Nevada Commercial Managed Care Programs

PROVIDER MANUAL (v.062014)

This Manual and information contained within are confidential and to be used only by Premier Access contracted oral health professions. Any use, dissemination, distribution or copying of the information contained here for any non-intended purpose without prior written authorization from Premier Access is prohibited.

Premier Access' benefits are underwritten by Access Dental Plan of Nevada.

Premier Access
8890 Cal Center Drive
Attn: Provider Services
Sacramento, California 95865-9010
www.premierlife.com
Toll Free: (888) 620-2447
Fax: (916) 648-7741

Introduction

Thank you for your participation in the Premier Access programs. This Provider Manual applies to operations for applicable programs and products underwritten by Access Dental Plan of Nevada. For the purpose of describing the Provider Manual, Access Dental Plan shall be referred to as **"Premier Access".**

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

It is important to Premier Access that we build strong relationships with our contracted dental care professionals. And it is also important to Premier Access that our contracted dental care professionals build solid doctor-patient relationships with our Members. This manual provides you with many of the tools that will help you accomplish both goals.

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.

Forbes® named Premier Access one of the
"Top Ten Most Dependable Insurance
Professionals of the Western United States."
Forbes® Magazine, June 2008

A.M. Best rates Premier Access with an Excellent A- rating for 10 years

General Information

QUICK REFERENCE CONTACT INFORMATION

Name of Contact	Local Number	Toll-Free	Website/Email
24-Hour Emergency		(800) 800-4290	
Dental Consultant **(Dentist Use)**	(916) 563-6011	(800) 270-6743 Ext. 6011	DentalConsultant@premierlife.com
Emergency Fax Referral	(916) 648-7741	(877) 648-7741	
Forms (to order)	(916) 563-6025	(800) 640-4466	info@premierlife.com
Grievances	(916) 563-6013	(800) 448-4733	Grievance@premierlife.com
Provider Services		(800) 640-4466	Provider_Info@premierlife.com
Specialty Referral/Claims	(916) 563-6012	(800) 270-6743 Ext. 6012	AccessReferral@premierlife.com

CUSTOMER SERVICE

Commercial Dental Managed Care (DHMO)	(866) 650-3660
Health Benefit Exchange Plans (HBEX)	(877) 782.0800

Our Customer Service Representatives are available to assist you
Monday through Friday from 8:00 am to 6:00 pm.
Website: www.premierlife.com
Email: MemberServices@premierlife.com

For patient eligibility, patient benefit schedules, patient evidence of coverage and additional forms, such as: Grievance, Encounter, and Specialty Referral forms, please visit our website at: www.premierlife.com.

TO WRITE REGARDING:	FOR PROGRAMS:	CONTACT ADDRESS:
GRIEVANCES	ALL PROGRAMS	ACCESS DENTAL/PREMIER ACCESS GRIEVANCE DEPARTMENT P.O. BOX 255039, SACRAMENTO CA 95865-5039
CLAIMS SPECIALTY REFERRAL DEPT	DHMO, HBEX	ACCESS DENTAL/PREMIER ACCESS CLAIMS DEPT/SPECIALTY REFERRAL P.O. BOX 659032, SACRAMENTO CA 95865-9032

DENTAL HOME

(See the specific Policies regarding this topic within the Quality Management section or click here)

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 that by the age of one year, 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 6 months of age, 6 months after 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.

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

AAPD Policies and guidelines can be found online at:
http://www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY AND AVAILABILITY ACT (HIPAA)

The Health Insurance Portability Accountability and Availability Act, is a Federal Law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Developed by the Department of Health and Human Services, these standards provide Patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country.

We are committed to complying with the requirements and standards of the Health Insurance Portability Accountability and Availability Act (HIPAA).

Premier Access has a Privacy Officer to develop, implement, maintain and provide oversight of our HIPAA Compliance Program as well as assist with the education and training of our employees on the requirements and implications of HIPAA.

Should you have any questions regarding HIPAA and/or Premier Access compliance, please contact the Privacy Officer via email at: PrivacyOfficer@premierlife.com or via telephone at 916-920-2500.

MEMBER'S RIGHTS AND RESPONSIBILITIES

(See the Policy regarding this topic within the Education Policy section or click here to go to all Policies)

To build a strong doctor-patient relationship, there are responsibilities that must be met by both doctor and patient; and a member has certain rights that must also be recognized.

A member has the right to …

- Be treated with respect and dignity
- Have dental records kept confidential
- Access to care within a reasonable amount of time
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand
- Participate in candid discussions and decisions about dental care needs, including appropriate or dentally necessary treatment options for the condition(s) regardless of cost or regardless of whether the treatment is covered by Premier Access
- Request an interpreter at no cost to the Member
- File grievances through Premier Access and be assisted by office to file should they have an issue that is not being addressed in the Provider's practice.

A member has the responsibility to …

- Treat Dentists and their office staff with respect and courtesy
- Present their plan-specific identification card at each appointment
- Notify the Dentist at least 24 hours in advance if they cannot keep an appointment
- Understand how the Premier Access Plan operates and what benefits are available to them
- Cooperate with the Dentist and follow the prescribed course of treatment
- Ask questions about any dental condition and make certain that the explanations and instructions are understandable
- Make correct co-payments as determined by the Plan benefits

PROVIDER'S RESPONSIBILITIES

A Primary Care Dentist must…

- Provide or coordinate all dental care for the enrollee 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 Enrollee'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 Nevada Revised Statutes Chapter 631 – Dentistry and Dental Hygiene.
- Complete and return quarterly Provider Survey within 10 days of mailing
- Maintain dental records for five years from the date of service and make dental records available during regular business hours
- Provide documentation within 5 days of receiving an acknowledgment letter from 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 by calling the Plan's Customer Services Representative at 1-800-70-SMILE

These are a few of the responsibilities of a Premier Access 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.

SPECIALIST’S RESPONSIBILITIES

A Dental Care Specialist must…

- Provide specialty care in a timely manner to Members when prior authorization has been obtained
- Work closely with Primary Care Dentists to enhance continuity of Patient care
- Send a notification to the PCD upon completion of treatment
- Collect any applicable Patient co-payment.
- Submit a narrative of findings to the Plan
- Participate in Quality Management Program and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements
- Maintain dental records for five years from the date of service 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 Nevada Revised Statutes Chapter 631 – Dentistry and Dental Hygiene.
- Inform the Members of availability of free language assistance services for any linguistic need by calling the Plan’s Customer Services Representative at 1-800-70-SMILE
- Provide documentation within 5 days of receiving an acknowledgement letter from Premier Access regarding a Patient complaint
- Provide a complete copy of dental records including x-rays upon request from the Member or from Premier Access
- Provide 24-hour emergency service, seven days a week
- Reschedule any appointments promptly in a manner that is appropriate for the Enrollee’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 a Premier Access 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.

Administration

ONLINE ADMINISTRATIVE SUPPORT

The Premier Access website provides you with the support you need to effectively and efficiently manage your Premier Access patient base. You can verify Member eligibility; check on claims, view benefits and much more.

To register:

- Go to the Provider's page at **www.Premierlife.com**
- Click on the "Register Here" button.
- Once you have registered with a logon and password, you will be able to directly access the information for Members assigned to your practice.

MEMBER ELIGIBILITY VERIFICATION

Dental HMO Members are enrolled in a specific provider facility and that is the facility that must provide the Member's care. Make sure you verify that a Member is enrolled in your facility before the initial appointment.

You have three options to verify that a Member is assigned to your practice:

- Online at www.premierlife.com
- Facility rosters mailed to you each month
- Customer Services number found on the Member's ID Card or Contact Page in this Manual.

Each Member will have a Premier Access Identification Card but the card alone does not confirm current eligibility and assignment. Check with the Plan by contacting Member Services or logging online.

Sample Card

Front	*Back*
Premier Access **<Plan or Program Name>** Group: Group No: Member ID: Effective: Member: Subscriber: For benefits, eligibility, or to find a dentist, visit **www.premierlife.com** or call **(XXX) XXX-XXXX**.	To receive dental services, please contact your assigned Primary Care Dentist. This card does not guarantee eligibility. To verify eligibility, to locate a provider or if you have a dental emergency in or out of the service area during your regular provider office hours, call Member Services' toll-free number on the front of the card. Emergency services are those performed for the direct relief of pain, as defined in your Evidence of Coverage. If you Primary Care Dentist is unavailable, any provider may treat your emergency and will be reimbursed without prior authorization. DHMO Benefits for Emergency Care, not provided by the Primary Care Dentist, are limited to a maximum of $100 per incident, less the applicable Co-Payment. The member identified on this card may not be balanced billed for covered services. All claim, prior authorization, and referral forms should be sent to: **Premier Access** **P.O. Box XXXXXX** **Sacramento, CA 95865-XXXX** DHMO benefits are offered by Access Dental Plan, of Nevada a specialized health care service plan in Nevada

REFERRALS

(See the Policy regarding this topic within the Claims, Referrals & Prior Authorizations Policy section or click here to go to all Policies)

Prior authorization is required in some Programs or Plans for specialist referrals Program and/or Plan requirements are described in the Evidence of Coverage, Certificate of Insurance, and applicable Provider Manual.

For Plans and/or Programs that require prior authorization, all non-emergency Specialist referrals require prior authorization as well as preauthorization of the Specialist's treatment plan. Emergency services do not require prior approval or preauthorization.

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

PRIOR AUTHORIZATION

(See the Policy regarding this topic within the Claims, Referrals & Prior Authorization Policy section or click here to go to all Policies)

The application of Prior Authorization varies between Programs; see the specific Policies regarding this topic within this Manual.

ENCOUNTER REPORTING REQUIREMENTS

(See the Policy regarding this topic within the Claims, Referrals & Prior Authorization Policy section or click here to go to all Policies)

Encounter information is an important source of information regarding the quality of care that Premier Access Providers deliver to our Members and must be reported to reflect all services provided to Premier Access members. Providers are encouraged to use an ADA claim form to report encounter information to Premier Access. You will find this form in the Administrative Forms section of this Manual.

CLAIMS

(See the Policy regarding this topic within the Claims, Referrals & Prior Authorization Policy section or click here to go to all Policies)

Premier Access will verify and acknowledge the receipt of each claim, whether complete or not and disclose the recorded date of receipt via the Premier Access website at www.premierlife.com.

Claims will be processed in 30 business days of receipt.

PROVIDER DISPUTE RESOLUTION

(See the Policy regarding this topic within the Grievance and Appeals Policy section or click here to go to all Policies)

If a claim has been denied, you have the right to dispute that finding. Likewise, if Premier Access sends you notice of an overpayment, you have the right to dispute that finding.

Practice Protocols

ADVERSE DETERMINATIONS, PROVIDER APPEALS & DISPUTES

(See the Policy regarding this topic within the Grievance and Appeals Policy section or click here to go to all Policies)

All Premier Access network providers may appeal an adverse determination which results in termination of a Provider Contract arrangement relating to quality of care issues. If a Provider wishes to appeal an adverse decision, the appeal must include an identification of the grounds for an appeal and a clear and concise statement of the facts and issues in support of the appeal.

Appeals must be requested in writing and submitted to:

Premier Access
Attn: Dental Director
P. O. Box 255039
Sacramento, CA 95865-5039
Email: Grievance@premierlife.com

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

(See the Policy regarding this topic within the Access and Availability Policy section or click here to go to all Policies)

Office must have Active after hours Monitoring system either via answering machine, answering sevice, cell phone or pager 24/7 for contact or instructions. Members must be informed of same.

An answering service or a telephone answering machine is required during non-business hours, which must provide instructions on how Members may obtain urgent or emergency care. This includes, when applicable, how to contact another Provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

ANTI-FRAUD PROGRAM

(See the Policy regarding this topic within the Quality Management Policy section or click here to go to all Policies)

Premier Access provides information to all employees, contractors, subcontractors and agents about the federal and State False Claims Acts; remedies available under these acts; and how employees and others can use them; and about whistleblower protections for individuals who report suspected false claims.

Possible False Claims Act violations should be reported to the Premier Access Fraud Officer for further investigation. The Fraud Officer can be contacted by phone at (916) 920-2500 or by mail at the following address: Anti-Fraud Officer, Access Dental Plan/Premier Access, P.O. Box 659010, Sacramento, CA 95865-9010.

You may report possible violations directly to the Federal Department of Health and Human Services (DHHS). The Office of the Inspector General also maintains a hotline, which offers a confidential means for reporting vital information. The Hotline can be contacted:

Phone: 1-800-HHS-TIPS
Fax: 1-800-223-2164
Email: HHSTips@oig.hhs.gov
Mail: Office of the Inspector General HHS TIPS Hotline; P.O. Box 23489 Washington, DC 20026

APPEALS & GRIEVANCES

(See the Policy regarding this topic within the Grievances and Appeals Policy section or click here to go to all Policies)

The main objective of the Provider and Member grievance process is to ensure an effective system for addressing and resolving complaints and grievances in a timely manner.

Members or their designee can file grievances for any incident or action that is the subject of the Member's dissatisfaction.

A Grievance Form is included in the EOC or COI booklet disseminated to all new Members and in the Provider Manual. Grievance Forms are also available in Provider offices and online on the Premier Access website at: www.premierlife.com.

APPOINTMENT SCHEDULING & WAIT TIMES

(See the Policy regarding this topic within the Access and Availability Policy section or click here to go to all Policies)

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.

Emergency care shall be available to Members 24 hours a day, seven days a week.

When it is necessary for a Provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee'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 Premier Access: You will receive an Accessibility Survey on a regular basis to obtain information on appointment availability, waiting time, acceptance of new Members and staffing changes. Please complete each survey and return it in a timely manner.

CARIES RISK ASSESSMENT

(See the Policy regarding this topic within the Quality Management Policy section or click here to go to all Policies)

A Risk Assessment Form has been created to establish 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.

CASE MANAGEMENT

(See the Policy regarding this topic within the Claims, Referrals & Prior Authorization Policy section or click here to go to all Policies)

All complex and special needs cases are to be referred to the Premier Access 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.

DENTAL PERIODICITY SCHEDULE FOR CHILDREN

(See the Policy regarding this topic within the Quality Management Policy section or click here to go to all Policies)

Premier Access supports the periodicity schedule recommended by the American Academy of Pediatric Dentistry. We believe this approach to treating children will aid in providing preventive dental services based on reasonable guidelines in accordance with a standard dental periodicity schedule.

INFECTION CONTROL

(See the Policy regarding this topic within the Quality Management Policy section or click here to go to all Policies)

Premier Access requires all Providers to comply with the standard precautions and infection control measures as outlined and mandated by the Nevada State Board of Dental Examiners, Regulation Nevada Administrative Code (NAC) 631.178. Premier Access expects all Providers to comply with these regulations.

INITIAL DENTAL ASSESSMENT

(See the Policy regarding this topic within the Access and Availability Policy section or click here to go to all Policies)

Initial dental care assessments must include a dental history, clinical examination and radiographs as needed, in the judgment of the PCD. PCDs shall additionally discuss general disease prevention and follow-up treatments as necessary with Members.

Primary Care Dentists are required to perform an initial dental assessment unless the Member has been treated within the last twelve months by his/her Primary Care Dentist. To facilitate this process, Premier Access sends a notification to every Member explaining the initial assessment program.

LANGUAGE ASSISTANCE PROGRAM

(See the Policy regarding this topic within the Access and Availability Policy section or click here to go to all Policies)

Premier Access 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.

Premier Access 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 Premier Access and Access Dental Members free of charge and can be arranged through the Premier Access Customer Services Department.

Free language assistance services are available 24 hours a day, 7 days a week. You may access the interpreting services by calling the Plan's Member Service Representatives at 1-800-70-SMILE.

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.

If interpreting services are needed, contact Premier Access to obtain information regarding the Member's language preference.

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 Premier Access on a quarterly basis.) Compliance with the Language Assistance Program policies will be confirmed during quality assurance audits.

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

MEMBER ASSIGNMENT, CHANGES, REASSIGNMENT

(See the Policy regarding this topic within the Access and Availability Policy section or click here to go to all Policies)

Members are assigned based either on a) Member's request for a specific provider or b) the nearest Provider to the Member's residence.

You will receive a monthly "roster" (membership listing) at the beginning of each month. The Members enrolled in your facility will be shown along with the capitation that is being pre-paid for the month.

ON-SITE QUALITY MANAGEMENT (QM) SURVEYS:

(See the Policy regarding this topic within the Quality Management Policy section or click here to go to all Policies)

Premier Access performs QM surveys regularly. In most instances, the Dental Director and/or designated Dental Consultant (Auditor) visit the Provider offices annually according to established enrollment thresholds . The frequency of the site visits may vary. Premier Access views the site visits of the Provider offices as a way to assist Providers in complying with regulations related to the operations of dental offices.

Premier Access believes that Provider offices benefit from the consulting services of our Auditors. These services are provided in a non-adversarial, professional manner, at no charge to the dental office, with respect for the Provider's privacy and patient schedule.

OPTIONAL TREATMENT

(See the Policy regarding this topic within the Quality Management Policy section or click here to go to all Policies)

Optional treatment is not an excluded benefit. It is an upgraded alternative procedure presented by the Provider to satisfy the same function of the covered procedure and is chosen by the Member and it is subject to the limitations and exclusions of the Program.

PATIENT SAFETY & RISK MANAGEMENT

(See the Policy regarding this topic within the Quality Management Policy section or click here to go to all Policies)

Premier Access recognizes patient safety as an essential component of quality oral health care for all Members and encourages dentists to consider thoughtfully the environment in which they deliver dental care services. We have created this Policy to identify required and recommended patient safety activities for all contracted Providers, promoting the highest standard of care.

QUALITY MANAGEMENT PROGRAM

(See the Policy regarding this topic within the Quality Management Policy section or click here to go to all Policies)

The Quality Management Program (QMP) is designed to ensure that Premier Access provides the highest quality dental care to all Members, with an emphasis on dental disease prevention and the provision of exceptional customer service to Members.

As a licensed health care service plan in Nevada, Premier Access /Access Dental is regulated by the Nevada Division of Insurance (NDOI). The NDOI's regulations require all Plans to maintain a Quality Management Program (QMP). The QMP provides specific policies relating to Member and Provider grievances/appeals, monitoring of Provider offices/patients and monitoring of dental care and services provided to our Members.

Premier Access contracted Dental Providers are expected to participate in the quality management process by cooperating with all QMP activities, recommendations and corrective actions. In addition, dental Providers are encouraged to be actively involved with establishing dental policies, standards, practice guidelines and review criteria.

Quality Management Committee

The Board of Directors has ultimate oversight responsibility for monitoring and ensuring the delivery of the highest quality, cost effective dental care and services to our members. The Board of Directors has delegated day to day QMP operational responsibilities to the Dental Director, with oversight responsibilities delegated to the Quality Management Committee (QMC). The Dental Director, under the direction of the Premier Access Chief Executive Officer (CEO), chairs the committee.

The QMC has the responsibility to…

- Make recommendations for dental policies standards, practice guidelines and review criteria;
- Manage dental care functions to ensure high quality, cost effective dental care;
- Review individual cases and aggregate data to assess the level of quality of care and service provided to Members;
- Collaborate with the Peer Review Subcommittee that makes recommendations for corrective actions when needed;
- Conduct follow-up monitoring to ensure effectiveness of corrective actions.

Provider participation is an integral component of the QMC and its subcommittees. Providers are the primary decision-makers on quality issues relating to the delivery of dental care. The Dental Director, with QMC approval, selects Providers for participation on committees.

Becoming a Committee Member

Providers who are interested in becoming a member of the Premier Access Public Policy Committee, QMC and/or Subcommittees may submit a request to the Dental Director at the following address:

Premier Access
Attn: Dental Director
8890 Cal Center Drive
Sacramento, CA 95826

SECOND OPINION

(See the Policy regarding this topic within the Claims, Referrals & Prior Authorization Policy section or click here to go to all Policies)

Premier Access Members are entitled to a second opinion regarding a treatment plan. A request for a second opinion may be submitted by a participating PCD or any other participating Provider such as a Specialist, who is treating a Member. If a Member requests a second opinion, your office should contact Premier Access and request a referral to another Provider.

Commercial Dental Managed Care Program

Commercial Dental Managed Care Program

Below is a description of Access Dentals' Commercial Dental Managed Care Program coverage

The benefits and copayments for Commercial Dental Managed Care coverage can be found on the Premier Access website. Premier Access provides group dental benefits to employers and union groups. Under the prepaid Commercial Dental Managed Care Program, Members have a copayment for certain services. The Primary Care Dentist (PCD) must collect the copayment at the time of delivery of service.

Copayment

Premier Access offers several commercial product copayment schedules which are listed on the Premier Access website at: www.premierlife.com. These copayments are amounts that should be collected by the Provider from the Members at the time of delivery of service.

Provider must refer to Member's eligibility, located online to determine Member's copayment schedule as the covered benefits and co-payment vary between Plans. You may contact our Provider Services Department or visit our website to obtain the copayment schedules.

Benefits Plan Summary

The following lists are allowed dental benefits the Member can obtain through the Plan, if applicable to your Plan, when the services are necessary and consistent with professionally recognized standards of practice, subject to the exceptions and limitations listed here:

❖ Diagnostic and Preventive Benefits

Description

- Benefit includes:
- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Radiographs (x-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type.

Limitations

Radiographs (x-rays) is limited as follows:

- Bitewing x-rays in conjunction with periodic examinations are limited to one series of two or four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.*
- Full mouth x-rays in conjunction with periodic examinations are limited to once every 60 consecutive months Panoramic film x-rays are limited to once every 60 consecutive months.*
- Prophylaxis services (cleanings) are limited to one every six month period.
- Dental sealant treatments are limited to un-restored permanent first and second molars for children under the age of 14 years.

❖ Restorative Dentistry

<u>Description</u>

Restorations include:

- Amalgam or composite resin for the treatment of caries
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

<u>Limitations</u>

Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam or composite resin; any other restoration such as a crown is considered optional.
- Composite resin on posterior teeth is optional.*

Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary

❖ Oral Surgery

<u>Description</u>

Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy

- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation

The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Removal of pathology-free 3rd molars is not covered.

Biopsy of oral tissue does not include pathology laboratory services.

❖ Endodontic

Description

Endodonitcs benefits include:

- Direct and indirect pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited re-treatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

Limitations

Root canal therapy, including culture canal, is limited as follows:

- Re-treatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or re-treatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
- Retreatment of a root canal, within a 24 month period, is not payable to the same provider that did the original root canal.

❖ Periodontics

Description

Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis

- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy

Limitation

Periodontal scaling and root planing, and subgingival curettage are limited to four (4) quadrant treatments in any 12 consecutive months.*

❖ Prosthodontics

Description

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal.
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Limitations

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every 60 consecutive months, except when the crown is no longer functional as determined by the Plan.*
- Only acrylic crowns and stainless steel crowns are a benefit for children under 16 years of age. If other types of crowns are chosen as an optional benefit for children under 16 years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers are considered optional.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the Member must pay the difference in cost between the fixed bridge and a space maintainer.

- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

❖ Removable Prosthetics

Description

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, and clasps
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Stayplates

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within 60 consecutive months, unless*:
    - It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or;
    - The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within 60 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.*
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture

- Implants are considered an optional benefit
- Stayplates are a benefit for the replacement of an extracted anterior tooth during the healing period. Limited to (1) per arch in any 12 consecutive months.

❖ Adjunctive General Services

<u>Description</u>

Other dental benefits include:

- Local anesthetics
- Oral sedation. For children under 6 years of age when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed for children under 13 years of age in a dental office by a practitioner acting within the scope of their licensure.*
- Emergency treatment, palliative treatment
- Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

❖ Exclusions and Limitations

The following dental Benefits are excluded under the Plan:

1. Treatment which: a) is not included in the list of Covered Services and Supplies; b) is not Dentally Necessary; or c) is Experimental in nature.
2. Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
3. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the policy.
4. Replacement of a lost or stolen appliance including but not limited to, full or partial dentures, space maintainers and crowns and bridges.
5. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions.
6. Missed dental appointments.
7. Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders.
8. Treatment for a jaw fracture.
9. Services or supplies provided by a dentist, dental hygienist, denturist or doctor who is: a) a close relative or a person who ordinarily resides with You or an Eligible Dependent; b) an employee of the employer; c) the employer.

10. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
11. Services and supplies obtained while outside the United States, except for Emergency Care.
12. Services or supplies resulting from or in the course of your or your Eligible Dependent's regular occupation for pay or profit for which you or your Eligible Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify Us of all such benefits.
13. Any Charges which are:
    a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and supplies.
    b. Not imposed against the person or for which the person is not liable.
    c. Reimbursable by Medicare Part A and Part B. If an Eligible Person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her Benefits under this policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for Eligible Persons insured under employers who notify Us that they employ 20 or more employees during the previous business year, this exclusion will not apply to an actively at work employee and/or his or her spouse who is age 65 or older if the employee elects coverage under this policy instead of coverage under Medicare.
14. Services and supplies provided primarily for cosmetic purposes.
15. Services and supplies which may not reasonably be expected to successfully correct the Eligible Person's dental condition for a period of at least three years, as determined by Premier Access.
16. Orthodontic services, supplies, appliances and orthodontic-related services, unless an orthodontic rider was included in the policy.
17. Extraction of asymptomatic, pathology-free third molars (wisdom teeth).
18. Therapeutic drug injection.
19. Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
20. General anesthesia or intravenous/conscious sedation.
21. Excision of cysts and neoplasms.
22. Osseous or muco-gingival surgery.
23. Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes.
24. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The covered charge for the services is based on the single dental procedure code that accurately represents the treatment performed.
25. Replacement of stayplates.
26. Dispensing of drugs not normally supplied in a dental office.
27. Malignancies.

28. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
29. The cost of precious metals used in any form of dental Benefits.
30. Implant-supported dental appliances, implant placement, maintenance, removal and all other services associated with dental implants. Please refer to your Schedule of Benefits for more specific information.
31. Dental services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonably should have known that an Emergency Care situation did not exist.
32. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.

Limitations of Other Coverage:

1. This dental coverage is not designed to duplicate any Benefits to which Members are entitled under government programs, including CHAMPUS, Medicaid/CHIP or Workers' Compensation. By executing an enrollment application, a Member agrees to complete and submit to the Plan such consents, releases, assignments, and other documents reasonably requested by the Plan or order to obtain or assure CHAMPUS or Medicaid/CHIP reimbursement or reimbursement under the Workers' Compensation Law.
2. Benefits provided by a pediatric dentist are limited to children under six years of age following an attempt by the assigned Primary Care Dentist to treat the child and upon Prior Authorization by Premier Access, less applicable Copayments.

*** Please refer to the Premier Access website: www.premierlife.com for Co-Pay Schedules, Limitations and Exclusions for your respective Plan.**

Administrative Forms

TRANSFER REQUEST FORM

Date:______________________________________
Member Name:________________________________
Member ID #:_________________________________
Member Telephone #:__________________________

Dental Office Name:_________________________
Office Telephone #:__________________________

GEOGRAPHIC MANAGED CARE	COMMERCIAL MANAGED CARE	HEALTHY FAMILIES PROGRAM	LOS ANGELES PREPAID HEALTH PROGRAM
❑ **GMC**	❑ **DHMO**	❑ **HFP**	❑ **LAPHP**

Reason for Request: All Provider Transfer Requests will be processed by the Plan within 30 days from the date of receipt. All approved transfers will be result in the deletion of the Member from the next month's roster. Providers will be notified by the Plan, in writing, of any denied requests.

- ❑ Member is repeatedly verbally abusive to the provider, auxiliary or administrative staff or other Plan members.
- ❑ Member physically assaulted the provider or staff person or another member or threatened another individual with a weapon on provider's premises. In this instance, the provider shall file a police report and file charges against the member.
- ❑ Member was disruptive to the provider's office operations.
- ❑ Member has allowed the fraudulent use of his/her coverage under the Plan, which includes his/her allowance of others to use his/her membership card to receive services from Providers.
- ❑ Member has failed to follow prescribed treatment (including failure to keep established appointments). This shall not, in and of itself, be good cause for a request for Member reassignment unless the provider can demonstrate that, as a result of the failure, the Provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated under the Plan and the rate-setting assumptions.

Additional comments for transfer:____

____

PLEASE STATE THE MISSED APPOINTMENT DATES:____________________________________

Dentist's Signature:____ **Date:**______________________

PLEASE MAIL REQUEST TO: ACCESS /PREMIER ACCESS, P.O. BOX 659005, SACRAMENTO, CA 95865-9005
ATTENTION: CUSTOMER SERVICE DEPARTMENT

FOR ACCESS DENTAL PLAN OFFICE USE ONLY:

Person Receiving Complaint:____
Date of Action:____
Action Taken:____

____

SPECIALIST REFERRAL FORM

Mail to: Access Dental Plan – Referral Department
PO Box 659005 – Sacramento, CA 95865-9005
Telephone: 800-270-6743 x6012 Fax: 877-648-7741

PLEASE CHECK APPROPRIATE BOXES:

☐ **Routine Referral** ☐ **Emergency Referral**

☐ **GMC** ☐ **DHMO-Commercial Managed Care** ☐ **LAPHP**

PATIENT INFORMATION		PRIMARY CARE DENTIST INFORMATION
Patient Name:		Provider Name:
Parent's Name (if minor):		Provider Office Number:
CIN Number:		Provider Phone Number:
Phone:	DOB:	Provider Fax Number:
Address:		Address:
City, State, Zip:		City, State, Zip:
Social Security Number (optional):		License Number:

REQUEST FOR REFERRAL: ☐ **Endodontist** ☐ **Pedodontist** ☐**Periodontist** ☐ **Oral surgeon** ☐ **Orthodontist** ☐ **Other**

ATTACHMENTS: ☐ **X-rays included:** ☐ **YES** ☐ **No** **If yes, how many?________ (PLEASE ATTACH FILMS TO THIS FORM)**

PLEASE REFER TO THE ACCESS DENTAL SPECIALTY CARE GUIDELINES ON THE BACK OF THIS FORM FOR DETAILS REGARDING THE DOCUMENTATION REQUIRED TO PROCESS YOUR SPECIALTY REFERRAL.

DESCRIBE THE PROCEDURE AND REASON FOR SPECIALTY REFERRAL

PATIENT MUST BE ELIGIBLE FOR COVERAGE AT TIME OF SERVICE

SPECIALIST: PLEASE RETURN X-RAYS WHEN TREATMENT IS COMPLETED

IN MY PROFESSIONAL JUDGMENT THE TREATMENT LISTED REQUIRES A SPECIALIST: ☐ **YES** ☐ **NO**

REFERRING DENTIST SIGNATURE: ______________________________ **DATE:**______________________

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF APPROVAL.

FOR ACCESS DENTAL PLAN USE ONLY

Eligibility: ☐ Yes ☐ No Date: Initial:

PLEASE SEE ATTACHED RESPONSE TO SPECIALTY REFERRAL REQUEST FOR THE FOLLOWING

☐ Approved	Date:	Initial:
☐ Modified	Date:	Initial:
☐ Insufficient Information	Date:	Initial:
☐ Denied	Date:	Initial:

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SPECIALTY CARE GUIDELINES FOR ALL PROGRAMS

Purpose:

To provide uniform guidelines of responsibility for General Dentists, to ensure that the level of specialized care provided by general practitioners is appropriate. The general Dentist is responsible for providing routine emergency and after hours emergency care, diagnostic and treatment planning procedures, diagnostic therapy, and the coordination of multi-disciplined treatment as needed.

Policy:

It is the policy of Access Dental Plan that general dentists provide the complete range of dental treatments for which they are licensed. Patients are only referred to a specialist for treatment of conditions that are beyond the capability of the general practitioner. Referral Department will make decisions on authorizations based on the information provided by the referring provider. The accuracy of this information will be verified based on the written referral request submitted by the referring provider.

In cases where a referring dentist inappropriately refers a member to a specialist, the referring dentist may be financially responsible for specialty dental care. The member will only be financially responsible for applicable co-payment (if any) and the treating specialist shall receive payment of benefits for covered services. The referring dentist may be subject to a back charge to cover the costs the Plan incurred for the inappropriate referral. The referring dentist may appeal the determination in writing via letter, e-mail or facsimile and the Plan will process the appeal request in accordance with any regulatory requirements and existing policies and procedures.

An inappropriate referral is defined as:

- A specialty dental care referral when the member is not eligible for benefits;
- A specialty dental care referral for services that do not meet the conditions listed for specialty referral guidelines below; or
- A specialty dental care referral to a non-contracted dentist providing specialty care without prior authorization of benefits from the Plan for non emergency services;

Endodontics

All routine endodontic procedures are the responsibility of the general Dentist. This includes initial treatment of root canal fillings for single and multi-canal teeth. The Dentist must also provide emergency pulpal, I & D, and bleaching treatment. Referrals may be made for complicated "tried and failed" cases, apicoectomies, and retro fillings.

Pedodontics

The general Dentist is responsible for the routine care of children of all ages. Routine care includes extractions, fillings, stainless steel crowns, pulpotomy, space maintainers, sealants, prophylaxis, and fluoride treatment. Young children with complicated management problems may constitute an appropriate referral to a specialist if at least two documented attempts with date of attempts, have been made by the Dentist in treating the patient. Some Patients with special health care needs may be considered as exceptions to this policy.

For HFP program members, approvals of pedodontic referrals will not be authorized for children ages 6 years and older. **For GMC and LAPHP** programs members, approvals of pedodontic referrals will not be authorized for children ages 11 years and older.

Periodontics

The general Dentist is responsible for the diagnosis and maintenance of his/her patient's periodontal care. The Dentist must be adept at surveying the patient's periodontal situation and home care motivation. The Dentist is responsible for all non-surgical treatment including, but not limited to, prophylaxis, subgingival curettage, root planning, oral hygiene instruction, and minor occlusal adjustment.

Specialty referral procedures may include: gingival surgery, osseous surgery, complete occlusal equilibration and orthodontic appliances. All periodontal referrals must indicate that the following procedures have been performed by the general Dentist prior to the referral:

1. Complete exam 2.Full Mouth X-rays 3.Full periodontal examination

4. Full mouth root planning 5.Recall periodontic exam within 3-6 months from the date of the initial root planning.

Oral Surgery

The general Dentist is responsible for providing Oral Surgery for erupted and devastated dentition including surgical extractions, root sectioning and retrieval, soft tissue impaction, intra-oral I & D, and/or routine minor surgical procedures. THE PLAN will cover extractions of impacted teeth only with an existing pathology, immature, erupting third molars, which are currently impacted (usually on patients 18 years or younger) are not a covered benefit. Extraction of impacted, asymptomatic teeth with no pathology on adult patients is not a benefit of THE PLAN. Part and full bony symptomatic impactions, biopsies, and osseous re-contouring and patients requiring hospital dentistry and specialist involvement due to the medical problem, may be referred to an Oral Surgeon.

Anesthesia

The general Dentist is expected to be an expert in controlling pain through the use of relaxation techniques and local anesthesia.

Orthodontics

General Dentists are not expected to have extensive orthodontic training and are not required to provide this care. Not all Access Dental Plan members have orthodontic coverage. Member referrals will be expedited through the Dental Director's office to orthodontic offices within the panel. Please see your provider manual for Healthy Families Program requirements through the California Children's Services Program.

Other

An authorization for a second opinion.

INTENTIONALLY LEFT BLANK

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 <u>#1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS</u> **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 or mandibular protrusion (reverse overjet) greater than 3.5mm. 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 ________

TOTAL SCORE: ________

IF A PATIENT DOES NOT SCORE 26 OR ABOVE <u>NOR MEETS ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS</u>, HE/SHE MAY BE ELIGIBLE UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – SUPPLEMENTAL SERVICES (EPSDT–SS) EXCEPTION IF MEDICAL NECESSITY IS DOCUMENTED.

☐**EPSDT–SS EXCEPTION:** (Indicate with an 'X' and attach medical evidence and appropriate documentation for each of the following eight areas on a separate piece of paper <u>IN ADDITION TO COMPLETING THE HLD SCORE SHEET ABOVE.</u>)

a) Principal diagnosis and significant associated diagnosis; and **DO NOT WRITE IN THIS AREA.**
b) Prognosis; and
c) Date of onset of the illness or condition and etiology if known; and
d) Clinical significance or functional impairment caused by the illness or condition; and
e) Specific types of services to be rendered by each discipline associated with the total treatment plan; and
f) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals; and
g) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care; and
h) Any other documentation which may assist the Department in making the required determinations.

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 or mandibular protrusion (reverse overjet) greater than 3.5mm:** 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 <u>greater</u> than 9mm or mandibular protrusion (reverse overjet) is <u>greater</u> than 3.5mm, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

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.**

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CLAIM / ENCOUNTER FORM

Attending Dentist's Statement II ☐ GMC ☐ HFP ☐ LAPHP ☐ DHMO CHDP Patient? ○ Yes ○ No

Check one: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services ☐ Encounter	Carrier name and address:

PATIENT SECTION

1. Patient Name First Mi Last	Relationship to employee ☐ self ☐ child ☐ spouse ☐ other____	Sex M. F.	4. Patient birth date MM DD YYYY	5. If full time student school city
6. Employee / Subscriber name and mailing address	7. Employee / Subscriber / CIN Soc. Sec. number	8. Employee / Subscriber birth date MM DD YYYY	9. Employer (company) name and address	10. Group number
11. Is patient covered by another plan of benefits? Dental____ Medical____	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of employer	
14-a. Employee / subscriber name (if different than patient's)	14-b. Employee / subscriber soc. Sec. number	14-c. Employee / subscriber birth date MM DD YYYY	15. Relationship to patient ☐ self ☐ child ☐ spouse ☐ other____	

DENTIST SECTION

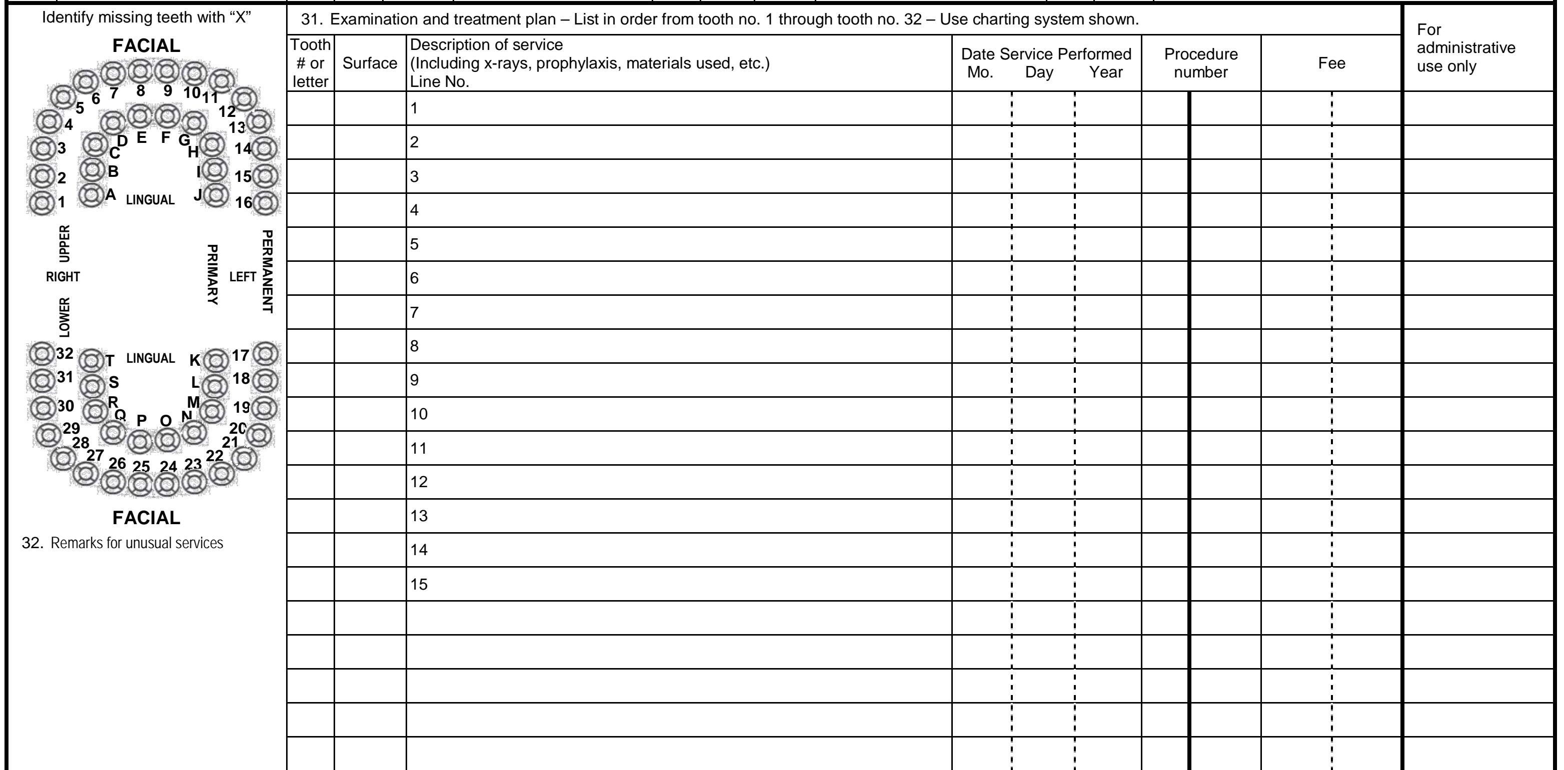
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

► **Signed (Patient, or parent if minor)** **Date**

I hear by authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

► **Signed (Insured person)** **Date**

16. Dentist name	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates.
17. Mailing address	25. Is treatment result of auto accident?			
	26. Other accident?			
City, State, Zip	27. Are any services covered by another plan?			
18. Dentist Soc. Sec. or T.I.N. 19. Dentist license no. 20. Dentist phone no.	28. If prosthesis, is this initial placement?			(If no, reason for replacement) prior 29. Date of Placement
21. First visit date Current series 22. Place of treatment Office Hosp. ECF Other 23. Radiographs or models enclosed? No Yes How Many	30. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed Mos. treatment remaining



Identify missing teeth with "X"

FACIAL / LINGUAL / UPPER / LOWER / RIGHT / LEFT / PRIMARY / PERMANENT / FACIAL

32. Remarks for unusual services

31. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Use charting system shown.

Tooth # or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.) Line No.	Date Service Performed Mo. Day Year	Procedure number	Fee	For administrative use only
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

I hear by certify that the procedures as indicated by date have been completed and that the fee submitted are the actual fees I have charged and intend to collect for those procedures.

► Signed (dentist) Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

MAIL TO: Access Dental/Premier Access
P.O. Box 659005
Sacramento, CA 95865-9005

PHONE: LAPHP 888-414-4110
HFP 888-849-8440
GMC 916-646-2130
DHMO 866-650-3660

GRIEVANCE FORM

GEOGRAPHIC MANAGED CARE	COMMERCIAL MANAGED CARE	LOS ANGELES PREPAID HEALTH PROGRAM
❑ **GMC**	❑ **DHMO**	❑ **LAPHP**

Access Dental / Premier Access ("The "Plan") takes very seriously problems raised by its enrollees and endeavors to reach solutions acceptable to all concerned. To facilitate these efforts, please provide us with the following information. If you need assistance in completing this form, please contact any Plan Member Services Representative at 1-800-707-6453 or any Plan provider representative.

Name: ____

Address: ____

City: ______________________________ State: _________ Zip Code:__________ Telephone: (_____) ______- __________

NATURE OF COMPLAINT (BE AS SPECIFIC AS POSSIBLE & USE THE BACK OF THIS FORM IF MORE SPACE IS NEEDED):

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DATE OF INCIDENT GIVING RISE TO THIS COMPLAINT: ____

NAMES OF PLAN PERSONNEL INVOLVED IN INCIDENT: ____

____

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-866-707-6453)**, and use your health 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 health 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). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

PLEASE MAIL THIS FORM TO:

Grievance Department
Access Dental / Premier Access
P. O. Box: 255039
Sacramento, CA 95865-5039

Please do not write below this line – for Plan use only.

Name of Person Taking Complaint:______________________	**Date Received:**__________	**Time Received:**__________	**Date/Time Logged:**__________

FORMULARIO DE RECLAMO

SERVICIOS MÉDICOS ADMINISTRADOS GEOGRÁFICAMENTE	SERVICIOS MÉDICOS ADMINISTRADOS COMERCIALMENTE	PROGRAMA DE SALUD DE LOS ANGELES PAGADO
❑ **GMC**	❑ **DHMO**	❑ **LAPHP**

Access Dental / Premier Access ("El "Plan") toma muy en serio todo problema planteado por sus miembros y se esfuerza por lograr soluciones aceptables para todos los interesados. Para facilitar estos esfuerzos, por favor proporcione la siguiente información. Si necesita ayuda para completar este formulario, comuníquese con algún representante de Servicios al Miembro del Plan al 1-800-707-6453 o con cualquier representante del proveedor del Plan.

Nombre: ____

Dirección: ____

Ciudad: ____________________ Estado: __________ Código Postal:___________ Teléfono: (_____) ______- _____

NATURALEZA DE LA QUEJA (SEA LO MÁS ESPECÍFICO POSIBLE Y USE EL REVERSO DE ESTE FORMULARIO SI NECESITA MÁS ESPACIO):

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____

FECHA DEL INCIDENTE QUE OCASIONA ESTA QUEJA: ______________________________

NOMBRES DE LOS EMPLEADO DEL PLAN INVOLUCRADOS EN EL INCIDENTE: ______________________________

____

El Departamento de Atención Médica Supervisada de California es responsable de regular los planes de servicios médicos. Si tiene un reclamo contra su plan de salud, primero tiene que llamar por teléfono a su plan de salud al **(1-800-707-6453)** y usar el proceso de reclamo de su plan de salud antes de comunicarse con el departamento. La utilización de este procedimiento de reclamos no prohíbe ningún derecho o recurso potencial que pueda estar a su disponibilidad. Si necesita ayuda con un reclamo que implique una emergencia, un reclamo que su plan de salud no haya resuelto satisfactoriamente o un reclamo que haya permanecido sin solución por más de 30 días, puede llamar al departamento para solicitar asistencia. También puede ser elegible para una Revisión médica independiente (IMR, por sus siglas en inglés). Si usted es elegible para una IMR, el proceso de la IMR le proporcionará una revisión imparcial de las decisiones médicas tomadas por un plan de salud relacionado con una necesidad médica de un servicio o tratamiento propuesto, decisiones de cobertura para tratamientos experimentales o de investigación y disputas de pagos por servicios médicos urgentes o de emergencia. El departamento también tiene un número de teléfono gratuito **(1-888-HMO-2219)** y una línea TDD **(1-877-688-9891)** para personas con discapacidades auditivas y del lenguaje. El sitio Web en Internet del departamento, **(http://www.hmohelp.ca.gov)**, tiene formularios de quejas, formularios de solicitud de IMR e instrucciones en línea.

ENVÍE ESTE FORMULARIO POR CORREO A:

Grievance Department
Access Dental / Premier Access
P. O. Box 255039
Sacramento, CA 95865-5039

Por favor no escriba debajo de esta línea – para uso exclusivo del Plan.

Nombre de la persona que recibe la queja:__________________	**Fecha Recibido:**__________	**Tiempo Recibido:**__________	**Fecha/hora de registro:**__________

POLICIES & PROCEDURES

The following policies have been provided to assist you in providing care to your Premier Access patients. Each policy was created to provide you with complete procedural instructions and/or information about the specific policy topic.

These policies supersede any other information and/or instructions found elsewhere. They can be linked to online by pressing the Policy Number provided below.

ACCESS & AVAILABILITY

AA.001.01	Appointment Availability and Wait time standards
AA.003.01	Monitoring Compliance with Access and Availability Standards
AA.004.01	Language Assistance Program
AA.005.01	Missed Appointment Policy
AA.006.01	Access & Availability - General

CLAIMS, REFERRALS & PRIOR AUTHORIZATIONS

CL.001.01	Claims Processing
CL.002.01	Prior Authorizations - General
CL.003.01	Referrals for Specialty Care - General
CL.004.01	Specialty Care General Review Criteria
CL.005.01	CCS Eligibility
CL.007.01	Optional Treatment - Non-Medicaid Programs
CL.008.01	Case Management and Care Coordination
CL.009.01	Second Opinions
CL.010.01	Specialty Care Review Timeframes
CL.011.01	Emergency Dental Care
CL.012.01	Denials

EDUCATION

ED.005.01	Member Rights and Responsibilities

GRIEVANCES & APPEALS

GA.001.02	Grievance System
GA.002.01	Provider Dispute Resolution Mechanism

QUALITY MANAGEMENT

QM.001.01	Caries Risk Assessment
QM.002.01	Patient Safety
QM.003.01	Infection Control
QM.004.01	Dental Periodicity Schedule for Children
QM.005.01	Dental Home
QM.008.01	Facility and Chart Reviews

QM.013.01 Provider Performance
QM.016.01 Preventive Dentistry Guidelines
QM.017.01 Potential Quality Issues
QM.023.01 Provider Performance - Corrective Actions
QM.026.01 Continuity & Coordination of Care
QM.030.01 Confidentiality - Chart Maintenance
QM.031.01 Chart Requests
QM.038.01 Fraud and Abuse
QM.041.01 Provider Satisfaction Survey
QM.042.01 Maintenance of Dental Charts

UTILIZATION MANAGEMENT

UM.003.01 Standards & Methodology for Orthodontia
UM.005.01 Encounter Data