PROVIDER MANUAL
UTAH GOVERNMENT PROGRAMS

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

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Table of Contents

INTRODUCTION

Thank you for your participation in the Premier Access programs. This Provider Manual applies to operations for applicable programs and products underwritten by Premier Access Insurance Company. For the purpose of describing the Provider Manual, Premier Access Insurance Company 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 Members.

Any changes to the guidelines in this Manual will be communicated 60 days prior to implementation by Premier Access.

It is important to Premier Access that we build strong relationships with our contracted dental care professionals. 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 A- rating for 10 years

Forms and this manual can also be found on our website at:
www.premierlife.com

GENERAL INFORMATION

CONTACT INFORMATION

QUICK REFERENCE CONTACT INFORMATION

Name of Contact	Toll-Free	Website/Email
24-Hour Emergency	(800) 870-4290	
Dental Consultant **(Dentist use)**	(888) 634-6074 Ext. 6011	DentalConsultant@premierlife.com
Emergency Fax Referral	(877) 648-7741	
Forms (to order)	(888) 620-2447	Info@premierlife.com
Grievances	(800) 448-4733	Grievance@premierlife.com
Provider Services	(888) 620-2447	ProviderRelations@premierlife.com
Referrals/Claims	(877) 541-5415	

CUSTOMER SERVICE

Utah Children's Health Insurance Program (CHIP)	(877) 854-4242
Utah Medicaid	(877) 541-5415

Our Customer Service Representatives are available to assist you

Monday through Friday from 8:00 am to 5:00 pm (Mountain Time)

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 Referral forms, please visit our website at: **www.premierlife.com**

CONTACT ADDRESSES

TO WRITE REGARDING:	FOR PROGRAMS:	CONTACT ADDRESS
GRIEVANCES	CHIP, Medicaid	PREMIER ACCESS GRIEVANCE DEPARTMENT P.O. BOX 255039 SACRAMENTO CA 95865-5039
REFERRALS	CHIP, Medicaid	PREMIER ACCESS CLAIMS DEPT/ REFERRAL DEPT P.O. BOX 659032 SACRAMENTO CA 95865-9032
CLAIMS	CHIP, Medicaid	PREMIER ACCESS CLAIMS DEPARTMENT P.O. BOX 659010 SACRAMENTO CA 95865-9010

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 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

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
- Obtain 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 obtain assistance from Premier Access in filing such grievances.

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
- 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
- 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, if applicable
- 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 referring them to the Plan's Member Services Department at the number listed in the Contact Information section of this manual, and on the member's Premier Access Identification Card.

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 (888) 620-2447.

SPECIALIST'S RESPONSIBILITIES

A Dental Care Specialist must…

- Provide specialty care in a timely manner to Members when the applicable prior authorization has been obtained
- Work closely with Primary Care Dentists (PCDs) to enhance continuity of Patient care
- Send a notification to the PCD upon completion of treatment
- 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
- Inform the Members of availability of free language assistance services for any linguistic need by referring them to Premier's Member Services Department at the number listed in the Contact Information section of this manual, and also listed in the member's Premier Access Identification Card.
- 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 Specialist. 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 (888) 620-2447.

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 login and password, you will be able to directly access the information for your Premier Access patients.

MEMBER ELIGIBILITY VERIFICATION

You are able to verify a member's eligibility online at www.premierlife.com. You may also call the Customer Service number found on the Member's ID Card or Contact Page in this Manual.

For additional information specific to the Medicaid program, please refer to the additional information under the Utah Government Dental Programs section in this Manual.

Each Member will have a Premier Access Identification Card but the card alone does not confirm current eligibility and authorization to be seen in your office. Check with the Plan by contacting Member Services.

Medicaid members also receive a monthly state-issued Medicaid card in addition to the Premier Access card. The state-issued Medicaid card will list a dental plan if the member is enrolled with a dental plan for a given month. If the member's state-issued card does not have a dental plan listed, the member is eligible under Medicaid Fee-For-Service. Services provided in that month should be billed to Medicaid Fee-For-Service, not to a dental plan.

Sample Card

Front

Premier Access
<Plan or Program Name>

Member: ID:
Plan Effective:

For benefits, eligibility, or to find a dentist,
visit **www.premierlife.com** or call **(XXX) XXX-XXXX**.

Back

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

PRIOR AUTHORIZATION

The application of Prior Authorization varies between Programs; see the Utah Government Dental Programs section in this Manual.

CLAIMS

Claims must be submitted within 12 months of the date of service. 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.

PROVIDER DISPUTE RESOLUTION

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

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

Your after-hours response system must enable Members to reach an on-call Dentist, 24 hours a day, seven days a week.

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

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, 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

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 Member Handbook 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

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.

- Appointments for routine, non-urgent care must be available to members within 21 days.
- Appointments for urgent care that can be treated in a provider's office must be available within the same day.
- 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

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.

CASE MANAGEMENT

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 disabilities who are in need of dental care from Providers who have experience working with these patients.

DENTAL PERIODICITY SCHEDULE FOR CHILDREN

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.

INITIAL DENTAL ASSESSMENT

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.

LANGUAGE ASSISTANCE PROGRAM

Premier Access maintains a Language Assistance Program to assist Members with limited English language proficiency so 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 Members free of charge and can be arranged through the Premier Access Customer Service 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 Department, as listed in the Contact Information section of this manual.

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.

ON-SITE QUALITY MANAGEMENT (QM) AUDITS

Premier Access performs site visits to panel dental offices regularly. In most instances, the Dental Director and/or Dental Consultant (Auditor) visit the Provider offices according to established utilization thresholds. The frequency of the site visits may be higher for certain programs. 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

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. There must be a written agreement between the Member and Provider for any optional or upgraded treatment that is to be performed prior to services being rendered.

PATIENT SAFETY & RISK MANAGEMENT

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

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.

Premier Access maintains an extensive Quality Management Program. 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 care provided to Members;
- Peer Review is a 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.

UTAH GOVERNMENT DENTAL PROGRAMS

UTAH MEDICAID

THE PLAN PROVIDES COVERAGE TO MEMBERS for all dental health care services available under the dental provisions of the Utah Medicaid Programs. This section of the Provider Manual contains a current list of procedure codes and descriptions for Utah Medicaid. It also contains information on prior authorization, payment policies, benefits, and exclusions.

Medicaid members receive their covered dental services from their Primary Care Dentist (PCD) without payment of any copayments. Collection of any amount from Medicaid Members towards a dental service that is a covered benefit is strictly prohibited under the provisions of your Provider Agreement. Maximum calendar year benefit is not applicable for beneficiaries on this program.

Dental services are available to Members who are pregnant women or who are individuals eligible under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) also known in Utah as Child Health Evaluation and Care (CHEC).

CHEC Services

Medicaid Providers must provide CHEC Enrollees preventative screening and other necessary dental care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

The Coverage and Reimbursement Lookup Tool

The Coverage and Reimbursement Lookup Tool found on the Medicaid website at http://health.utah.gov/medicaid contains the exhaustive list of covered services that Premier Access provides and the criteria that must be met for each service.

Provider Contract Types and Member Assignments

Providers are contracted on a fee-for-service or capitated basis.

- Under a **fee-for-service** arrangement, members are not assigned to the provider facility.
- Under a **capitated** arrangement, members are assigned to the specific provider facility. A roster of assigned members is sent to the facility each month. If an assigned member needs treatment from a provider outside the assigned facility, the Primary Care Dentist must submit a referral request to Premier Access.

Members assigned to a capitated office must access care from that office. If a member would like to go to a different capitated office or a fee-for-service office, the member must call Premier Access to notify us of the change. As a standard procedure, the change will be effective the first of the following month. However, Premier Access is able to make the change effective immediately in certain circumstances.

For all providers, it is important to verify a member's eligibility **and** to verify if the member is assigned to a specific facility before providing services.

Referrals

For providers under a fee-for-service arrangement, prior authorization is not required for referral to another provider.

For providers under a capitated arrangement, prior authorization is required for referrals. Please refer to the Referral Guidelines and Form in the Administrative Forms section at the end of this Manual.

Note: A referral is not required for an orthodontic consultation. The consultation must be performed by a contracted orthodontist.

Members with Special Health Care Needs

If you identify a member with a Special Health Care Need and are not able to provide the required care for the member, contact Premier Access. We will coordinate the required care for the member.

Dental Spend-Ups

Medicaid clients in the dental program may choose to upgrade a covered service to a non-covered service if they assume the responsibility for the difference in the fees for the covered and non-covered services. The only dental procedures which a Medicaid client may choose to upgrade are as follows:

1. Covered stainless steel crowns to non-covered porcelain or cast gold crowns
2. Covered anterior stainless steel crowns (deciduous) to non-covered anterior stainless steel crowns with facings
   (composite facings added or commercial or lab prepared facings)
3. Other covered dental procedures when authorized by the dental plan or through a hearing process

Patient Choice of a Non-Covered Service which is an Upgrade from a Covered Service

Generally, a provider may not bill a Medicaid patient for the difference between the Premier Access payment and the Provider's customary fee, as the Premier Access payment is considered payment in full. However, when a patient requests a service not covered by Medicaid, such as a non-covered composite resin filling instead of a covered sliver filling, a Provider may bill the Medicaid patient when ALL FOUR conditions below are met:

1. The Provider has established policy for billing all Enrollees for services not covered by a third party. (The charge cannot be billed only to Medicaid patients).
2. The Enrollee is advised prior to receiving a non-covered service that Medicaid will not pay for the service.
3. The Enrollee agrees to be personally responsible for the payment.
4. The agreement is made in writing, prior to treatment, between the Provider and the Enrollee which details the service and the amount to be paid by the patient.

The patient makes the choice. The Provider CANNOT mandate nor insist the covered procedure be upgraded.

Unless all four conditions are met, the Provider may not bill the patient for the non-covered service, even if the Provider chooses not to bill Premier Access. Further, the patient's Medicaid ID card may not be held by the Provider as guarantee of payment by the patient, nor may any other restrictions be placed upon the patient.

Second Opinions

Under Utah Medicaid, second opinions are only covered if requested by Medicaid.

Restriction Program

The State of Utah will determine if a Member needs to be placed into the Restriction Program. This Program safeguards against inappropriate and excessive use of Medicaid services. Members selected for enrollment are informed of the reasons for the issuance of a Restriction Program card, and restricted to one Primary Care Provider and one pharmacy. For Members in the Restriction Program, Medicaid will only pay claims for services rendered by the providers listed on the card and by providers to who the Member has been appropriately referred. However, emergency services are not restricted to these providers.

For more information, contact the State of Utah Department of Health at 1-801-538-9045 or email: medicaidrestriction@utah.gov.

Treatment at Surgery Centers

Prior authorization is not required to provide treatment at a surgery center. If the procedure(s) being performed requires prior authorization, authorization for the procedure must be obtained prior to treatment. The provider must coordinate with the medical carrier for facility charges. Facility charges are not covered under the dental plan.

Broken Appointments

A member may be billed for a missed appointment charge if all of the following conditions are met:

- The office has a policy that states what an acceptable cancellation is.
  (For example, the member must notify the office at least 24 hours before appointment.)
- The member agreed in writing to pay the charge if he or she misses an appointment.
- The missed appointment policy is the same for all patients.

Exclusions

Medicaid does NOT cover the following:

1. Cast crowns (porcelain fused to metal) on posterior permanent teeth or on primary teeth
2. Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex
3. Fixed bridges or pontics
4. Dental implants, including but not limited to endosteal implants, eposteal implants, transosteal implants, subperisteal implants
5. Tooth transplantation
6. Ridge augmentation
7. Osteotomies
8. Vestibuloplasty
9. Alveoloplasty
10. Occlusal appliances, habit control appliances or interceptive orthodontic treatment
11. Treatment of temporomandibular joint syndrome or its prevention, sequel, subluxation, therapy, arthostomy, meniscectomy or condylectomy
12. House calls

13. Consultations and second opinions not requested by Medicaid
14. Processing claim forms
15. Charges for lab tests or pathology reports (the lab or pathologist must bill the charges directly to Medicaid)
16. General anesthesia for removal of an erupted tooth, unless medically necessary
17. Services which require pre authorization and are provided before the prior authorization is given. However, this exclusion does not apply to an emergency service
18. Oral sedation and behavior management fees
19. Temporary dentures or temporary stayplate partial dentures
20. Limited orthodontic treatment, including removable appliance therapies
21. Removable appliances in conjunction with fixed banded treatment
22. Habit control appliances
23. Incomplete root canal

Procedure Guidelines for Utah Medicaid

The table below provides the guideline for each procedure covered by Medicaid.

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D0120	PERIODIC ORAL EVALUATION-ESTABLISHED PATIENT	No	No	Two per calendar year per provider, or one per calendar year per provider in addition to a comprehensive oral evaluation.
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	No	No	
D0150	COMPREHENSIVE ORAL EVAL-NEW OR ESTABLISHED PATIENT	No	No	One time only per provider.
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	No	No	
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	No	No	1) More than 12 periapicals taken during a single visit will be considered a full mouth series. 2) Any periapical x-rays billed additionally with D0210 will be rebundled and considered part of the full mouth series. 3) X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	No	No	
D0270	BITEWING-SINGLE FILM	No	No	
D0272	BITEWINGS-TWO FILMS	No	No	
D0274	BITEWINGS - FOUR FILMS	No	No	
D0330	PANORAMIC FILM	No	No	1) May be billed with bitewings. 2) A panoramic x-ray with more than bitewings, 2 or 4 films, plus 2 periapicals will rebundle to D0210. 3) Panoramic x-rays and full series x-rays shall not be taken more often than one every two years unless there is specific dental diagnostic need documented in the patient's records.
D0470	DIAGNOSTIC CASTS	No	No	
D1110	PROPHYLAXIS - ADULT	No	No	Two per calendar year. Limited to ages 16-20.
D1120	PROPHYLAXIS - CHILD	No	No	Two per calendar year, with or without fluoride. EPSDT ONLY
D1208	TOPICAL APP OF FLUORIDE	No	No	Limited to ages 0 through 18.
D1351	SEALANT - PER TOOTH	No	No	1st and 2nd permanent molars or premolars (bicuspids), caries free, without restoration. Once every 2 years. EPSDT ONLY
D1510	SPACE MAINTAINER-FIXED UNILATERAL	No	No	EPSDT ONLY
D1515	SPACE MAINTAINER-FIXED BILATERAL	No	No	EPSDT ONLY
D1520	SPACE MAINTAINER-REMOVABLE UNILATERAL	No	No	EPSDT ONLY
D1525	SPACE MAINTAINER-REMOVABLE BILATERAL	No	No	EPSDT ONLY
D1550	RECEMENTATION OF SPACE MAINTAINER	No	No	EPSDT ONLY
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	No	No	
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	No	No	
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	No	No	
D2161	AMALGAM-FOUR OR MORE SURFACES,PRIMARY OR PERMANENT	No	No	
D2330	RESIN - ONE SURFACE, ANTERIOR	No	No	

* The Plan reserves the right on any claim to require patient chart documentation, including x-rays, for dental consultant review prior to payment.

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D2331	RESIN - TWO SURFACES, ANTERIOR	No	No	
D2332	RESIN - THREE SURFACES, ANTERIOR	No	No	
D2335	RESIN-4 OR MORE SURFACE/INVOLV INCISAL ANGLE,ANTER	No	No	
D2391	RESIN-BASED COMPOSITE,ONE SURFACE,POSTERIOR	No	No	
D2392	RESIN-BASED COMPOSITE,TWO SURFACES,POSTERIOR	No	No	
D2393	RESIN-BASED COMPOSITE,THREE SURFACES,POSTERIOR	No	No	
D2394	RESIN-BASED COMPOSITE,FOUR OR + SURFACES,POSTERIOR	No	No	
D2751	CROWN-PORCELAIN FUSED TO PREDOMINATELY BASE METAL	Yes	Yes	Provider must send periapical x-rays. Permanent anterior teeth only. It is not allowable to bill for a core and build-up with pins, D2950, except in the exceptional instance where extensive build-up is needed. EPSDT ONLY
D2920	RECEMENT CROWN	No	No	
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	No	No	Primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth, same date of service. Bill for one or the other but not both procedures. It is not allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown on a primary tooth. Not a benefit for primary teeth near exfoliation. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 is not permitted on a primary tooth. The treating provider will be responsible for any replacements necessary within 24 month period following placement. EPSDT ONLY
D2931	PREFABRICAT STAINLESS STEEL CROWN-PERMANENT TOOTH	No	No	Medicaid will not reimburse for a permanent stainless steel crown, D2931, and alloy or composite fillings for the same tooth, same date of service. It is allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown – permanent . Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 and D2954 may be billed in conjunction with a permanent tooth when dentally necessary. The treating proivder will be responsible for any replacements necessary within a 24 month period following placement.
D2950	CORE BUILD-UP, INCLUDING ANY PINS	No	Yes	Valid for teeth numbers 2 – 15 and 18 - 31. Fee is included under crowns except in the exceptional instance where extensive build-up is needed. Amalgam or plastic build up including pins. Permitted on permanent teeth, as dentally necessary. Include with preauthorization request for crown.
D2951	PIN RETENTION-PER TOOTH,IN ADDITION TO RESTORATION	No	No	Valid for teeth numbers 2 – 25 and 18 - 31. This is included in the cost of the prefabricated or laboratory crown and cannot be billed separately. A benefit for permanent teeth only when billed with an amalgam or composite restoration on the same date of service. Once per tooth regardless of the number of pins. Covered for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or for an anterior restoration when extensive coronal destruction involves the incisal angle.
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	No	Yes	Valid for teeth numbers 2 – 15 and 18 - 31. Covered with prefabricated or laboratory processed crowns when medically necessary for retention of the crown on root canal treated permanent teeth. Include with preauthorization request for crown. Preauthorization is not required on stainless steel crowns.
D2980	CROWN REPAIR, BY REPORT	No	No	

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D3220	THERAPEUTIC PULPOTOMY,(EXCL FINAL RESTOR)APPL MEDI	No	No	Primary teeth only. This procedure does not require preauthorization. Submission of x-rays, photographs or written documentation demonstrating medical necessity is not required for payment. Requires a tooth code. A benefit for primary teeth only, limited to once per tooth. Not a benefit for a tooth near exfoliation, a tooth with a necrotic pulp or a periapical lesion, or for a tooth that is non restorable. This procedure is for the surgical removal of the entire portion of the pulp coronal to the dentinocemental junction with the aim of maintaining the vitality of the remaining radicular portion by means of an adequate dressing.
D3310	ROOT CANAL THERAPY,ANTERIOR(EXCLUD FINAL RESTOR)	No	Yes	Permanent teeth. Requires a tooth code. A benefit once per tooth for initial root canal therapy. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim. **EPSDT Only**
D3320	ROOT CANAL THERAPY,BICUSPID(EXCLUD FINAL RESTORAT)	No	Yes	Permanent teeth. Requires a tooth code. A benefit once per tooth for initial root canal therapy. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim. **EPSDT Only**
D3330	ROOT CANAL THERAPY,MOLAR(EXCLUD FINAL RESTORATION)	No	Yes	Root canal therapy is a covered benefit excluding third molars. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee. Requires a tooth code. A benefit once per tooth for initial root canal therapy. Not a benefit for 3rd molars unless the 3rd molar is in the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim. EPSDT ONLY
D3410	APICOECTOMY / PERIRADICULAR SURGERY - ANTERIOR	No	Yes	Requires a tooth code. A benefit for permanent anterior teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. EPSDT ONLY
D3421	APICOECTOMY/PERIRADICULAR SURG-BICUSPID(1ST ROOT)	No	Yes	Requires a tooth code. A benefit for permanent bicuspid teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426). EPSDT ONLY
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR(1ST ROOT)	No	Yes	Requires a tooth code. A benefit for permanent molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EA ADDTL ROOT)	No	Yes	Requires a tooth code. A benefit for permanent 1st and 2nd molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. Not a benefit for 3rd molars, unless the 3rd molar is in the 1st or 2nd molar position or is an abutment for an existing fixed partial denture/removable partial denture with cast clasps or rests. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).
D3430	RETROGRADE FILLING-PER ROOT	No	Yes	Excludes permanent third molars.

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	Yes	No	For drug-induced gingival hyperplasia only. (such as Dilantin and Cyclosporin . Preauthorization is required. Photographs of the involved area required. Shall include a definitive periodontal diagnosis. A current and complete periodontal evaluation chart is required for preauthorization except in cases of pseudopockets as a result of gingival hyperplasia, which is demonstrated on a photograph. Requires a quadrant code (4 or more teeth).
D4341	PERIODONTAL SCALING/ROOT PLANING-4 OR>CONTIG,QUAD	Yes	Yes	Preauthorization is required. Preoperative x-rays are required. Shall include a definitive periodontal diagnosis and a minimum of one 4mm+ pocket on each diseased tooth. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (4 or more teeth). May be done once a year per quadrant.
D4355	FULL MOUTH DEBRIDE COMPREHENSIVE EVAL & DIAGNOSIS	Yes	No	Must have subgingival calculus present. Oral debridement may be done once per year and may be done in conjunction with a prophylaxis in cases requiring subgingival scaling.Preauthorization is required. Preoperative x-rays are required. Shall include a definitive periodontal diagnosis and a minimum of one 4mm+ pocket on each diseased tooth. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (4 or more teeth). EPSDT ONLY
D5110	COMPLETE UPPER DENTURES(INCLUD POSTDELIVERY CARE)	Yes	Yes	Preauthorization is required. X-rays for all opposing natural teeth required. A benefit once in a 5 year period (D5110, D5130, D5860). All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5120	COMPLETE LOWER DENTURES(INCLUD POSTDELIVERY CARE)	Yes	Yes	Preauthorization is required. X-rays for all opposing natural teeth required. A benefit once in a 5 year period (D5120, D5140, D5860). All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5130	IMMEDIATE UPPER DENTURES(INCLUD POSTDELIVERY CARE)	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth required. Limited to once per lifetime per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five year period of an immediate denture. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5140	IMMEDIATE LOWER DENTURES(INCLUD POSTDELIVERY CARE)	Yes	Yes	Prior authorization must be obtained before removing teeth in preparation for the immediate denture. X-rays for all remaining natural teeth required. Limited to once per lifetime per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five year period of an immediate denture. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5211	UPPER PARTIAL-RESIN BASE(INCL CLASP,RESTS & TEETH)	Yes	Yes	Non-Emergency: 1. Prior authorization must be obtained before fabricating the partial denture. 2. There must be an anterior tooth missing or the partial denture must restore mastication ability. 3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4. There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6. Provider must send the following: A. Mounted periapical x-rays or Panorex; B. List of teeth to be replaced. Emergency: Anterior #6 – 11 only Same criteria as D5211, Non-Emergency, PLUS one of the following: 1. Tooth is fractured or avulsed, or 2. Abscess requires immediate removal of tooth. Telephone authorization to be followed by submittal of x-rays with the claim.

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D5212	LOWER PARTIAL-RESIN BASE(INCL CLASPS,RESTS,TEETH)	Yes	Yes	Non-Emergency: 1. Prior authorization must be obtained before fabricating the partial denture. 2. There must be an anterior tooth missing or the partial denture must restore mastication ability. 3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4. There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6. Provider must send the following: A. Mounted periapical x-rays or Panorex; B. List of teeth to be replaced. Emergency: Anterior #22 - 27 only. Same criteria as D5212, Non-Emergency, PLUS one of the following: 1. Tooth is fractured or avulsed, or 2. Abscess requires immediate removal of tooth. Telephone authorization to be followed by submittal of x-rays with the claim. Non-Emergency
D5213	UPPER PARTIAL-CAST METAL FRAME W RESIN DENTURE BAS	Yes	Yes	1. Prior authorization must be obtained before fabricating the partial denture. 2. There must be an anterior tooth missing or the partial denture must restore mastication ability. 3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4. There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5. A partial denture will be covered if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6. Provider must send the following: A. Mounted periapical x-rays or Panorex; B. List of teeth to be replaced. .
D5214	LOWER PARTIAL-CAST METAL FRAME W RESIN DENTURE BAS	Yes	Yes	1. Prior authorization must be obtained before fabricating the partial denture. 2. There must be an anterior tooth missing or the partial denture must restore mastication ability. 3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4. There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6. Provider must send the following: A. Mounted periapical x-rays or Panorex; B. List of teeth to be replaced.
D5410	ADJUST COMPLETE DENTURE-UPPER	No	No	Payable to dentist who did not originally provide the denture. May be payable to originating dentist six months post delivery. Not a benefit on the same date of service or within 6 months of denture, reline or repair. EPSDT ONLY
D5411	ADJUST COMPLETE DENTURE-LOWER	No	No	Payable to dentist who did not originally provide the denture. May be payable to originating dentist six months post delivery. Not a benefit on the same date of service or within 6 months of denture, reline or repair. EPSDT ONLY
D5421	ADJUST PARTIAL DENTURE-UPPER	No	No	Payable to dentist who did not originally provide the denture. May be payable to originating dentist six months post delivery. Not a benefit on the same date of service or within 6 months of denture, reline or repair. EPSDT ONLY
D5422	ADJUST PARTIAL DENTURE - LOWER	No	No	Payable to dentist who did not originally provide the denture. May be payable to originating dentist six months post delivery. Not a benefit on the same date of service or within 6 months of denture, reline or repair. EPSDT ONLY
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5610	REPAIR RESIN DENTURE BASE - PARTIAL DENTURE	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5630	REPAIR OR REPLACE BROKEN CLASP	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5640	REPLACE BROKEN TEETH - PER TOOTH	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.
D5750	RELINE COMPLETE UPPER DENTURE (LABORATORY)	No	No	Valid only for hard relines completed by a laboratory. It is difficult to establish a time for a reline following an immediate denture, but typically, hard relines must be delayed until bone resorption has stabilized following the extractions which would be 6 to 12 months following the extractions. . Limited to two relines per year per arch. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5751	RELINE COMPLETE LOWER DENTURE (LABORATORY)	No	No	Valid only for hard relines completed by a laboratory. It is difficult to establish a time for a reline following an immediate denture, but typically, hard relines must be delayed until bone resorption has stabilized following the extractions which would be 6 to 12 months following the extractions. . Limited to two relines per year per arch. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5760	RELINE UPPER PARTIAL DENTURE (LABORATORY)	No	No	All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5761	RELINE LOWER PARTIAL DENTURE (LABORATORY)	No	No	All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5931	OBTURATOR PROSTHESIS, SURGICAL	No	No	EPSDT ONLY
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	No	No	
D5954	PALATAL AUGMENTATION PROSTHESIS	Yes	No	
D5955	PALATAL LIFT PROSTHESIS	Yes	No	EPSDT ONLY
D7111	EXTRACTION,CORONAL REMNANTS-DECIDUOUS TOOTH	No	No	X-rays are not required. Requires a tooth code. Not a benefit for asymptomatic teeth. EPSDT ONLY
D7140	EXTRACTION,ERUPTED TOOTH OR EXPOSED ROOT	No	No	X-rays are not required. Requires a tooth code. Not a benefit for asymptomatic teeth. Ortho-only extractions are covered.
D7210	SURG REMOVAL ERUPTED TOOTH REQ ELEV FLAP,BONE RMVL	No	Yes	Preoperative x-rays should be submitted with the claim. A benefit when the removal of any erupted tooth requires the elevation of mucoperiosteal flap and the removal of substantial alveolar one or sectioning of the tooth. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered.
D7220	REMOVAL OF IMPACTED TOOTH--SOFT TISSUE	No	Yes	Preoperative x-rays should be submitted with the claim. A benefit when the removal of any erupted tooth requires the elevation of mucoperiosteal flap and the removal of substantial alveolar one or sectioning of the tooth. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered. EPSDT ONLY

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D7230	REMOVAL OF IMPACTED TOOTH--PARTIALLY BONY	No	Yes	Preoperative x-rays should be submitted with the claim. A benefit when the removal of any erupted tooth requires the elevation of mucoperiosteal flap and the removal of substantial alveolar one or sectioning of the tooth. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered. EPSDT ONLY
D7240	REMOVAL OF IMPACTED TOOTH--COMPLETELY BONY	No	Yes	Preoperative x-rays should be submitted with the claim. A benefit when the removal of any erupted tooth requires the elevation of mucoperiosteal flap and the removal of substantial alveolar one or sectioning of the tooth. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered. EPSDT ONLY
D7270	TOOTH REIMPLANT/STABILIZ ACCIDENT EVULSE/DISPLACED	No	Yes	Preoperative x-rays should be submitted with the claim. Requires a tooth code. EPSDT ONLY
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	No	Yes	All except primary teeth and third molars. Preoperative x-rays should be submitted with the claim. Preauthorization is recommended but not required. The procedure is limited to patients in active orthodontic treatment and the fee includes any orthodontic attachments. EPSDT ONLY
D7283	PLACEMENT OF DEV FACILITATE ERUPTION IMPACTD TOOTH	Yes	Yes	Clients approved for orthodontia treatment and are currently receiving orthodontia services under a PA from Utah Medicaid, will be approved for a Prior Authorization of D7283. .
D7286	BIOPSY OF ORAL TISSUE - SOFT	No	No	Pathology report should be submitted with the claim. Treatment includes the fee for the resection of tumors and the resection of cysts.
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	No	Yes	Operative and pathology reports should be submitted with the claim. Pre-op and Post operative x-rays must be submitted with the claim.
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	No	Yes	Operative and pathology reports should be submitted with the claim. EPSDT ONLY
D7412	EXCISION OF BENIGN LESION,COMPLICATED	No	Yes	EPSDT ONLY
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	No	Yes	EPSDT ONLY
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM	No	Yes	EPSDT ONLY
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	Yes	Yes	Must be done in conjunction with a new denture or partial denture fabrication. Preoperative x-rays must be submitted with claim. Please identify the quadrant treated by abbreviation in the area for the oral cavity.
D7510	INCISION & DRAINAGE OF ABCESS-INTRAORAL SOFT TISS	No	No	Written documentation required. Requires a quadrant code. Limited to once per quadrant per date of service. Not covered as a separate charge if any other definitive treatment is performed on the same date of service. Fee includes incision, placement and removal of a surgical draining device.
D7670	ALVEOLUS-CLOSE REDUC,MAY INCLUDE STABILIZ OF TEETH	No	No	
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	No	No	
D7960	FRENULECTOMY - SEPARATE PROCEDURE	Yes	Yes	Written documentation including rationale demonstrating medical necessity and the specific treatment area.

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D8080	COMPRHENSIVE ORTHODONTIC TREAT,ADOLESCENT DENTITN	Yes	Yes	Prior authorization required. Ortho benefits are only covered if the client scores 30 or greater on the Salzmann Index.
D8680	ORTHODONTIC RETENTION	Yes	No	Prior authorization required at the completion of orthodontic treatment.
D8690	ORTHODONTIC TREATMENT (ALTERNATIVE BILLING)	Yes	No	EPSDT ONLY
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	No	No	This service is limited to one per lifetime for those who are receiving orthodontic treatment paid by Utah Medicaid. EPSDT ONLY
D9110	PALLIATIVE(EMER)TRTMNT DENTL PAIN-MINOR PROCEDURE	No	No	Limited to once per date of service when no other treatment is performed.
D9220	DEEP SEDATION/GENERAL ANESTHESIA-FIRST 30 MINUTES	No	No	1. For patient 4 years of age or younger, prior approval is not required. 2. Patient is at least 5 years of age with a physical or mental disability. Document the physical or mental disability which justifies the use of general anesthesia. 3. Patient is 5 - 8 years of age and without physical or mental disability, the patient must have a documented condition such as a failure and inability to treat when using a premedication which justifies the use of general anesthesia. 4. Patient is at least 9 years of age and without physical or mental disability, the patient must have a documented condition such as such as a failure and inability to treat when using a pre-medication which justifies the use of general anesthesia, OR in conjunction with the extraction of a partial or full boney impacted third molar. .
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EA ADD 15 MINUTES	No	No	Must be billed in conjunction with D9220 above.
D9241	INTRAVEN CONSCIOUS SEDATION/ANALGESIA-FIRST 30 MIN	No	No	Document in the patient record the physical or mental disability or other condition which necessitates use of I.V. sedation. Anxiety does not qualify as a medical condition. . Prior authorization is not required when service is performed by a dentist with state licensure to perform I.V. sedation. EPSDT ONLY
D9242	INTRAVN CONSCIOUS SEDATION/ANALGESIA-EA ADD 15 MIN	No	No	Document in the patient record the physical or mental disability or other condition which necessitates use of I.V. sedation. Anxiety does not qualify as a medical condition. . Prior authorization is not required when service is performed by a dentist with state licensure to perform I.V. sedation.
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	No	No	The code is covered for intramuscular and non-intravenous conscious sedation only and includes the sedative drug. EPSDT Only
D9310	CONSULTATION (DIAG SRVC BY DENTIST O/T TREAT PRACT)	No	No	Specialist Only - separate fee only if patient is not treated by the consulting specialist.
D9420	HOSPITAL CALL	No	No	
D9440	OFFICE VISIT-AFTER REGULARLY SCHEDULED HOURS	No	No	For use only in a situation where the dentist is called away from home to return to the office in the evening, night or early morning, or a non-business day, when staff is not present to treat an emergency condition which cannot be scheduled. Document time in patient's record.

ADMINISTRATIVE FORMS

PREMIER ACCESS

CLAIM / ENCOUNTER FORM

Attending Dentist's Statement II ☐ CHIP ☐ MEDICAID

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.

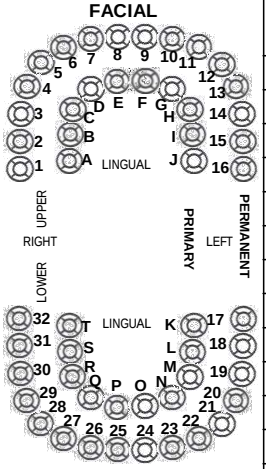
▶ **Signed (Patient, or parent if minor)** **Date**

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

Identify missing teeth with "X"



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: Premier Access
P.O. Box 659010
Sacramento, CA 95865-9010

PHONE: CHIP 1-877-854-4242
Medicaid 1-877-541-5415

Premier Access Insurance Company
8890 Cal Center Drive
Sacramento, CA 95826
FAX: 866.379.3247
WWW.PREMIERLIFE.COM

GRIEVANCE FORM

CHILDREN'S HEALTH INSURANCE PROGRAM
(Member Services: 1-877-854-4242)
❑ **CHIP**

UTAH MEDICAID
(Member Services 1-877-541-5415)
❑ **UT-MC**

Premier Access Insurance Company ("Premier") 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 Premier Member Services 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):

DATE OF INCIDENT GIVING RISE TO THIS COMPLAINT: _____

NAMES OF PLAN PERSONNEL INVOLVED IN INCIDENT: _____

PLEASE MAIL or EMAILTHIS FORM TO:

Premier Access Insurance Company

Attention: Grievances/Appeals Department

P. O. Box 255039
Sacramento, CA 95865-5039

GreivanceDept@PremierLife.com

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

Grievance Received By:_____ **Date Received:**_____ **Time Received:**_____ **Grievance Log Completed By:**_____

PREMIER ACCESS
Dental and Vision

Premier Access Insurance Company
P.O. Box 659010
Sacramento, CA 95865-9010
WWW.PREMIERLIFE.COM

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

Name of Member:_____ I.D. Number: _____

Address of Member: _____

I authorize **Premier Access Insurance Company** to use and disclose a copy of the specific health and dental information described below.

Information consisting of: *(Check all that apply.)*

❒ Eligibility ❒ Benefits ❒ Claims ❒ Prior Authorizations/Specialty Referrals

❒ Other (*Please specify*) _____

Name of the Person(s) or Organization(s) to whom you authorize us to use or disclose your information:

Please check all that apply, and list the name or organization:

❒ Spouse _____ ❒ Mother _____

❒ Employer _____ ❒ Father _____

❒ Child _____ ❒ Other _____

For the purpose of: *(Describe intended use or purpose of this disclosure)*

_____

_____

Expiration of Authorization: *(For how long do you wish this Authorization to last)*

❒ 1 year ❒ 3 years ❒ 5 years ❒ No expiration ❒ Other _____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date: _____
Signature of Member (*or authorized representative, if Member is a minor*)

Printed Name of Authorized Representative _____

Relationship to Member _____

Please mail this form to the above-mentioned address to the attention of Customer Service. You may also FAX the form to 916.646.9000 to the Attention of Customer Service.

FOR INTERNAL USE ONLY		
Date Received	Entered into Member's Record By	Date original given to Privacy Officer

ORTHODONTIC SERVICE
SALZMANN EVALUATION INDEX

PATIENT'S NAME – LAST, FIRST, MIDDLE INITIAL	Member #	Date of Birth

REFERRING DENTIST

ORTHODONTIST'S NAME	Tax ID	DATE OF ASSESSMENT

HANDICAPPING MALOCCLUSION ASSESSMENT RECORD

A. Intra – Arch Deviation

SCORE TEETH AFFECTED ONLY		MISSING	CROWDED	ROTATED	SPACING		NO.	POINT VALUE	SCORE
					Open	Closed			
MAXILLA	ANT.							X2	
	POST.							X1	
MANDIBLE	ANT.							X1	
	POST.							X1	

ANT = Anterior Teeth (4 incisors)
POST = Posterior Teeth (Include canine, premolars and first molars)
NO. = Number of teeth affected

TOTAL SCORE

B. Inter – Arch Deviation

1. Anterior Segment

SCORE MAXILLARY TEETH AFFECTED ONLY EXCEPT OVERBITE*	OVERJET	OVERBITE	CROSSBITE	OPENBITE	NO.	POINT VALUE	SCORE
						X2	

*Score Maxillary or Mandibular Incisors
No. = Number of teeth affected

TOTAL SCORE

2. Posterior Segment

SCORE AFFECTED TEETH ONLY	RELATE MANDIBULAR TO MAXILLARY TEETH				SCORE AFFECTED MAXILLARY TEETH ONLY				NO.	POINT VALUE	SCORE
	DISTAL		MESIAL		CROSSBITE		OPENBITE				
	Right	Left	Right	Left	Right	Left	Right	Left			
CANINE										X1	
1ST PREMOLAR										X1	
2ND PREMOLAR										X1	
1ST MOLAR										X1	

TOTAL SCORE

When intra- and inter-arch maxillary incisor score is 6 or more to denote esthetic handicap, add 8 points.

GRAND TOTAL

No primary teeth may exist and a Salzmann Evaluation Index score of 30 points or more must be achieved to be eligible for orthodontic benefits under the Utah Children's Health Insurance Program (CHIP) and Utah Medicaid.

PLEASE COMPLETE THE FOLLOWING IN DETAIL:

DESCRIPTION OF PATIENT'S CONDITION AND DIAGNOSIS:

DIAGNOSTIC PROCEDURES:

TREATMENT PLAN:

REMARKS:

Detailed Instructions for Completing the Salzmann Index Evaluation

Introduction

This assessment record (not an examination) is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment.

A. Intra-Arch Deviations

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record." The scoring can be entered later.

1. Anterior segment: A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.
   - Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
   - Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
   - Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.
   - Spacing:
     - Open spacing refers to tooth separation that exposes to view the interdental papillac on the alveolar crest. Score the number of papillae visible (not teeth).
     - Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior segment: A value of 1 point is scored of each tooth affected.
   - Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
   - Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

Posterior segment continued…

- Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.
- Spacing:
  - Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).
  - Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

B. Interarch Deviations

When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior segment: A value of 2 points is scored for each affected maxillary tooth only.
   - Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.
   - Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.
   - Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.
   - Open-bite refers to vertical interach dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.

2. Posterior segment: A value of 1 point is scored for each affected tooth.
   - Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.
   - Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.
   - Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

REFERRAL GUIDELINES
Medicaid Capitated Program

Purpose:

To provide uniform guidelines of responsibility for General Dentists under the Medicaid capitated program, 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:

Under the Medicaid capitated program, prior authorization is required for referral outside of the capitated facility. It is the policy of Premier Access that general dentists provide the complete range of dental treatments for which they are licensed. Patients are only referred to a provider outside the capitated facility for treatment of conditions that are beyond the capability of the general practitioner. The 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 provider outside of his/her facility, the referring dentist may be financially responsible for the dental care. The member will only be financially responsible for applicable co-payment (if any) and the treating provider 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 referral when the member is not eligible for benefits;
- A referral for services that do not meet the conditions listed for referral guidelines below; or
- A 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.

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.

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.

Utah Medicaid Capitated Program

Mail: Premier Access Referral Dept.
P.O. Box 659005
Sacramento, CA 95865-9005
Telephone: 877-541-5415 Fax: 877-648-7741

PLEASE CHECK APPROPRIATE

O Routine Referral **O Emergency Referral**

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: O Endodontist O Pedodontist O Other
O Oral surgeon O Periodontist

ATTACHMENTS: O X-rays included: O YES O NO If yes, how many?_____(PLEASE ATTACH FILMS TO THIS FORM)

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

DESCRIBE THE PROCEDURE AND REASON FOR REFERRAL

	PATIENT MUST BE ELIGIBLE FOR COVERAGE AT TIME OF SERVICE
	REFERRED PROVIDER: PLEASE RETURN X-RAYS WHEN TREATMENT IS COMPLETED

IN MY PROFESSIONAL JUDGMENT THE TREATMENT LISTED REQUIRES : TREATMENT BY A PROVIDER OUTSIDE OF MY FACILITY O YES O NO

REFERRING DENTIST SIGNATURE: _____ **DATE:** _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF APPROVAL

FOR ACCESS DENTAL/PREMIER ACCESS PLAN USE ONLY

PLEASE SEE ATTACHED RESPONSE TO REFERRAL REQUEST FOR THE FOLLOWING

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

PREMIER ACCESS

Transfer Request Form
Utah Medicaid Capitated Program

Date:_____

Dental Office Name:_____ Member Name:_____

Office Telephone #:_____ Member ID #:_____

Member Telephone #:_____

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 list the missed appointment dates: _____

Dentist's Signature:_____ Date:_____

PLEASE MAIL REQUEST TO: PREMIER ACCESS, P.O. BOX 659010, SACRAMENTO, CA 95865-9010

Attention: Provider Services Department

FOR PREMIER ACCESS OFFICE USE ONLY:

Person Receiving Complaint:_____ Date of Action:_____

Action Taken:_____

_____