about the way your dental care services were handled by your dentist or Access Dental Plan.	An appeal is a request for Access Dental Plan to review one of the following: • Request for services is denied or the approved services are less than what was requested • Previously authorized service is terminated, reduced, or suspended • Payment for a service is denied in whole or in part, and the denial could result in the member being liable for payment • An Access Dental Plan network provider fails to provide services in a timely manner (e.g., appointment wait time requirement not met) • Access Dental Plan failed to meet the timeframes for the Grievance and Appeals process.
What is an expedited request?	Not applicable for grievances.	An expedited appeal is a request for a quick decision. This is done to avoid possible harm to a member's life, health, or ability to function.
Who can file?	The member or provider.	The member, member's legally authorized representative, or a provider (on behalf of the member with the member's written consent).
How do I file?	A grievance can be filed orally or in writing.	An appeal can be filed orally or in writing. Written appeals can be submitted via mail, email, or fax. If submitting supporting documents, a written appeal is recommended. Call customer service to file an oral appeal.
When can I file?	A grievance can be filed at any time.	An appeal must be filed within 30 calendar days from the date of the Notice of Action. For services previously approved: If the original approval has not expired and the member wants to continue services while the appeal is processed, an appeal must be filed the later of the following: • By the intended effective date of the Action • Within 10 days of the Notice of Action
Can I receive services while my request is reviewed?	Not applicable for grievances	Disputed services can continue while the appeal is in process if all of the following apply: • The member requests to continue services • The appeal for the termination, suspension or reduction of a previously approved service • The original approval has not expired • The appeal was requested on time
How long does it take to process?	The grievance process takes up to 90 calendar days. A notice is sent with the decision. *	The appeal process takes up to 30 calendar days. A notice is sent with the decision. Quick or expedited appeals take up to three working days to process. You will receive notice of the decision. *

*Premier may take an additional 14 days for processing if either the member requests an extension, or there is a need for more information, and it is in the best interest of the member. You will receive a notice of the reason for delay.

Fax: 602-638-5956

Email: GrievanceDept@premierlife.com

Attn: Grievances/Appeals Dept.

Access Dental
PO Box 38312
Phoenix, AZ 85069
premierlife.com

Member Notice of Rights

IF YOU DO NOT AGREE WITH THE DECISION YOUR DENTAL PLAN MADE FOR YOUR DENTAL CARE YOU CAN ASK YOUR DENTAL PLAN FOR AN APPEAL.

HOW DO I ASK FOR AN APPEAL?

You have 60 days from the date of this Notice of Action letter to ask for an appeal. If your dental plan decided to reduce, suspend or terminate a service(s) you are getting now, you may be able to keep getting the service(s) until your appeal is decided. This is called Aid Paid Pending. To qualify for Aid Paid Pending, you must ask your dental plan for an appeal within 10 days from the date of this Notice of Action letter, or before the date your dental plan says the change to your service(s) will happen. Even though your dental plan must give you Aid Paid Pending when you ask for an appeal within these timelines above, you should let your dental plan know when you ask for an appeal that you want to get Aid Paid Pending until your appeal is decided.

If you miss the 10-day period to request an appeal OR do not ask for an appeal before the date the change to your service(s) will happen, you still have 60 days from the date of this Notice of Action letter to ask for an appeal. However, you will not get Aid Paid Pending while your appeal is being decided.

You can ask for an appeal yourself. Or, you can have someone like a relative, friend, advocate, dentist, or attorney to ask for one for you. This person is called an Authorized Representative. Your dental plan can provide a form for you to identify your Authorized Representative. You, or your Authorized Representative, can send in anything you want your dental plan to look at to make a decision on your appeal. A dentist who is different from the dentist who made the first decision will look at your appeal.

You can file an appeal by phone, in writing, or electronically:

- By phone: Contact Access Dental Plan between 8:00 a.m. until 6:00 p.m. (PST) Monday through Friday, excluding observed holidays by calling **800-640-4466**
- If you cannot hear or speak well, please call **877-688-9891**
- In writing: Fill out an appeal form or write a letter and send it to:

  Access Dental Plan
  Claims Department, Attn: Appeals
  P.O. Box 38312
  Phoenix, AZ 85069

Your dentist's office will have appeal forms available. Your dental plan can also send a form to you.

- Electronically: Visit your dental plan's website. Go to Access Dental Plan **www.premierlife.com**

WHEN WILL MY APPEAL BE DECIDED?

For Standard Appeals, your dental plan must respond to your appeal in writing within 30 days. If you think waiting 30 days will hurt your health, you may be able to get a decision in 72 hours. When you ask for an appeal with your dental plan, say why waiting will hurt your health. Make sure you ask for an Expedited Appeal.

For Expedited Appeals, your dental plan must try to give you an oral notice of its decision on your appeal. For both Standard and Expedited appeals, your dental plan will mail you a Notice of Appeal Resolution letter. This letter will tell you what your dental plan decided on your appeal.

CAN I ASK FOR AN INDEPENDENT MEDICAL REVIEW AND A STATE HEARING?

An Independent Medical Review is where a dentist(s) that is not related to the dental plan will review your case. A State Hearing is where a judge will review your case.

If you disagree with your dental plan's decision regarding your service(s), you can ask your dental plan for an appeal. If you still disagree with your dental plan's decision on your appeal, or it has been at least 30 days since you filed your appeal with your dental plan, you can request an Independent Medical Review with the Department of Managed Health Care (DMHC). DMHC staff will determine whether your issue qualifies for an Independent Medical Review.

In most instances, you are not eligible to request a State Hearing until you have first completed your dental plan's internal appeal process. However, there are times when you can directly request a State Hearing. This can happen if your dental plan did not notify you correctly or timely about your service(s). This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- The dental plan did not make this Notice of Action letter available to you in your preferred language.
- The dental plan made a mistake that affects any of your rights.
- The dental plan did not give you a written Notice of Action letter informing you of its intended action regarding your service(s).
- The dental plan made a mistake in its written Notice of Appeal Resolution letter.
- The dental plan did not decide your appeal within 30 days and send you a Notice of Appeal Resolution letter.
- The dental plan decided your case was urgent, but did not respond to your appeal within 72 hours and send you a Notice of Appeal Resolution letter.

Sometimes, you can ask for both an Independent Medical Review and a State Hearing at the same time. You can also ask for one before the other to see if one will resolve your problem first. For example, if you ask for an Independent Medical Review first, and you do not agree with what was decided, you can ask for a State Hearing. But, if you ask for a State Hearing first, and your hearing has already taken place, you cannot ask for an Independent Medical Review. In this case, the State Hearing has the final say.

You will not have to pay for an Independent Medical Review or a State Hearing.

HOW DO I REQUEST AN INDEPENDENT MEDICAL REVIEW?

The paragraph below provides you with information on how to request an Independent Medical Review with DMHC. [1] Note that the term grievance is talking about both complaints and appeals:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your dental plan, you should first telephone your Dental plan at (***Dental Plan's telephone number***) and use your dental plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your dental plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR).

[1] Health and Safety Code (HSC) Section 1368.02(b). HSC is searchable at: **https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml**

If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a dental plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-**

466-2219) and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **https://www.dmhc.ca.gov/**has complaint forms, IMR application forms, and instructions online."

HOW DO I REQUEST A STATE HEARING?

As stated above, you may be eligible to request a State Hearing.

You can ask for a State Hearing in the following ways:

- Online at **https://www.cdss.ca.gov/**
- By phone: Call **1-800-743-8525**. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD **1-800-952-8349**.
- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

  Mail: California Department of Social Services State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  Fax: **(916) 309-3487** or toll-free at **1-833-281-0903**

  Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think that waiting 90 days will hurt your health, you can request an Expedited Hearing. If the State Hearings Division approves your request for an Expedited Hearing, you may be able to get a hearing decision within 3 days from the date it receives your case file from your dental plan.

You can ask for an Expedited Hearing by calling the State Hearings Division at the number above. Or, you can send the State Hearing form or a letter to the State Hearings Division. You must explain how waiting for up to 90 days for a decision will harm your life, health or ability to get or keep maximum function. You can also get a letter from your dentist to help show why you need an Expedited Hearing.

You can speak for yourself at the State Hearing. Or, you can have someone like a relative, friend, advocate, dentist, or attorney speak for you. If you want someone else to speak for you, then you must sign a form telling the State Hearings Division that the person can speak for you. This person is called an Authorized Representative.

LEGAL HELP

You may be able to get free legal help. Call the [Name and Telephone Number of the County's Consumer Rights Hotline]. You may also call the local Legal Aid Office in your county at **888-804-3536**.

Orthodontic Continuation of Care Form

Member ID Number:

Member Name (Last/First):

Date of Birth:

Name of Previous Vendor that Issued Original Approval:

Binding Date:

Care Rate Approved by Previous Vendor: $

Amount Paid for Dates of Service that Occurred Prior to Access Dental Plan: $

Amounts Owed for Dates of Service that Occurred Prior to Access Dental: $

Balance Expected for Future Dates of Service: $

Number of Adjustments Remaining: _____

Additional Information Required: _____

Completed ADA claim form listing services to be rendered.

Copy of the original orthodontic approval if the member is transferring from an existing Medical Assistance program:

If the member started treatment under commercial insurance or fee-for-service, we must receive the photographs of the original diagnostic models (or digital equivalent such as OrthoCAD), intraoral and extraoral diagnostic photographs, banding date and detailed payment history.

Mail to:

Access Dental Plan
Attention: Dental Claims
P.O. Box 38312
Phoenix, AZ 85069

Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Provider **Patient**

Name:_____ **Name:**_____

Number:_____

Date:_____

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF THE CONDITION IS ABSENT

CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS **HLD Score**

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation)
   Indicate an 'X' if present and score no further..... _____
2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist)
   Indicate an 'X' if present and score no further..... _____
3. Deep impinging overbite **WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE. TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT.**
   Indicate an 'X' if present and score no further..... _____
4. Crossbite of individual anterior teeth **WHEN CLINICAL ATTACHMENT LOSS AND RECESSION OF THE GINGIVAL MARGIN ARE PRESENT**
   Indicate an 'X' if present and score no further..... _____
5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.)
   Indicate an 'X' if present and score no further..... _____

6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties. Indicate an 'X' if present and score no further ..... _____

THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

6B. Overjet equal to or less than 9 mm..... _____

7. Overbite in mm..... _____
8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm..... _____ x 5 = _____
9. Open bite in mm..... _____ x 4 = _____

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.

10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars) _____ (tooth numbers) _____ (total) x 3 = _____
11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE) _____ (maxilla) _____ (mandible) _____ (total) x 5 = _____
12. Labio-Lingual spread in mm..... _____
13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bi-lateral posterior crossbite).....Score 4 _____

AUTHORIZATION OF SERVICES IS BASED ON MEDICAL NECESSITY. IF A PATIENT DOES NOT HAVE ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS OR DOES NOT SCORE 26 OR ABOVE, THE PATIENT MAY STILL BE ELIGIBLE FOR THESE SERVICES BASED ON EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) CRITERIA NECESSARY TO CORRECT OR AMELIORATE THE PATIENT'S CONDITION. FOR A FURTHER EXPLANATION OF EPSDT CRITERIA, PLEASE SEE THE ORTHODONTICS SECTION OF THE CALIFORNIA MEDI-CAL DENTAL PROGRAM PROVIDER HANDBOOK.

Handicapping Labio-Lingual Deviation (HLD) Index California Modification Scoring Instructions

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

6A Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties: Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and it's corresponding lower central or lateral incisor. If the overjet is greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) is greater than 3.5mm with masticatory and speech difficulties, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring. Photographs shall be submitted for this automatic exception.)

6B Overjet equal to or less than 9mm: Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.

7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)

8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion

(reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).

9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

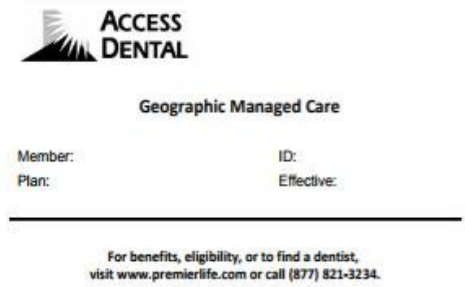
11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

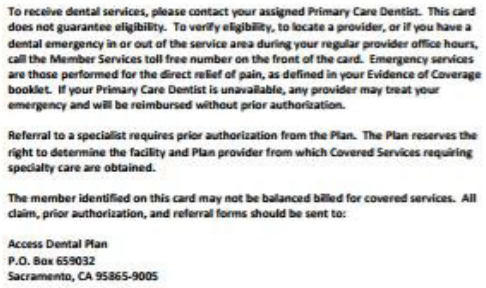
12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio- lingual spread, but only the most severe individual measurement should be entered on the score sheet.

13. **Posterior Unilateral Crossbite**: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERIAL CROSSBITE.**

Member ID Card

GMC Plan:





LAPHP Plan: