


The Avēsis Kentucky Medicaid Provider Manual for Humana – CareSource

Humana. CareSource

avēsis
a GUARDIAN company

Welcome

Dear Doctor:

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

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

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

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

This Humana – CareSource manual outlines many of the policies and procedures that govern how we manage this plan. We invite you to pull out the Humana – CareSource Quick Reference Guide in the addendum; this offers you phone numbers, email addresses and web tools to help you navigate the plan.

If you require assistance or information that is not included within this document, please contact our Provider Services Department. This office is typically staffed Monday through Friday from 7 a.m. until 8 p.m. Eastern time, excluding observed holidays.

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

Sincerely,

Michael Exler

Dr. Michael Exler, DDS

Vice President, National Dental Director

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Quick Reference Guide for Humana – CareSource of Kentucky

Avēsis Executive Offices 10324 S. Dolfield Road Owings Mills, MD 21117-3991 (410) 581-8700 (800) 643-1132	Avēsis Corporate Offices 10400 N. 25th Avenue, Suite 200 Phoenix, AZ 85021-1696 (602) 241-3400 (800) 522-0258
Electronic Funds Transfer (EFT) Avēsis Third Party Administrators, Inc. Attention: Finance P.O. Box 316 Owings Mills, MD 21117	Appeals Avēsis Third Party Administrators, Inc. Attention: Dental Appeals P.O. Box 38300 Phoenix, AZ 85069-8300
Pre-authorization Avēsis Third Party Administrators Attention: Dental Pre-Authorization P.O. Box 38300 Phoenix, AZ 85069-8300	Post Review Avēsis Third Party Administrators Attention: Dental Post Review P.O. Box 38300 Phoenix, AZ 85069-8300
Dental Claims Avēsis Third Party Administrators Attention: Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300	Corrected Claims Avēsis Third Party Administrators Attention: Dental Corrected Claims P.O. Box 38300 Phoenix, AZ 85069-8300
Provider/Customer Services (888) 211-0599 Monday – Friday, 8 a.m. – 6 p.m. Eastern time, except observed holidays	Avēsis Provider Portal/Website www.avesis.com Avēsis IVR: (866) 234-4806
Avēsis Kentucky State Dental Director Jerry W. Caudill, DMD, FAGD, MAGD, CDC, FPFA, FICD (502) 662-2101 jcaudill@avesis.com	
Humana – CareSource Customer Service (866) 206-0272	Humana – CareSource Member Services (855) 852-7005 TTY: (800) 648-6056
Humana – CareSource 24-hour Nurse Line (866) 206-9599 TTY: (800) 648-6056 or 711	Humana – CareSource Special Needs Assistance (866) 206-0272

Sample ID Card

Members should present a Humana – CareSource ID card. Medical Assistance members may also present their Medical Assistance card. Providers are responsible for verifying eligibility and benefits prior to an appointment.

You may verify in one of three ways using your Avēsis Provider PIN and the member's identification number:

- Call the Interactive Voice Response (IVR) system at (866) 234-4806
- Visit www.avesis.com
- Call Avēsis Provider Services at (888) 211-0599

Language Assistance

For your convenience, we are providing the following notice translated into the most common non-English languages used across the United States. You are welcome to use this language to support your compliance with federal linguistic access rules. In English, it reads:

Attention: If you speak [insert language here}, free language support services are available to you. Call (855) 202-1059.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (855) 202-1059.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (855) 202-1059.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (855) 202-1059.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (855) 202-1059.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para TTY: (855) 202-1059.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (855) 202-1059.

Persian/Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

فراهم می باشد. با (855) 202-1059 تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (855) 202-1059.

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε TTY: (855) 202-1059.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (855) 202-1059.

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (855) 202-1059.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (855) 202-1059.。

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (855) 202-1059.

まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (855) 202-1059 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

Gọi số (855) 202-1059.

Program Overview

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

In early 2016, Avēsis became a wholly owned subsidiary of The Guardian Life Insurance Company of America, a distinction that brings even more capabilities to our firm. Guardian has put its policyholders and clients above all else for more than 150 years. Adhering to high standards, doing the right thing, and making people count are the founding principles that have kept Guardian financially sound and made them one of the largest insurance companies in the country.

Using this Provider Manual

Your dental provider manual is intended to be a comprehensive reference tool to help you and your office team efficiently service our members.

Over the course of your participation in the Avēsis provider network, we will periodically update this manual to reflect strategic improvements to our program. The most updated version of the manual, benefits grids and fee schedules will be on our website.

Provider Rights and Responsibilities

As a provider, you have the right and responsibility to:

- Communicate openly and freely with Avēsis
- Communicate openly and freely with members
- Suggest dental treatment options to members
- Recommend noncovered services to members
- Manage the dental healthcare needs of members to assure that all necessary services are made available in a timely manner

- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality, privacy and security
- Obtain written parental or guardian consent for treatment to be rendered to members who have not yet reached the age of majority or who have been determined to require guardianship, in accordance with state dental board rules or ADA guidelines
- Ensure disclosure form is signed for noncovered services by all parties prior to rendering service
- Obtain information regarding the status of claims
- Receive prompt payments from Avēsis for clean claims
- Resubmit a claim with additional information
- Make a complaint or file an appeal with Avēsis on behalf of a member with the member's consent
- Inform a member of appeal status
- Question policies and/or procedures that Avēsis has implemented
- Request prior authorization for services identified as requiring authorization
- Refer members to participating specialists for treatment that is outside your normal scope of practice
- Inquire about recredentialing
- Update credentialing materials, including state licensure, U.S. Drug Enforcement Administration (DEA) and professional liability insurance
- Abide by the rules and regulations set forth under applicable provisions of state or federal law
- Inform Avēsis in writing within two business days of any revocation, suspension and/or limitation of your practice, certification(s), and/or DEA license by any licensing or certification authority

As a member of the Avēsis provider network, you further understand that you and your dental office team are prohibited from:

- Discriminating against members based on race, color, creed, gender, national origin, ancestry, language, disability, age, religion, marital status, sexual orientation, health status, disease or pre-existing condition, mental or physical handicap, limited English proficiency or being part of any other protected class. To this end, you and your dental office team agree to comply with the Americans with Disabilities Act, the Rehabilitation Act of 1973 and all other applicable laws related to the same
- Discriminating against qualified individuals with disabilities for employment purposes
- Discriminating against employees based on race, color, religion, sex or national origin
- Offering or paying or accepting remuneration to or from other providers for the referral of members for services provided under the dental program
- Referring members directly or indirectly to or soliciting from other providers for financial consideration
- Referring members to an independent laboratory, pharmacy, radiology or other ancillary service in which you, your office or your professional corporation has an ownership interest

Member Rights and Responsibilities

Avēsis members have the right to:

- Communicate openly and freely with Avēsis and their dentists and other oral health providers without fear of retribution
- Expect privacy according to Health Insurance Portability and Accountability Act (HIPAA) and other state or federal guidelines
- Be treated with respect, courtesy and dignity
- Be treated the same as all other patients in the practice
- Be treated without discrimination based on race, religion, color, sex, national origin or disability
- Be informed of their oral health status and examination findings
- Participate in choosing treatment options
- Receive information on treatment options in a manner that they can understand, including receiving materials translated into their primary language, upon request

- Know whether treatment is medically necessary
- Know whether the treatment is experimental and give his/her consent
- Refuse any treatment, except as provided by law
- Be provided with a phone number in case of an emergency
- Obtain noncovered services only when a disclosure form is signed by all parties
- Submit a complaint against a provider, without fear of retribution
- Be informed of any appeals filed on their behalf
- Change providers
- File grievance issues with Avēsis
- Access their records to review and/or change

Members shall, to the best of their ability:

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

- Have the opportunity to ask about a fee associated with any noncovered service before the service is rendered
- Use best efforts to not miss or be late for an appointment
- Cancel scheduled appointment in advance, if unable to attend
- Provide emergency contact information
- Follow home care instructions
- Call the dentist of record in the event of an emergency
- Report suspected, fraud, waste and abuse

Treating Beneficiaries

Avēsis believes that all patients should be able to receive quality dental services from their chosen dentist or dental specialist. Our programs are intended to emphasize routine preventive services and proper restorative care. We expect our dentists and dental specialists to present all necessary treatment to our members, regardless of whether the services are covered under the plan. The patient should always be the final decision-maker regarding his/her dental health.

Role of the General/Pediatric Dentist

Avēsis considers the general/pediatric dentist to be the provider responsible for rendering all primary dental care to members. These responsibilities include performing an initial examination and taking basic radiographs that are necessary to diagnose and establish a treatment plan for each member.

The following additional services should be rendered by the general/pediatric dentist and should not be referred to a specialist unless the member presents with unusual complications or the services fall outside the scope of the provider's practice:

- Diagnostic and preventive care
- Extractions (D7140)
- Endodontic therapy on anterior and bicuspid teeth
- Nonsurgical periodontal services (e.g., scaling and root planing, full mouth debridement, etc.)
- Restorative dentistry

Covered Services

Coverage limitations and reimbursement guidelines specific to this plan are outlined in the Covered Benefits Schedule located in the addendum to this manual.

Noncovered services

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

- The member's willingness to accept noncovered procedures or treatments
- The member's acknowledgement that he/she received notice that the procedure is not a covered benefit
- The member's acknowledgement that he/she has been informed of the cost of the noncovered procedure or treatment
- Assurance that there are no covered benefits available to the member

Non-Covered Services Disclosure Form

To download the Non-Covered Services Disclosure form:

- Log into the secure provider portal at www.avesis.com.
- Select the **Knowledge Center** box from the Home screen or from the Knowledge Center tab found in the blue navigation bar.
- Select **Forms**.
- Search for the Non-Covered Services Disclosure form

For your convenience, a Non-Covered Services Disclosure form is available to document this process.

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

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

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

Verifying Eligibility

Confirming eligibility is an important step for every dental appointment. Avēsis strongly recommends that eligibility is verified for members on the day of the office visit. However, eligibility verification is not a guarantee of payment. Benefits are determined at the time the claim is processed.

Specific details on what constitutes eligibility for the plan may be found in the addendum to this document.

These are two ways you can verify a member's eligibility:

Setting Up Your Provider Username and Password

To register your new account:

- Visit https://www.avesis.com/Commercial/providers/Index.aspx.
- Select the **Medicare/ Medicaid** option above the login fields.

OPTION 1: Internet

- Go to www.avesis.com
- Enter your username and password to log into the secure provider portal
- Click "Eligibility Search" from the home screen or select "Member Search" within the Eligibility tab on the blue navigation bar
- Enter any of the following information:
    - Member's ID in the **Member Number** field
    - Member's first name, last name, and date of birth into the **First Name**, **Last Name**, and **Date of Birth** fields
    - Member's Social Security number and date of birth into the **SSN** and **Date of Birth** fields
- Receive a real-time response

OPTION 2: Provider Services

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

You also can check member eligibility using the interactive voice response (IVR) system. You may, but do not need to, talk with a customer service representative when checking eligibility.

When you use IVR or talk with the customer service representative, you will receive a real-time response.

Prior Authorization

Avēsis uses a prior authorization review process to manage the utilization of services. Services that require prior authorization are defined in this provider manual in the benefit grid in the addendum to this document. Nonemergency services requiring prior authorization must be approved prior to initiating these services.

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

A request for prior authorization must include:

- 2012 ADA Claim form, with the request for prior authorization box checked
- Pretreatment radiographs necessary for proper diagnosis and treatment
- Any other material required for proper diagnosis and treatment such as periodontal charts or ortho models
- Documentation of index criteria used to determine orthodontic necessity

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

- Pertinent dental history
- Pertinent medical history, if applicable
- Strategic importance of the tooth
- Condition of the remaining teeth
- Existence of all pathological conditions
- Preparatory services performed and completion date(s)
- Documentation of all missing teeth in the mouth
- Oral hygiene of the mouth

- All proposed dental work
- Identification of existing crowns, periodontal services, etc.
- Identification of the existence of full and/or partial denture(s), with the date of initial insertion
- Periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis
- Identification of abutment teeth by number

Prior authorization requests for periodontal services must include a comprehensive periodontal evaluation.

For those service programs where dental services are limited to those provided in an inpatient hospital, hospital short-procedure unit, or ambulatory surgical center, please include a statement identifying where the service will be provided.

Should a procedure need to be initiated due to an emergency, you may submit the service(s) for post-treatment review, including a narrative of the nature of the emergency.

Prior-authorization review requests may be submitted in one of three ways:

- Online through the provider portal at www.avesis.com
- Electronically in a HIPAA-compliant data file
- By mail, sending a completed, current ADA claim form to:
  Avēsis Third Party Administrators, Inc.
  Attention: Dental Prior authorization
  PO Box 38300
  Phoenix, AZ 85069-8300

Typically, within two business days of receipt of your prior authorization request, you will be notified if additional material is needed to make the determination or if the clinical reviewer has determined that the services requested are necessary.

If the additional information is requested, you will have 14 calendar days to provide the material. If the additional material is not received within 14 calendar days, a decision to approve or deny the service will be made based on the available information.

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

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

Typically, notification of the decision regarding the prior-authorization request will be mailed within two business days. If requested services are determined to be medically necessary, your notification will include an authorization number.

Once the determination has been communicated to you, you are responsible for advising the member of the review decision within two business days. Specific time frames for determinations are dictated by the program in which the member participates.

Avēsis will honor prior authorizations for 180 days from the date of approval.

If our records show that a prior authorization has been approved, but there has been no claim made against it within 45 days of the prior-authorization decision, we may initiate calls to the member reminding him/her of the availability of service.

Nonemergency treatment begun prior to the granting of authorization will be performed at the financial risk of the dental office. If authorization is denied, the dental office or treating provider may not bill the member, the health plan or Avēsis.

These data are complemented by trend information identified through utilization patterns gathered from our work. For example, if unusual practice patterns are identified in the application of crowns, we might flag this with a client, identifying a potential need for prior authorization to help reduce the volume of unnecessary crowns.

Medical Necessity

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

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

Post-treatment Review

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

Specific Current Dental Terminology (CDT) codes require post-treatment review based on their clinical nature. These codes are reflected in the benefit grids and indicate what kind of documentation is required.

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

The post-treatment review process is as follows:

- Providers have 180 days from the date of service to submit a retrospective review.
- Following receipt of a claim for a procedure or diagnostic code that requires post-treatment review, Avēsis will send a letter to the provider within two business days of receipt, requesting additional information in support of the medical necessity of the claim.
- Upon receipt of the requested information, we will review the file and make a determination based on guidelines and clinical criteria established for the procedure/service.
- Within 30 calendar days of receipt of all required information, we will notify the provider and/or member, as appropriate, of the decision in writing.
- If the post-treatment review is approved, the provider will then have to submit a standard claim to be paid.
- If the request does not meet the screening criteria or guidelines established for the procedure/service, the request will immediately be turned over to the Dental Advisory Board member or state dental director for review.
- In situations where an adverse determination may be made, the state dental director or member of the dental advisory board may first contact the provider to discuss all the case specifics and review all the supporting information available. Where appropriate, special circumstances that may require deviating from established norms will be taken into consideration.

Diagnostic Codes

The procedures and diagnostic codes to which post-treatment review applies may be found in the addendum to this manual.

- If it is the decision of the state dental director or advisory board to deny the claim, written notification of the adverse determination shall be communicated to the provider and member within 30 calendar days. This notification shall include:
    - Date of the determination
    - Principal reason(s) for the determination
    - Source of the criteria used to make the determination
    - Notification that the provider and/or member can obtain a copy of the actual benefit provision or clinical protocol on which the adverse determination was based
    - Instructions for initiating an appeal of the adverse determination
- Adverse determination notifications shall be signed by the state dental director and include contact information for Avēsis.
- Notifications of adverse determinations, whether for pre- or post-service reviews, will include a statement that the decision is based on appropriate care and service guidelines and that there is no reward for issuing denials nor are incentives offered to encourage inappropriate utilization.
- Review personnel will be qualified to speak with providers to obtain diagnosis and/or treatment information and shall be supervised by the vice president/national dental director for Avēsis.
- Personnel may use pre-established screening criteria that have been reviewed and approved for purposes of approving the requested treatment or materials. Screening criteria shall be periodically evaluated and updated by the vice president/national dental director for Avēsis and dental advisory board.
- You are responsible for submitting all the necessary documentation for the review process. This includes:
    - Completed 2012 ADA claim form
    - Pretreatment radiographs necessary for proper diagnosis and treatment
    - Any other material required for proper diagnosis and treatment, such as periodontal charts or ortho models
    - Documentation of index criteria used to determine orthodontic necessity

- Post-treatment review material may be submitted:
    - Electronically via the secure provider portal on our website, www.avesis.com
    - By mailing a current, completed ADA claim form to:
      Avēsis Third Party Administrators, Inc.
      Attention: Dental Post-Treatment Review
      PO Box 38300
      Phoenix, AZ 85069-8300
- Avēsis clinical staff will review these services after the treatment has been performed. If we do not receive this documentation, the claim will not be paid.

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

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

Inter-rater Reliability

Avēsis conducts inter-rater reliability (IRR) studies to help ensure the dental consultants who perform our prior-authorization and post-treatment review requests are consistently applying relevant clinical criteria to their decision-making.

Facilitated by the chief dental officer and the state dental director, this process involves the review of clinical prior-authorization requests from the previous quarter.

Each dental consultant is sent a case and asked to make a determination. Their results are compared to one another to determine whether each consultant came to the same conclusion, and the results are presented at a team meeting.

If there is not 90 percent agreement among the dental consultants in the disposition of the case, the dental consultants will review it at an IRR session. When inappropriate or extreme discrepancies exist between the determinations made in the actual clinical case and the recommendations made by the reviewers during the IRR activity, further interventions will be determined by the chief dental officer. For example, Avēsis may decide to update clinical guideline criteria or provide additional training to the dental consultants or UR processors. In certain instances, auditing of a case may be necessary.

After each IRR session, the chief dental officer or a designee will report the outcomes of the IRR to the Quality Management Committee.

Emergency (Urgent) Care

In accordance with Kentucky code Section 304-17A-600(17), urgent care means healthcare treatment with respect to which the application of the time periods for making nonurgent determination (a) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (b) in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

A dental emergency is a situation that cannot be treated simply by medication and that, left untreated, could affect the member's health or the stability of his/her dentition. Emergency services do *not* include:

- Prophylaxis, fluoride and routine examinations
- Routine restorations, including stainless steel and composite crowns
- Dentures, partial dentures and denture relines and repair
- Extraction of asymptomatic teeth, including third molars

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

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

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

(a) Render services in the dental office to treat the emergency

(b) Assist the patient in obtaining proper dental care from another dentist or specialist or a hospital emergency room, if the condition warrants emergency room treatment

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

- If the member calls with an emergency before noon on a business day, the member should receive a response that day, if possible.
- If the member calls with an emergency after noon on a business day, the member should receive a response that day, if possible, but no later than the following business day.
- If the member calls with an emergency during nonbusiness hours, your office must have an answering service or alternate number to reach the on-call provider.

Waiver of Prior Authorization for Emergencies

Avēsis recognizes that you may not be able to obtain a prior authorization in the case of an emergency. In this situation, following the delivery of treatment, please submit a completed 2012 ADA claim form with all supporting and required documentation, including:

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

Claims and accompanying information must be submitted within 30 calendar days of the issuance of temporary referral approval number. If the procedure does not occur within 30 calendar days, Avēsis will terminate the temporary referral approval and require that a new referral approval number be issued.

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

Referrals

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

To refer a patient to another provider, simply complete the referral form and return it to Avēsis by mail. The form is like the prior authorization form, with the addition of information about the names of the referring and referred providers.

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

Specialist Treatment

A member who requires a referral to a dental specialist can be referred directly to any specialist in the Avēsis network without prior authorization. The provider services department is available to assist you with locating a specialist who participates in the Avēsis network.

In addition, members may self-refer to any participating network specialist without authorization from Avēsis.

Out-of-Network Care

In general, members who receive dental benefits through Medicaid or Medicaid managed care have no options to receive out-of-network care. Oral health services must be provided by a doctor who has a Medicaid ID number and who meets the other conditions for services in the state or plan.

There may be exceptions in the event the member is out of state and requires emergency treatment. Your Humana – CareSource-covered patients should be instructed to contact your office if they are experiencing a dental emergency, so they can receive instruction on how to manage the condition until they can get to your office.

Office Accessibility

Services shall be provided to members in a timely manner and in accordance with your facility's routine practice pattern, with reasonable wait times for appointments for preventive care, hygiene care, urgent care and emergency care. In lieu of submitting quarterly reports stating average wait times for members, we will randomly telephone your facility to inquire about wait times; these calls may be anonymous.

Appointment wait time standards, typically set by the state or the health plan, may be found in the addendum to this document.

After-Hours Accessibility

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

Transfer of Care

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

If a successor dentist cannot get the required radiographs from the dentist from whom care is being transferred within 10 business days, the successor dentist should contact Avēsis Provider Services. We will notify the originating dentist or specialist in writing within 30 calendar days that the successor dentist or specialist did not receive diagnostic quality radiographs. In this notice, we will notify the member's originating dentist that Avēsis will charge them for radiographs that the successor dentist or specialist must retake for appropriate care if:

The originating dentist or specialist has provided radiographs that were not of diagnostic quality as determined by Avēsis clinical staff

OR

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

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

Continuity of Care

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

Please refer to the addendum to the document for details on the state or plan requirements regarding continuity of care for orthodontic treatment.

Continuity of care standards do not apply in the case of a treatment plan being transitioned between providers. In this case, transfer-of-care standards would apply.

Locum Tenens

Locum tenens arrangements are made between the providers whereas one provider will temporarily replace another provider for a period due to medical leave or vacation. Locum tenens should not be used to temporarily replace a noncredentialed or disciplined provider until he/she is restored to the network.

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

The locum tenens provider may not render services until the locum tenens relationship is approved by Avēsis. To secure approval, we first affirm that the locum tenens provider has a valid NPI and a valid state Medicaid number. Next, a member of our credentialing department will run two searches to determine whether there are any sanctions against the provider. Once these reports clear, the form is sent to a dental director for approval. From there, the locum tenens request goes to the credentialing committee for review and approval.

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

Locum Tenens Form

To download a copy of the Locum Tenens form:

- Log into the secure provider portal at www.avesis.com.
- Select the **Knowledge Center** box from the Home screen from the Knowledge Center tab found in the blue navigation bar.
- Select **Forms**.
- Search for the Locum Tenens form from the list.

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

Clinical Coordination

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

Patient Outreach

The Centers for Medicare & Medicaid Services (CMS) comprehensive and preventive child health program for individuals under the age of 21 is called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). EPSDT requires that every Avēsis network provider have a documented member outreach policy and procedures in place to ensure that members receive oral health services on a regular schedule. CMS specifically requires the following:

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

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

Missed Appointments

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

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

There may be outreach and documentation standards for managing missed appointments that are specific to your state. Please refer to the addendum to this manual for additional information.

Pregnant Women

Under CMS rules, women who are pregnant and lack insurance coverage may be eligible for limited coverage under Medicaid. This coverage typically begins on the date pregnancy is verified and ends the date of delivery. Coverage typically includes:

- Routine dental benefits for their age category (younger than 21 or older than 21)
- Periodontal coverage limited to comprehensive periodontal examinations, along with codes 4241, 4342, 4910 and 9215

State- or plan-specific requirements for the documentation of a member's pregnancy may be found in the addendum to this manual.

Patients with Special Needs

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

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

Cultural Competency and Language Services

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

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

The Avēsis Cultural Competency Program

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

- Visit www.avesis.com.
- Scroll to the bottom of the home page.
- Click the **Cultural Competency** link.

Cultural competency is more than a philosophy. It is also a legal requirement for the delivery of services. To this end, Avēsis complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability or sex. To help facilitate the fair and equal treatment of all members, Avēsis:

- Provides aid and services to people with disabilities to communicate effectively with us and your practice, such as:

- Qualified sign language interpreters
- Information written in other formats (Braille, large print, audio, accessible electronic formats, other formats)

- Provides language services to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If a member seen in your practice needs linguistic support, please contact our customer service line to make arrangements. If you are unable to coordinate linguistic support through our customer service team, please reach out to our vice president of compliance:

10324 S. Dolfield Rd.
Owings Mills, MD 21117
(800) 643-1132

Translation vs. Interpretation

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

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

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

Language Assistance

Avēsis employs customer service representatives who are fluent in Spanish. The representatives may be reached through the Spanish language queue at our toll-free number. Additionally, Avēsis contracts with a company that provides language assistance services in more than 175 languages for members with limited English proficiency. Avēsis pays all costs for this service.

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

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

For your convenience, we've provided translations of the most common 15 languages just after the Quick Reference Guide in the Addendum.

Deaf or Hard of Hearing Patients

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

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

Free Access to TRS

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

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

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

- Provide a quiet background for the patient
- Reduce echoes to enhance sound quality
- Add lights to enhance visibility
- Install flashing lights that work in conjunction with auditory safety alarms
- Clearly identify all buildings, floors, offices, and room numbers
- Include telecommunications relay services (TRS) to communicate by phone with a member with a hearing or speech disability

Your provider relations representative can provide you or your office staff with additional suggestions and ideas for improving the linguistic accessibility of your office.

Functional Illiteracy

A person with functional illiteracy is someone with basic education but whose reading and writing skills are inadequate for everyday needs. Health illiteracy is the degree to which individuals lack the capacity to obtain, process and understand basic health information and

services needed to make appropriate health decisions.[1] In fact, the most recent National Assessment of Adult Literacy (2006) reports that 22 percent of adults have basic health literacy, while 14 percent have below basic health literacy.[2]

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

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

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

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

Cultural Competency Training

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

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

[2] https://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2006483

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

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

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

Required Annual Cultural Competency Training

To gain access to the required training course:

- Log into the provider portal at www.avesis.com.
- Select **Message Center** from the Home screen.

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

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

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

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

Cultural Competency Grievances

If you believe Avēsis has failed to adequately provide cultural or linguistic support to a member in your care, you can file a grievance with us. This may be done in person or by phone, mail, fax or email. If you need help filing a grievance, the Vice President of Compliance is available to help you.

You may reach the Vice President of Compliance by:

Telephone: (800) 643-1132
Fax: (844) 344-7112
Mail: Compliance
10324 S. Dolfield Road

Owings Mills MD 21117
Email: compliance@avesis.com

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Recordkeeping

Your office shall maintain confidential and complete member medical records and personal information as required by applicable state and federal laws and regulations. Avēsis requires that member records and radiographs be maintained for at least 10 years.

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

- Administration documentation
    - Patient's identification number on all pages
    - Signed HIPAA confidentiality statement
    - Signed consent to permit Avēsis to access medical records upon request
    - Claims and billing records
    - The name and telephone number of the member's primary care physician (PCP)
- Medical documentation
    - The original handwritten personal signature, initials or electronic signature of practitioner performing the service, and initialed by the dentist, if he/she did not perform the service
    - Current health history
    - Complete medical history
    - Current prescription and nonprescription medications, including quantities and dosages

- Medication allergies and sensitivities, or reference "No Known Allergies" (NKA) to medications prominently on the record
- Any disorders and/or diseases
- Initial examination data
- Tobacco, alcohol and substance abuse history for patients 14 and younger
- A physical assessment, including member's current complaint, if relevant
- Diagnosis that is reasonably based on the history and/or examination
- Documentation that problems from previous visits were addressed
- Treatment plan consistent with the diagnosis, signed by the provider and adult member, parent/guardian or minor member
- Progress notes
- Date for return or follow-up visit
- All radiographs taken during the member's previous dental visits (dated and labeled)
- Copies of all authorizations or referrals
- Copies or notations regarding any drugs prescribed

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

- A health problem that requires premedication prior to treatment
- Current medications being taken that may contraindicate the use of other medications
- Infectious diseases that may endanger others

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

Confidentiality of Records

The confidentiality of member medical and billing records and personal information shall be maintained in accordance with all applicable federal and state law. You and your office shall not use any information received while providing services to members except as necessary for the

proper discharge of your obligations as an Avēsis network provider. You and your office agree to comply with all the applicable federal requirements for privacy and security of health information as set forth in HIPAA and the American Recovery and Reinvestment Act of 2009.

Records Audit

You may be required to disclose member records as required by state law.

Avēsis has the right to request copies of a member's complete record during the term of your provider agreement and up to 10 years after you leave the Avēsis provider network. In addition, member medical and billing records shall be subject to inspection, audit or copying by the plan, the state Medicaid agency, the U.S. Department of Health and Human Services, CMS and any other duly authorized representative of the state or federal government during normal business hours at your place of business.

Your office must provide a copy of the medical record to Avēsis at no charge to us.

Members have the right to request a copy of their records and amend or correct information contained therein.

Quality

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

- Quality standards
- Quality assurance
- Utilization review

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

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

Avēsis Quality Standards

The first component of a dental quality program is the establishment of standards all participating network providers are expected to fulfill. For Avēsis, these standards include:

- Dental Professional Standards of Care
- Standards for Member Records
- Standards for Member Contact and Appointments
- Standards for Member Contact Information and Outreach
- Standards for Member Appointments
- Standards for Infection Control
- Standards for Radiation Protection
- Standards for Treatment Planning
- Standards for Services Not Covered Under the Member's Plan
- Standards for Submitting Claims

The following sections address these individually.

Dental Professional Standards of Care

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

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

Standards for Member Records

Each member must have an individual record that is maintained at the dental office. The record should meet the requirements defined in the Recordkeeping section of this manual (see page 35). The records must be available for review by an Avēsis staff member during any facility review. If computerized, the records shall be nonchangeable; however, the system shall permit adding to the original record. All files must be properly backed up for protection, in accordance with applicable HIPAA requirements. The provider shall confirm that all records conform to applicable industry standards.

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

Standards for Member Contact and Appointments

Providers are required to maintain accurate contact information for each member at the time of each appointment and shall have appropriate contact information for parent(s) or legal guardian, if the member is under the age of majority.

Note: Providers are prohibited from billing Avēsis or the member for missed appointments.

Standards for Member Contact Information and Outreach

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

Members shall be offered appointments within the period dictated by the state and/or the specific health plan. Emergency coverage shall be in keeping with the requirements established in the Avēsis Provider Agreement, by the member's specific dental plan, and as described within this manual. No charges shall be permitted for late or broken appointments.

Standards for Member Appointments

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

Standards for Infection Control

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

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

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

Standards for Radiation Protection

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

Standards for Treatment Planning:

All treatment plans must be recorded and presented to the member and, if the member is a minor, to the parent. The member must be given the opportunity to accept or reject the treatment recommendations, and the member's response must be recorded in the member's record.

Standards for Services Not Covered Under the Member's Plan

Each office should be aware of dental services that are not covered under an Avēsis member's dental program.

If a member wants to have non-covered services and is willing and able to pay directly for those services, the Avēsis Non-Covered Services Disclosure form – or a similar form that contains all the elements on the Avēsis form – must be completed and maintained in the member's record.

Standards for Submitting Claims

Avēsis recommends that claims be submitted promptly and include all required documentation necessary for claim review.

Quality Assurance Program

Avēsis' primary quality assurance goals are to provide enrollees access to high-quality dental services that meet industry standards of care and to perform all necessary administrative services associated with the dental programs. Avēsis operates a Quality Assurance Program (QAP) to facilitate these goals as they pertain to quality-related issues.

The Avēsis QAP includes the following components to monitor the quality of care rendered through our dental programs:

- New provider credentialing
- Provider recredentialing
- Ongoing monitoring
- Provider site reviews
- Maintenance of the collection of provider credentialing documents that comply with National Committee for Quality Assurance (NCQA) credentialing standards
- Member complaint resolution
- Member satisfaction surveys
- Provider complaint resolution
- Provider satisfaction surveys
- Provider corrective action
- Service delivery studies (i.e., office reviews, performance report cards, etc.)
- Utilization review/utilization management
- Review of staff/internal corrective action plans (CAPs)
- QAP Evaluation

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

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

- Quality of care
- Access and availability
- Utilization management
- Complaints, appeals and grievances statistics

- Customer/member services

The QAP is reviewed and updated annually by the Avēsis Quality Oversight Committee. The committee is composed of senior staff of Avēsis and clinical staff, including the chief dental officer and state dental director. Members of each state's dental advisory board are also permitted to participate.

Utilization Management (UM)

The goals and objectives of the Avēsis UM program include:

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

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

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

Statistical Provider Review

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

The following items formulate the basis of the review:

- Average Service Comparison: Avēsis will prepare a summary of the statistical results by CDT code for each provider compared with the state average. We will perform this analysis only if the provider has treated a sufficient number of plan members in that quarter. Providers that qualify must fall within a reasonable range of the state average. Those providers falling outside of the range will be reviewed for over- or under-treatment patterns.

- Relative Service Comparison: Certain dental services are typically performed with or after other services. Avēsis will review a series of related dental services for appropriate care. Some examples include:

    - A root canal on a tooth, D3310 or D3320, followed by the placement of a stainless-steel crown, D2930

    - A fluoride treatment for a child being performed at the same appointment as his/her prophylaxis

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

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

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

Wait Time Review

In lieu of requiring providers to submit an average wait time report, Avēsis will perform random and anonymous surveys of practices to inquire whether scheduling wait times are excessive.

Providers found to have excessive wait times will be required to implement a corrective action plan.

If a member complains to Humana – CareSource, CMS, or the appropriate Kentucky state agency that wait times in your office are excessive *or* that it was difficult to make an appointment for routine care, Avēsis is required to contact your office to let you know a complaint was filed. Once you are notified, we will work with you to formulate a written corrective action plan, and then we will follow up to ensure that the action has been implemented.

Site Reviews

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

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

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

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

terminated from the network in accordance with the termination clause in the Provider Agreement.

Fraud, Waste and Abuse

CMS defines fraud as:

"An intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to him or some other person."

Examples of potential fraud, waste and abuse committed by providers may include, but are not limited to, the following.

- Actions that may constitute fraud include:
    - Knowingly billing for services not furnished or supplies not provided, including billing for appointments that the patient failed to keep
    - Knowingly altering claim forms, records or receipts to receive a higher payment
- Actions that may constitute Medicaid waste include:
    - Conducting excessive office visits
    - Prescribing more medications than necessary for the treatment of a specific condition
- Actions that may constitute Medicaid abuse include:
    - Billing for unnecessary services
    - Charging excessively for services or supplies
    - Misusing codes on a claim, such as upcoding or unbundling codes

Examples of potential fraud, waste and abuse committed by members may include knowingly making false statements or representations to become eligible for medical assistance or failing to provide all required information, such as other insurance coverage. Members who commit fraud may be prosecuted under state criminal laws and federal fraud and abuse laws.

Avēsis is committed to preventing, detecting and reporting possible fraud, waste and abuse. We expect that all our staff

Required CMS MLN Training

To gain access to the required training course:

- Log into the provider portal at www.avesis.com.
- Select **Message Center** from the Home screen.

and providers understand and adhere to the Avēsis Anti-Fraud Program. Compliance is everyone's responsibility.

Anti-fraud Training

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

The Centers for Medicare & Medicaid Services (CMS) requires that annual fraud, waste and abuse training is completed by all employees (providers and staff) in a practice that treats Medicaid and/or Medicare Advantage members. Additionally, any nonemployee providers (independent contractors) associated with the practice must complete the training.

For your convenience, Avēsis has placed a link to the fraud and compliance training available from the CMS Medicare Learning Network (MLN) in the secure provider portal of our website. Avēsis does not require that training is completed through us if similar training has been completed through another source.

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

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

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

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

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

Reporting Suspected Fraud, Waste and Abuse

All our providers and their office staff also are expected to be alert to possible fraud, waste and abuse and report any suspicious activity to Avēsis. The Avēsis fraud hotline number is (410) 413-9309. You may leave a message on the hotline's voice mail anonymously, as the

hotline is not answered in real time. Or you may leave your contact information so that we may provide you with updates on the investigation.

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

- The Kentucky Cabinet for Health and Family Services has a state hotline operated by the Office of Inspector General. Use this hotline to report suspected fraud and abuse for Medicaid recipients anonymously: (800) 372-2970. Providers may also submit a report by mail to:

  Office of Inspector General
  Division of Audits and Investigations
  275 East Main Street, 5 E-D
  Frankfort, KY 40621

- It is Humana – CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the Federal False Claims Act or any state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, you may contact our Special Investigations Unit. Reporting fraud, waste, or abuse can be anonymous or not.

  Providers may contact Humana – CareSource anonymously by:
  - Calling (855) 852-7005 and following menu options
  - Writing to:
    Humana – CareSource
    Attn: Special Investigations Unit
    P.O. Box 1940
    Dayton, OH 45401-1940

  Providers may contact Humana – CareSource nonanonymously by:
  - Faxing (800) 418-0248
  - Emailing fraud@caresource.com
  - Fraud, Waste, and Abuse Reporting Form online at www.caresource.com/ky

- Providers may also call the U.S. Department of Health and Human Services, Office of Inspector General OIG Hotline Operations at (800) 447-8477. This hotline is available Monday through Friday from 8:30 a.m. until 3:30 p.m. Eastern time. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

- You may mail a report to: VP, Compliance, Avēsis, 10324 S. Dolfield Road, Owings Mills, MD 21117.

Upon receipt of a report of suspected fraud, waste or abuse, Avēsis will work with relevant plan fraud units and the applicable state/federal fraud, waste and abuse authorities to investigate.

Humana – CareSource providers should reference 907 KAR 1:026 for further guidance.

Federal Laws and Statutes Affecting Providers

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

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

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

The state of Kentucky does not have a state False Claims Act, but has the following laws regarding fraudulent and false claims:

- KRS 205.211: The Cabinet for Health and Family Services can act to correct Medicaid overpayments.

- KRS 205.8467: A provider who knowingly submitted claims for which they were not entitled to payment shall be liable for:
    - Restitution of payments received in violation, and maximum legal rate on interest from the date of payment
    - A civil fine up to three times the amount of the overpayment
    - A civil fine of $500 for each false or fraudulent claim submitted
    - Payment of legal fees in investigation and enforcement
    - Removal as a Medicaid provider for two to six months upon the first offense, six months to one

Accessing the LEIE and EPLS

LEIE:
https://exclusions.oig.hhs.gov/

EPLS:
https://www.sam.gov/portal/SAM/?portal:componentId=8e1441a6-72e4-4ab0-86a8-b0884f22dc78&interactionstate=JBPNS_rO0ABXc0ABBfanNmQnJpZGdlVmlld0lkAAAAAQATL2pzZi9mdW5jdGlvbmFsLmpzcAAHX19FT0ZfXw**&portal:type=action##11

State Exclusions Databases:

https://www.exclusionscreening.com/state-exclusion-databases-medicaid-exclusion/

year for second offense, and one to five years for a third offense.

- KRS 205.8463: The Cabinet for Health and Family Services can prosecute persons who:
  - Knowingly or wantonly plan or agree to conspire to work together to obtain federal Medicaid payments under false application, claim, report or documents submitted to the Cabinet (Class A misdemeanor or Class D felony)
  - Intentionally, knowingly or wantonly makes a false or fraudulent statement or representation of entry in a claim, report, application or document supporting payment to the Cabinet's staff (Class A misdemeanor or Class D felony)
  - Knowingly makes or induces a false statement or false representation of material fact with intent to defraud (Class C felony)
  - Knowingly falsifies, conceals or covers up a material fact, or makes false or fraudulent statements or representation or uses false documents when handling payment issues related to Medicaid (Class D felony)

The complete set of Kentucky laws governing Medicaid fraud and abuse may be found in Kentucky Revised Statutes §§205.8451-205.8483.

In addition to federal and state laws, Humana – CareSource's policy prohibits retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file whistleblower lawsuits on behalf of the government. Anyone who believes that he or she has been subject to such retribution or retaliation should also report this to our Special Investigations Unit.

Additional information on the False Claims Act and our fraud, waste and abuse policies can be found at https://www.caresource.com/providers/kentucky/medicare-advantage/contact-us/fraud-waste-abuse/.

Humana – CareSource is prohibited by its federal and state contracts from knowingly having relationships who are debarred, suspended or otherwise excluded from participating in federal procurement and nonprocurement activities. Relationships must be terminated with trustees, officers, employees, providers or vendors identified as debarred, suspended or otherwise excluded from participation in federal or state healthcare programs. If you become aware that you or your office management staff possesses a prohibited affiliation, you must notify us *immediately* using the contact information in this addendum.

As a participating network provider, you are required to ensure that no staff providing services to medical assistance or Medicare Advantage members appears on any of these lists. If you identify yourself or a staff member on one of these lists, you must report the event to the VP, Compliance at Avēsis within two days by calling (410) 413-9309 or emailing compliance@avesis.com

Claims, Billing and Payment

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

Clean Claims

Avēsis requires that claims must be submitted on a completed ADA 2012 claim form.

A clean claim is one that includes all following information:

- Patient's plan ID number
- Patient's name, date of birth and gender
- Patient's address (street or P.O. Box, city, ZIP code)
- Subscriber's name
- Patient's relationship to subscriber
    - Subscriber's address, if different from patient (street or P.O. Box, city, ZIP code)
    - Subscriber's policy number, if different from patient
    - Subscriber's birthdate and gender, if different from patient
- Health plan name (Humana – CareSource)
- Disclosure of any other health benefit plans
- Patient's or authorized person's signature or notation that the signature is on file with the provider
    - Subscriber's or authorized person's signature or notation that the signature is on file with the provider, if different from the patient
- Date(s) of service
- Place-of-service codes
- CDT code for the service, including arch, tooth number, quadrant and tooth surface, as applicable
- ICD-10 code, if applicable

- Diagnosis by specific service
- Charge for each listed service
- Number of units
- Rendering provider's NPI, federal taxpayer ID and license numbers
- Total charge(s)
- Signature of provider who rendered service, including indication of professional license (e.g. DMD, DDS, etc.)
- Name and address of office or facility where services were rendered
- Provider's billing name and address

The claim must be accompanied by all necessary documentation.

Note: Missing or incorrect information will cause either a delay or nonpayment of a claim.

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

Claims Timelines

Avēsis adheres to Kentucky state laws requiring that all clean claims be processed and paid in a timely manner. It is our hope that you and your office will be able to use the following timelines for submitting, correcting, and/or appealing a claim with Avēsis:

- File claim no longer than 365 calendar days from the date of service. As of April 1, 2018, claims must be received within 180 days.
- Correct a claim no longer than 90 calendar days from the explanation of benefit date
- Appeal a claim no longer than 60 calendar days from the explanation of benefit date

Claims received after the filing deadline will be denied. There are no exceptions.

Including Documentation with Your Claim

Images, charting, notes, and narratives can be submitted directly through our website at www.avesis.com.

From the Claims Submission screen, you'll find a place to Enter Enclosures, where you can upload attachments. Please note that document names may not contain any special characters. We accept .doc, .tif, and .jpg files.

Avēsis also accepts electronic attachments via FastAttach™, a National Electronic Attachment, LLC (NEA) company, for prior authorization requests requiring these documents. For more information, contact FastAttach™ at: www.fast.nea.com or NEA at: (800) 782-5150.

How to Submit Claims

Claims must be submitted with an ADA 2012 claim form and all necessary documentation. A claim may be submitted in three ways:

- On our website at www.avesis.com.
  Please consult your portal user guide for a detailed explanation of how to securely submit claims online.

- By mail using a current ADA claim form to:
  Avēsis Third Party Administrators, Inc.
  Attention: Dental Claims
  PO Box 38300
  Phoenix, AZ 85069-8300

- Through one of three clearinghouses that can convert paper claims into HIPAA-compliant electronic data interchange (EDI) format:

  - Change Healthcare: For questions regarding Change Healthcare (formerly Emdeon Dental), contact them directly at (888) 255-7293.

  - DentalXChange: For questions regarding DentalXChange (formerly EHG), contact them directly at (800) 576-6412.

  - Tesia: For questions regarding Tesia, contact them directly at (800) 724-7240.

For these providers, the Avēsis payer identification number is 86098.

Claims Review Process

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

- Medically necessary services: Medically necessary dental services must be appropriate and consistent with the standard of care for dental practices. The nature of the diagnosis and the severity of the symptoms must not be provided solely for the convenience of the dental professional or facility or other entity. Furthermore, any omission of services has the potential to adversely affect the member's condition. There must be no other effective and more conservative or substantially less costly treatment available. Furthermore, for certain procedures requiring prior authorization as set forth herein, the procedure is medically necessary to prevent or minimize the recurrence and progression of periodontal disease in recipients who have been previously treated for periodontitis; prevent or reduce the incidence of tooth loss by monitoring the dentition and any

prosthetic replacements of the natural teeth; and increase the probability of locating and treating, in a timely manner, other diseases or conditions found within the oral cavity.

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

Direct supervision includes, at a minimum, periodic review of the patient's records and immediate availability of the provider to confer with the salaried employee performing the service regarding a member's condition. This does not mean that the enrolled provider must be present in the same room; however, the enrolled provider must be present at the site where services are rendered at the time they are performed (e.g., office suite, hospital or clinic).

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

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

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

Checking Claim Status

You can check the status of a claim via our provider service phone line detailed in the Quick Reference Guide to this manual or online using our secure provider portal.

When calling to follow up on a claim, please have thefollowing information ready:

- Patient's name
- Date of service
- Patient's date of birth

Checking Claim Status

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

- Log into the secure provider portal at www.avesis.com.
- Select the **Knowledge Center** box from the Home screen from the Knowledge Center tab found in the blue navigation bar.
- Select **Portal User Guides List**.
- Select **Search Claims User Guides**.

This is a step-by-step, with photographs to assist providers with checking the status of a claim.

- Member's name
- Member's ID number
- Member's group number
- Claim number

When checking claims status, you will be informed that the claim is either:

- Paid, including the check number and amount of the payment
- Denied
- Pended or in the process of being reviewed

Claims Payment

Avēsis is committed to processing and paying all clean claims as defined by state or federal regulations. Check runs are typically done weekly. All applicable member copayments will be deducted from billed amounts.

All clean claims submitted will be paid according to the Avēsis Provider Fee Schedule. Each claim must include the appropriate line item with your charges and applicable codes.

Members cannot be balance billed for any charges or penalties incurred because of late or incorrect submissions.

Under no circumstances may a provider bill for services rendered by another provider. Services performed by noncredentialed providers in a group practice are not covered. Services performed by locum tenens will be covered when Avēsis is notified in advance by the provider of the locum tenens situation.

Lesser of Billed Charges or Fee Schedule

Avēsis pays a provider the lesser of the provider's billed charge or the amount on the appropriate fee schedule.

Receiving Payment

Claims payments are issued by paper check, electronic funds transfer (EFT), or card payment services (CPS).

The latter two options allow your office to have more control of your electronic payment, which may eliminate the possibility of misplaced checks and help maintain positive cash flow.

Electronic Funds Transfer (EFT)

EFT payments are deposited into an account designated by your office. This account is funded weekly, pending the delivery of services rendered. The remittance advice will be mailed to the address of record in your file weekly and can be viewed on the secure provider portal section of our website, www.avesis.com.

Initiating EFT Payment Arrangements

If you wish to elect to have funds electronically deposited, please complete the Avēsis EFT form and fax it, along with a copy of a voided check from the account into which you want funds transferred, to (855) 828-5654.

Card Payment Services (CPS)

Avēsis has partnered with Card Payment Services (CPS) to transmit future claims payment transactions via a MasterCard® merchant account. This allows you to process payments in your office like other credit card transactions through your office's MasterCard terminal.

If you wish to use our card services, a completed Avēsis E-Payment Form, available in the "Forms" section of our Knowledge Center on our secure provider portal, must be on file to receive payment through a credit card terminal.

The completed form should be emailed to ProviderEPayment@avesis.com.

When you receive payment through CPS, you will receive your payment information and the related explanation of payment in the mail. Avēsis will send you the MasterCard number, security code, transaction amount and expiration date on the day that your account is funded by email or fax, as directed by you.

To transfer approved payment from Avēsis to your MasterCard account, please use the following steps:

- Enter the Avēsis six-digit bank identifying number (BIN) of 556766. This BIN will always be the same
- Enter the unique 10-digit transaction payment number supplied on the remittance advice
- Enter the unique, three-digit transaction security code supplied on the remittance advice
- Enter the exact amount of the payment
- Enter the transaction expiration date expressed as MMYY

Terminal Entry Example

BIN number 556766

Unique 10-digit transaction number (e.g., 1234567890)

Unique CVC code (e.g., 321)

Exact amount of payment for that check cycle (e.g., $1033.50)

Expiration date expressed as MMYY (e.g., 0218 for February 2018

Payments will be processed immediately and will be available to your office under the terms of the contract the office has with the MasterCard merchant account.

To allow Avēsis to provide notification as soon as the funds become available to the MasterCard account, Avēsis requires an active email address for your practice be on file.

Notifications are sent at the completion of the weekly claim payment cycle. In addition, this information will be available on the secure website at www.avesis.com and on the remittance advice.

Explanation of Payment (EOP)

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

Overpayment

There may be times when you or your practice are overpaid for a service provided to a member. There are two ways to return overpayment to Avēsis:

- Sending a check or money order: If you elect to send a check or money order, you must do so within 45 calendar days of receiving notification of the overpayment. The check must be made out to Avēsis and mailed to P.O. Box 38300, Phoenix, AZ 85069-8300. The check or money order must be accompanied by all COB documentation.

- Recoupment: Recoupment refers to the withholding of all or a portion of a future payment until an overpayment refund obligation is met. If no check or money order is received within 45 calendar days of notification of an overpayment, Avēsis will initiate the recoupment process with your practice. You will be notified in writing.

Member Billing

A member shall not be billed for covered benefits denied by Avēsis except where the denial is for covered benefits, the denial was based upon our finding that the services are not medically necessary, and the member still desires to receive the services. In these cases, there must be a Non-Covered Services Disclosure form on file, indicating the member understands that the service or procedure will not be covered by this insurance and that s/he will be liable for payment.

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

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

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

Coordination of Benefits

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

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

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

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

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

Submitting a Corrected Claim

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

- By mail to:
  Avēsis Third Party Administrators, Inc.
  Attn: Corrected Dental Claims
  P.O. Box 38300
  Phoenix, AZ 85069-8300
- Through our secure portal at www.avesis.com.

Claims Correction

You have a right to correct claim information that may have been submitted incorrectly. A corrected claim must be resubmitted within 90 calendar days of the original submission.

Corrected claims may be submitted by mail or the secure provider portal on our website. The corrected claim should include the ADA 2012 claim form with the corrected information and the words "CORRECTED CLAIM" at the top of the form.

Avēsis Provider Network

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

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

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

Support for the Avēsis provider network is provided by our clinical staff, including the Chief Dental Officer, National Dental Director and state dental directors.

Network Enrollment Requirements

Dentists are enrolled in our provider network if they:

- Continuously meet the Avēsis credentialing standards based upon the National Committee for Quality Assurance (NCQA) guidelines, as applicable
- Agree to adhere to the administrative procedures of both Avēsis and its partners (e.g., Health Maintenance Organizations [HMO] and insurance companies)

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

- For each individual dentist or facility who shall receive payment for services rendered to members, the following contracting paperwork is required:
    - Completed and signed Avēsis Provider Agreement
    - Signed W-9 (any version prior to 2014 will not be accepted)
    - Disclosure of ownership form, as required by the applicable state
    - Americans with Disabilities Act (ADA) survey regarding the accessibility of your office for members with special needs or hearing impairments, in addition to details on your practice's ability to treat developmentally disabled patients.
    - Copy of IRS approval of tax identification number letter

- For each dentist in the office who will be rendering services to members, the following credentialing paperwork is required:
    - Completed and signed Avēsis or state-specific application, as appropriate, including work history
    - Copy of current state license
    - Copy of current DEA or state controlled dangerous substances (CDS) certificate, if applicable
    - Evidence of current professional liability insurance ($1 million/$3 million minimum limits required for all CMS providers) or business insurance for dispensing providers without professional liability coverage, except where participating in a state Patient Compensation Fund, in which case the certificate of insurance must indicate required underlying insurance limits and fund participation
    - Signed credentialing release and questionnaire/attestation pages
    - Documentation explaining any affirmative answers from the attestation page
    - Evidence of board certification, if applicable
    - NPI
    - Disclosure of any of provider's employees who have been debarred or excluded from any federal or state healthcare programs
    - Disclosure of criminal convictions by an employee of the provider if related to federal healthcare programs
    - If participating in Medicaid program(s), the provider's Medicaid identification number(s)

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

The department reviews the application and credentials for completeness and checks primary sources, in accordance with NCQA guidelines. Additional information may be requested of the provider. We may use a Certified Verification Organization (CVO) to verify information.

After the primary source verifications are completed, the provider's credentialing file is presented to the Avēsis Credentialing Committee for review. The Credentialing Committee approves or denies the application.

Avēsis will provide written notification to the provider within 60 calendar days of the Committee's decision.

Incomplete Submissions

Within five business days of receipt of an incomplete application, we will contact your office by phone, fax or email to discuss and request the missing information. This request will include the name and contact information for the Avēsis Credentialing Specialist making the request. It also will specify that the missing information be supplied within five business days.

Review of the application is suspended until all information is received.

Correcting Information in Your Network Enrollment Package

If the information is received from the CVO or through other source verification that is materially different from that supplied by the provider in the application, the provider will be notified within five business days and given an opportunity to review and modify the information. We will continuously attempt to secure the requested information. On credentialing applications, we will typically halt work if we cannot secure the requested materials by day 30. On recredentialing applications, we will halt work if we cannot secure requested materials within 90 days of the initial request.

Credentialing Details

Our credentialing approach ensures the Avēsis network is efficient, is of high quality, and consists of licensed providers who practice independently (without supervision) and comply with all local, state and federal regulations, including NCQA standards. Our program also meets the requirements set forth in 42 CFR §438.12, §438.206, §438.214, §438.224 and §438.230. The dental provider types subject to Avēsis credentialing and recredentialing include:

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

Any of the licensed provider types listed above can apply to participate in our program by submitting the following current information to our Credentialing Committee for approval:

- A completed and signed agreement
- Provider information, including:
    - Date of birth
    - Social security number
    - Professional education and training

- Board certification, if any
- Work history for the last five years
- Proof of professional liability insurance

In the submission, all gaps must be explained, all attestation questions must be completed, a Credentials Release of Verification must be included, and all affirmative responses must include a written explanation.

Avēsis performs primary source verification using NCQA-approved sources. We complete a credentialing checklist for each provider. For each element, this process includes:

- Source used
- Date of verification
- Signature or initials of the person who verified the information
- Report date, if applicable

The initial application must be signed and dated by the provider and include the completed attestation questions dated within 180 days.

Upon completion of primary source verification, the provider's file is presented to the Avēsis Credentialing Committee.

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

State Medicaid exclusions databases can be found at the following websites:

- https://oig.hhs.gov/exclusions/
- https://www.sam.gov/portal/public/SAM/
- www.npdb.com

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

Providers who want to participate in the Medicare Advantage program cannot opt-out of Medicare. Medicare Opt-Out lists are maintained for each Medicare region. These Opt-Out lists also are checked at least quarterly. If a provider has opted out of Medicare, the provider may not provide services to Medicare Advantage members.

Recredentialing Details

Avēsis recredentials all directly contracted providers every 36 months (counted from the month the provider's credentials were last reviewed by our Credentialing Committee), reviewing all recredentialing files for review. Providers must show they:

- Satisfy the Avēsis credentialing requirements met during the time of initial credentialing (Avēsis confirms this by completing primary source verification on each application element except verification of education)
- Are not listed in any claim or utilization files indicating a pattern of inappropriate billing or utilization
- Are free of any substantiated member complaints regarding quality of care or quality of service issues
- Remain in good standing with federal and state regulatory bodies

If a provider does not satisfy one or more of these criteria, our Credentialing team flags the provider for a detailed review. The Credentialing Committee will determine if the issues rise to a level of concern that disqualifies the provider from treating Avēsis members and vote to terminate the provider from the network.

The Credentialing Committee reviews all recredentialing files.

Credentialing Timelines

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

Credentialing Denials

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

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

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

The provider's denial letter will note the specific reasons for the denial and the criteria Avēsis used. In addition, providers with multiple disciplinary actions, with National Practitioner Date Base (NPDB) reports, or whose licenses are on probation may be denied at the discretion of the Committee and upon recommendation by the Chief Dental Officer or National Dental Director.

Credentialing Denial Appeals Process

When a denial of an application for credentialing or recredentialing is sent to a provider, it will include notification that the provider may appeal the denial by sending a letter to the Chief Dental Officer or National Dental Director.

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

The provider has the right to review any information submitted in support of the credentialing appeal except for information that is protected by peer review or law. All requests to review information must be made in writing and directed to the Credentialing Department. The provider will be notified of this right in the denial or termination letter. Copies of the information will be sent within 30 days of a written request signed by the provider.

The provider has the right to correct erroneous information with the primary source from which it was obtained. The provider must notify Avēsis in writing that the erroneous information has been corrected within 30 days of receipt of the denial or termination letter and may request that their appeal be suspended until the corrected information is received. The provider shall be notified of this right in the denial or termination letter. The primary source may require the provider to work with them directly to correct the misinformation.

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

Council for Affordable Quality Healthcare (CAQH)

Avēsis is a subscriber to CAQH and accepts CAQH applications from dental providers.

The CAQH application can be used in the following states by simply sending your CAQH number (how, to whom):

- District of Columbia
- Indiana
- Kansas
- Missouri
- Ohio
- Rhode Island
- Vermont

For those states with state-specific CAQH applications, providers must also share this CAQH application as part of the application process. This applies to applications in:

- Colorado
- Illinois
- Kentucky
- Louisiana
- Maryland
- Nevada
- New Mexico
- North Carolina
- Oklahoma
- West Virginia

If you are not set up in CAQH to permit Avēsis to obtain the

Delegated Credentialing

Typically, Avēsis performs the primary credentialing functions, but on occasion, we delegate all or portions of credentialing to another group or entity. At a minimum, a delegated entity must meet the requirements for credentialing and recredentialing outlined in the full Avēsis credentialing policies and procedures in addition to the relevant requirements of NCQA and our health plan partners. Avēsis retains the right to deny or terminate network participation to any provider covered by a delegated credentialing arrangement.

Before accepting a group for delegated credentialing, we perform a predelegation review to ensure that group complies with Avēsis credentialing criteria. The review includes:

- A complete Delegated Credentialing Intake Form
- Verification that the group does not subdelegate any credentialing or recredentialing functions
- Proof that the group's credentialing policies are reviewed annually and updated as necessary
- Proof of the group's NCQA, Utilization Review Accreditation Commission (URAC), or Joint Commission Credentials Verification Organization Accreditation or Certification
- Successful completion of a predelegation audit by Avēsis

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

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

- No federal and state sanctions or exclusions

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

Practice Information in the Avēsis Database

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

Documentation stored on file includes:

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

Changing Practice Information

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

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

Each change in participation status must be reported to the Avēsis Provider Network Department at least 30 business days before the

Practice Update Form

To download a copy of the Practice Update form:

- Log into the secure provider portal at www.avesis.com.
- Select the **Knowledge Center** box from the Home screen or the Knowledge Center tab found in the blue navigation bar.
- Select **Forms**.
- Search for the Practice Update form from the list.

effective date of the change. Avēsis will accept a signed letter on office letterhead explaining the change in participation or a completed Practice Update form with a corresponding W-9, if applicable.

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

Provider and Practice Support Tools

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

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

Provider Portal

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

- Communicate through alerts/announcements, archived messages and electronic mail
- Search member eligibility
- Submit, modify and void claims electronically
- Search remittance advice and explanation of benefits information
- Browse our comprehensive knowledge center
- Access all documents associated with Avēsis business

Forms available through the portal include:

- Locum Tenens
- EFT
- Avēsis Provider Update Form
- Non-Disclosure Form
- Mastercard Payments Form
- Continuation of Care for Orthodontic Services

- Eligibility Fax

Provider Educational Programming

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

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

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

Learning Through the Avēsis Provider Portal

To access learning resources on the provider portal:

- Log into the secure provider portal at www.avesis.com.
- Select the **Knowledge Center** box from the Home screen from the Knowledge Center tab found in the blue navigation bar.
- From this screen, you have access to various guides, FAQs, regulations, and our video library. Select a dynamic box to access the associated document.

Educational programming may be delivered in myriad ways, including:

- Provider newsletter
- Online education programming through the secure provider portal on the Avēsis website
- Regional provider education meetings, as necessary
- In the office or over the phone

Avēsis Dental Advisory Board

Avēsis welcomes involvement from the dentists who participate in our network. To provide opportunities for feedback from the local dental communities, Avēsis has established Dental Advisory Boards for the states and markets where we arrange for services.

The Dental Advisory Board is composed of volunteer providers from the specific state or market and the State Dental Director and other Avēsis clinical staff. Board responsibilities include:

- Establishing lines of communication between Avēsis and the provider stakeholder communities
- Facilitating access to the local provider network for Avēsis' recruitment staff
- Educating Avēsis on market specific considerations
- Elevating care delivery and/or operating issues that are affecting the local provider community
- Understanding, providing feedback and/or recommending network related policy or procedural changes
- Incorporating Plan feedback into network provider relations.

Avēsis values feedback from local providers in informing the customization of materials and policies to meet the dental and oral health needs of the community. The Board may also be provided copies of provider communications for review and comment prior to distribution to the provider communication at large. Meetings are typically held quarterly but frequency may vary as dictated by the needs of the state/market.

Role of the State Dental Director

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

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

Leaving the Network

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

Voluntary Termination

If you or your office no longer wishes to see our members, you must notify us in writing and agree to comply with the continuity of care policy for the plan for which you provide services. Generally, you may close your practice to our members effective the first of the following month,

provided you gave us written notice at least five business days before the end of the month; otherwise, the policy will become effective the first of the following month.

Involuntary Termination

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

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

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

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

- A provider breaches a material term of his/her agreement or the provider manual, including, without limitation, the representations and warranties or responsibilities defined in these documents and in such a way that the problem cannot be mediated
- The provider poses an imminent danger to Avēsis members or the public health, safety and welfare
- The provider is charged with a felony or a crime of moral turpitude
- The provider is convicted of an offense related to Medicare or Medicaid

- The provider fails to satisfy the credentialing or recredentialing program requirements
- The provider ceases participation in Avēsis network through nonrenewal of the credentialing application or denial of approval for participation

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

Termination Appeals

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

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

Providers terminated for a reason other than a quality issue do not have provider rights. A provider may reapply for inclusion in the network. Providers will only be allowed one reapplication to the network each 12-month period.

Suspension

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

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

Complaints and Appeals

Avēsis has designated personnel who are available to receive phone calls or encrypted emails regarding complaints or appeals. If you make a complaint or appeal, all the specifics surrounding it will be thoroughly investigated and documented. Investigation

Submitting Complaints and Appeals

Make complaints and appeals in writing to:

Avēsis Third Party Administrators, Inc.
Attn: Complaints and Appeals
P.O. Box 38300
Phoenix, AZ 85069-8300

and resolution shall be made using applicable statutory, regulatory and contractual provisions. Often issues can be resolved before it rises to the level of a formal complaint or appeal by working with your provider relations representative to understand the concern. Please feel free to contact your provider relations representative or our provider services team who are standing by to assist you with any questions or concerns you may have. Of course, you may always file a complaint or appeal. Information on that process follows.

Complaints

A provider may file a complaint by calling or writing Avēsis. Should you require assistance, Avēsis' customer service and provider services departments can assist you. The complaint must include the reason for the issue or concern and any supporting documentation. Upon receipt, we will conduct a thorough investigation of the complaint. If needed, we may request additional information from you. Avēsis will then review all documentation and issue a resolution letter.

Appeals

There are two types of appeals providers can file: member and provider. These categorizations apply no matter who files the actual appeal. Providers may file a "member appeal" which is clinical in nature and typically involves the denial of a service for medical necessity reasons. A provider appeal concerns contract issues or claims payment. With either type of appeal, you should submit your appeal in writing and provide supporting documentation.

Member/Clinical Appeal

Avēsis is not delegated to resolve member appeals and grievances. If a member wants to file a grievance or appeal, the member should contact the Member Services number listed on the member ID card. If a member contacts the Avēsis Member Services department, Avēsis will transfer the call to the appropriate department for assistance. While Avēsis is not delegated for this responsibility, we will cooperate with and assist Humana – CareSource in resolving member concerns. All appeal and grievance procedures comply with federal and state regulations and meet appropriate accreditation standards.

Members receive instructions on how to file an appeal or grievance in their plan documents. Members may contact the Member Services number on their ID cards for assistance or access the Humana – CareSource website at www.caresource.com

State Fair Hearing Appeal

A member may ask for a State Fair Hearing Appeal. A member requests this appeal by sending a letter to the Department for Medicaid Services within 30 days of the date of the notice by referencing the denial of the external independent third-party review. A decision of the administrative hearing tribunal shall be final for purposes of judicial appeal. Kentucky Regulation SB 20, Chapter 205:

"Not withstanding any law to the contrary, a provider who has exhausted the written internal appeals process of a Medicaid managed care organization shall be entitled to an external independent third party review on the Medicaid managed care organization's final decision that denies, in whole or in part, a healthcare service to an enrollee or a claim for reimbursement to a provider for a healthcare service rendered by the provider to an enrollee of the Medicaid managed care organization. Multiple claims may be determined in one (1) action upon request of a party in accordance with administrative regulations promulgated by the department.

- A Medicaid managed care organization's letter to a provider reflecting the final decision of the provider's internal appeal shall include:
    - A statement that the provider's internal appeal rights within the Medicaid managed care organization have been exhausted;
    - A statement that the provider is entitled to an external independent third-party review; and
    - The time period and address to request an external independent third-party review.
- A party shall be entitled to appeal a final decision of the external independent third-party review to the administrative hearing tribunal within the Cabinet for Health and Family Services for an administrative hearing to be held in accordance with KRS Chapter 13B. An appeal shall be filed within thirty (30) days from the appealing party's receipt of the final decision of the external independent third-party review. A decision of the administrative hearing tribunal shall be final for purposes of judicial appeal.
- Within one-hundred twenty (120) days after the effective date of this Act, the department shall promulgate administrative regulations to implement the external independent third-party review as required by this section.
- The department shall promulgate administrative regulations to establish reasonable fees, not to exceed one-thousand dollars ($1,000), to defray expenses associated with an administrative hearing that shall be paid by the party who does not prevail in the administrative hearing.
- This section shall apply to all contracts or master agreements between Medicaid managed care organizations and the Commonwealth of Kentucky entered into or renewed on or after July 1, 2016."

If the member is seeking an appeal and wants to continue services, he or she must file the appeal to the Department for Medicaid Services within 10 days of the date of the notice.

If a provider believes the usual time frames for deciding a grievance will harm the member's health, the provider or member can call the Kentucky Department for Medicaid Services at (800) 365-2570 to request an expedited state fair hearing. Providers must send a fax to (502) 564-6917 with an explanation of medical necessity for timeliness.

The State Fair Hearing Appeal should be sent to:

Kentucky Department for Medicaid Services
Division of Administration and Financial Management
275 E. Main Street, 6C-C
Frankfort, KY 40621
(800) 635-2579
TTY: (800) 627-4702

Provider Appeal

Upon receipt, we will conduct a thorough investigation of the provider appeal. We will review all information related to your appeal including documentation you submit. If needed, we may request additional information from you. Avēsis will then review all documentation and issue a resolution letter to you.

If we agree with your position, we will either reverse the denied claim or correct the identified issue. We will notify you of the decision and the correction in writing.

If we uphold our initial decision, we will notify you in writing. There are no further appeal levels. However, you may pursue further review by following the dispute resolution process outlined in your provider agreement.

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

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

Provider Approvals for Nonemergency Situations

Nonemergency treatment begun prior to the granting of authorization will be performed at the financial risk of the dental office. If authorization is denied, the dental office or treating provider may not bill the member, the sponsor or Avēsis.

You will receive an authorization number within two business days of receipt of the request, if the services are approved. Should the Avēsis Kentucky State Dental Director determine that the service is not necessary, you will be notified within two business days of receipt of all required

information. If additional documentation is required to decide, you will be notified within two business days. If we do not receive the additional information within 14 days, the decision to approve or deny the service will be made based on the available information. Authorization determinations will be communicated in writing within two business days of the initial communication. Once the determination has been communicated to you, you are responsible for advising the member of the review decision.

Provider Appeal Process for Denial of Claim(s)

Administrative Appeals

Administrative appeals are those involving adverse determinations for reasons other than medical necessity (e.g., timeliness of filing, no prior authorizations, etc.).

1. Submit your written request for the claim to be reviewed, including the justification for the service, within 30 days of receipt of the adverse determination.
2. The Claims Manager will review the appeal within 30 calendar days of receipt. If, based upon the information provided, it is determined that the claim should be paid, the initial determination will be reversed and the claim will be paid within 15 business days.
3. If the Claims Manager determines that the claim should not be reimbursed, the provider will be notified of the decision and advised that administrative appeals are only reviewed one at a time.

Medically Necessary Appeals

Medically necessary appeals are those involving adverse determinations due to an absence of medical necessity.

1. Submit a written notice of appeal to Avēsis within 30 days of receipt of the adverse determination. The appeal should include documentation not previously provided in support of the appeal.
2. The Avēsis Kentucky State Dental Director will review the appeal and, if necessary, speak directly with the provider, unless he made the initial determination, in which case the appeal will be reviewed by a member of the Avēsis Dental Advisory Board instead.
3. A decision to either support or reverse the initial determination will be made within 30 days of receipt of the appeal. If the adverse determination is upheld, the provider will be notified in writing within 10 business days. If the initial determination is reversed, the claim will be processed and paid within 15 business days.

External Independent Third-party Review

According to the Humana – CareSource 2017 Provider Manual:

Humana – CareSource will comply with all rights and requirements conferred to health partners, pursuant to 907 KAR 17:035.

a. Once a healthcare provider has exhausted all internal appeal rights, the provider can request an external independent review. A provider cannot request an external independent review if the member has exercised his/her right for a state hearing.

b. The healthcare provider must submit a request for external independent review within 63 calendar days of receiving final decision on their internal appeal.

c. After Humana – CareSource receives a request from a healthcare provider for external independent review, Humana – CareSource will send the provider an acknowledgement letter within five business days. Humana – CareSource also will send an acknowledgement letter to the member if the request involves an authorization denial.

d. Humana – CareSource will submit all related documentation to the external review entity within 15 business days of receiving the request.

e. The external independent review entity will issue a final decision with 30 calendar days of receiving the review packet from Humana – CareSource.

f. Humana – CareSource and the healthcare provider both have the right to appeal the decision of the external independent review entity to a state hearing proceeding. The request for a state hearing must be sent to the state within 30 calendar days of the external independent review entity's decision.

Clinical Criteria – Kentucky

Documentation requests for information regarding treatment are evaluated using codes as defined in the American Dental Association's (ADA) code manuals. Determinations are reached using generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans or descriptive narratives. In some instances, the state legislature or other state or federal agencies will define the requirements for dental procedures and medical necessity.

These criteria and policies are designed as guidelines for dental service authorization and payment decisions and are not intended to be all-inclusive or absolute. Additional narrative information is appreciated for special situations. We recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria

Sources for Information about Evidence-based Dentistry

ADA: http://www.ada.org/en

AAOMS: http://www.aaoms.org/

AAP: https://www.perio.org/

AAO: https://www.aaoinfo.org/

AADC: https://www.aadc.org/

that will be consistent with both the concept of local community standards and the current ADA concept of evidence-based dentistry.

These are generalized criteria. Services described may not be covered in each particular dental program. In addition, there may be additional program specific criteria regarding authorization for specific services. Therefore, it is essential you review the Benefits Covered section before providing any treatment.

Periodicity Schedules

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

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

The periodicity schedule for your state can be found at http://www.aapd.org/media/Policies_Guidelines/G_DentalPeriodicitySchedule.pdf.

General Criteria for Diagnostic Services

The codes in this section recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of some data and components of the dental examination may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Additional diagnostic and/or definitive procedures are to be reported separately.

General Criteria for Diagnostic Imaging

- Diagnostic images should be taken only for clinical reasons as determined by the patient's dentist.
- Images should be of diagnostic quality and properly identified and dated.
- All original images are a part of the patient's clinical record and should be retained by the dentist.

- Originals should not be used to fulfill requests made by patients or third parties for copies of records.

Kentucky Criteria for Diagnostic Imaging

Prior authorization for children under the age of six is not required for oral surgeons for a panoramic radiograph (D0330).

General Criteria for Preventive

- Prescription-strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste. (CDT codes D1206 and D1208)
- Space Maintainers (passive appliances) are designed to prevent tooth movement. (CDT codes D1510 – D1575)

Kentucky Criteria for D1351 and D1354

- D1351 sealant – per tooth
  Sealants, code D1351 (per the KAR) can only be applied to an occlusal surface that is noncavitated. A sealant shall not be covered in conjunction with a restorative procedure for the same tooth on the same surface on the same date of service. Current AAPD/ADA guidelines recommend and allow placement of sealants over incipient, noncavitated caries. (https://www.ada.org/en/member-center/oral-health-topics/dental-sealants)

- D1354 interim caries arresting medicament application – per tooth

  This code became effective as of Jan. 1, 2017 and the criteria below becomes effective 90 days from the date of the notice. This code is applicable for all ages and for both primary and permanent dentition. Prior authorization is not required; however, retained documentation is twofold and must be stored in the member's chart (or scanned into digital records).

  A. First, office staff and parent/guardian must sign and date the Avēsis Silver Diamine Consent form or sign and date the chart with an acknowledgement that the Avēsis Silver Diamine Consent form was reviewed and treatment approved. This form is available at www.avesis.com.

  B. Secondly, an age-appropriate ADA Caries Risk Assessment form must be completed. This form is also available at www.avesis.com. It is not reimbursable. The tooth number(s) **and** quadrant(s) must be included on claims.
  C. Lastly, the benefit and limitations are stated below:
     1. One application per six months per quadrant, per dentist or dental group.
     2. Limited to a total of four applications per lifetime per quadrant.

3. High-caries risk patients only (D0603) must be submitted on the same claim as the silver diamine fluoride (SDF) treatment thus attesting the patient's ADA CAMBRA score is "high caries risk."
4. No age restriction.
5. No extraction or restoration of a treated tooth within 90 days, except for special circumstances. If a patient returns sooner with pain, the dentist may do extraction, pulpotomy, endodontics, apexification and/or restorations to address pain. This will require a pre-authorization (online turnaround time is approximately 48 hours) and a narrative requesting exception and review by a dental consultant. For emergency pain or infection, provider may render treatment and submit claim and narrative for post-treatment review. The above exception is not applicable for cosmetic reasons.
6. At least one tooth in quadrant with decay into dentin.
7. Should not be applied to exposed pulps.
8. Fluoride (D1206 or D1208) cannot be billed on the same date of service as D1354.

General Criteria for Restorative Procedures

- Restorative services shall be a benefit when medically necessary, when carious activity or fractures have extended through the dentinoenamel junction (DEJ) and when the tooth demonstrates a reasonable longevity.
- All surfaces on a single tooth restored with the same restorative material shall be considered connected, for payment purposes, if performed on the same date of service.
- Payment is made for a tooth surface only once for the same date of service regardless of the number or combination of restorative materials placed on that surface.
- Tooth and soft tissue preparation, anesthesia, crown lengthening, cement bases, direct and indirect pulp capping, bonding agents, occlusal adjustments, polishing, local anesthesia and any other associated procedures are included in the fee for a completed restorative service.

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

General Criteria for Crowns and Onlays

- In general, criteria for crowns and onlays will be met only for permanent teeth or primary teeth where no permanent successor is present needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and that destruction should involve four or more surfaces and two or more cusps.

- Permanent bicuspid (premolar) teeth must have pathologic destruction to the tooth by caries or trauma, and that destruction should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and that destruction must involve four or more surfaces and at least 50 percent of the incisal edge.
- Teeth with existing crowns/onlays with new qualifying pathology (i.e., decay, fractured off-tooth structure or significant fracture of existing restorative material).

A request for a crown following endodontic therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- The endodontic treatment of the tooth should show a fill sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The endodontic fill must be properly condensed or obturated.
- Endodontic filling material must not extend excessively beyond the apex.
- The crown must be opposed by a tooth or denture in the opposite arch or is an abutment for a partial denture.
- The tooth should demonstrate no probing more than 5 mm and have adequate supporting bone.
- The patient must be free from active and advanced periodontal disease.

Authorizations for crowns or onlays will **not** meet criteria if:

- A lesser means of restoration is possible
- Tooth has subosseous and/or furcation caries

General Criteria to Allow Core Buildups

- Buildups are a covered benefit when 50 percent or more of the natural coronal structure of the tooth is destroyed by decay or is missing due to fracture – which means that more than 180 degrees of the tooth structure is missing circumferentially down to or closer than 2 mm from the gum tissue (less than 2 mm of vertical height remaining for two cusps on a molar and one cusp for a premolar).
- For anterior teeth, this means that more than half of the mesial/distal width of the incisal edge is missing down past the junction of the incisal third and middle third of the tooth.
- All buildups are subject to review.
- Buildups are covered on endodontically treated anterior teeth only if the above criteria are met.
- Buildups are routinely covered on posterior endodontically treated teeth.
- If replacing an existing crown or onlay with another crown, a buildup is an additional benefit only if new pathology compromises the existing substructure necessitating

placement of a new substructure/core and meets the above buildup criteria. Buildup is not an additional benefit with placement of an onlay.

General Criteria to Allow Post and Core

- Limited to permanent teeth.
- The tooth must be endodontically treated.
- The endodontically treated tooth must show adequate root canal fill without excessive over fill.
- The tooth must present with a minimum of 50 percent bone support.
- The tooth must be sufficiently broken down where a more conservative base or buildup would be contraindicated.
- The risk of root fracture or splitting the root by placing a post is minimal.

General Criteria to Allow Endodontics

Requests for services must meet the following basic criteria:
Endodontic therapy on permanent teeth D3310 – D3330, D3346 – D3348

- Allowed services for teeth 2 – 15, 18 – 31.
- All canals must be instrumented, cleaned, and sealed within 3mm of the radiographic apex.
- Tooth must present with endodontic pathology, symptoms.
- Tooth must be restorable.
- Tooth must present with at least 50 percent bone support.
- Patient must be free of periodontal disease.
- Tooth must be damaged as a result of trauma or carious exposure.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Endodontic therapy will **not** meet criteria if:

- The endodontic treatment is for aesthetic reasons
- Gross periapical or periodontal pathosis is demonstrated radiographically
- Caries is demonstrated radiographically to be present along the crestal bone or into the furcation, deeming the tooth non-restorable
- The generally poor oral condition does not justify root canal therapy.
- Endodontic therapy is not payable for third molars, unless they are an abutment for a partial denture.
- The tooth has advanced periodontal disease and/or pocket depths greater than 5mm
- Endodontic therapy is in anticipation of placement of an overdenture.
- An endodontic filling material not accepted by the Federal Food and Drug Administration is used.

Criteria for Periodontal Treatment

Gingivectomy or gingivoplasty

Criteria for approval of gingivectomy or gingivoplasty include evidence of one or more of the following per the Kentucky Administrative Regulation (KAR):

(a) A recipient with gingival overgrowth due to a:

1. Congenital condition
2. Hereditary condition, or
3. Drug-induced condition, and

(b) 1 per tooth per quadrant, per provider, per recipient per 12-month period.

1. Coverage of a quadrant procedure shall require a minimum of 4 teeth within the same quadrant.
2. Coverage of per-tooth procedure shall be limited to no more than 3 teeth within the same quadrant.
3. Coverage of a gingivectomy or gingivoplasty procedure shall require documentation in the recipient's medical record that includes:
   a. Pocket-depth measurements;
   b. A history of nonsurgical services; and
   c. A prognosis.

Periodontal scaling and root planing

Criteria for approval of periodontal scaling and root planing should include evidence of one or more of the following:

- Radiographically demonstrated evidence of bone loss greater than 2mm beyond the CEJ.
- 5 mm pocket depths on at least four or more teeth in each quadrant with periodontal charting no more than a year old.

Full mouth debridement

Criteria for approval of full mouth debridement include evidence of one or more of the following per the KAR:

- (6)(a) A full mouth debridement shall only be covered for a pregnant woman.
- (b) More than one full mouth debridement per pregnancy shall not be covered.

Periodontal maintenance procedures

Criteria for approval of periodontal maintenance include evidence of one or more of the following:

- Documentation of previous periodontal treatment dates
- Continuous documentation of significant hard and soft tissue changes

General Criteria for Prosthodontics (Removable)

- Local anesthesia is usually considered to be part of fixed prosthodontic procedures.
- Provisional prosthesis designed for a limited period of time, after which is to be replaced by a more definitive restoration.

Kentucky Criteria for Prosthodontics (removable and maxillofacial prosthetics)

- Date of delivery is the date of service.
- Denture adjustments, repairs and relines are not payable within six months of initial delivery.
- CDT codes D5820 interim partial denture (maxillary) and D5821 interim partial denture (mandibular) are only payable if used during the transition from primary to permanent dentition, for space management or for interceptive orthodontics.
- Payable maxillofacial prosthetics in Kentucky require prior authorization with a narrative detailing medical necessity.

General Criteria for Implant Services

- Local anesthesia is usually considered to be part of implant services.
- A thorough history and clinical examination leading to the evaluation of the patient's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan.
- A conservative treatment plan should be considered prior to providing a patient with one or more implants. Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:
    - Adverse systemic factors such as diabetes and history of recent smoking habit
    - Poor oral hygiene and tissue management by the patient
    - Inadequate osseo-integration of the dental implant(s) (mobility)
    - Excessive parafunction or occlusal loading
    - Poor positioning of the dental implant(s)
    - Excessive loss of bone around the implant prior to its restoration
    - Mobility of the implant(s) prior to placement of the prosthesis
    - Inadequate number of implants or poor bone quality for long-span prostheses
    - Need to restore the appearance of gingival tissues in high-esthetic areas
    - When the patient is younger than 16, unless unusual conditions prevail

Restoration

- The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate codes and guidelines.
- Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system, to the bone or affect the integrity of the implant system itself.

- Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.
- Jaw relationship and intra arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

General Criteria for Prosthodontics, Fixed

- Each retainer and each pontic constitutes a unit in a fixed partial denture.
- Local anesthesia is usually considered to be part of fixed prosthodontic procedures.
- The term fixed partial denture (FPD) is synonymous with fixed bridge or bridgework.
- Fixed partial denture prosthetic procedures include routine temporary prosthetics. When indicated, interim or provisional codes should be reported separately.
- Dentures that are lost, stolen or broken are not sufficient justification for replacement. The fees for cast restorations and prosthetic procedures by the same dentist/dental office are DISALLOWED.
- Dentures must be made in a traditional laboratory.
- Any characterization, staining, overdentures or metal bases are specialized techniques or procedures and an allowance will be made for conventional dentures. Any additional fee is the patient's responsibility.

General Criteria for Oral and Maxillofacial Surgery

General Criteria for Dental Extractions

- Tooth is non-restorable due to caries or the extent of fractured off tooth structure
- Pulpal and/or periapical pathology
- Pathological cyst formation
- Second or subsequent episodes of pericoronitis (unless the first episode is particularly severe) that cannot be resolved through the use of antibiotics, irrigations or other topical treatment
- Osteomyelitis
- Cellulitis
- Tumor removal that also requires removal of tooth for access
- Tooth is positioned ectopically and prevents the eruption of an adjacent tooth
- Internal/external resorption of a tooth or adjacent tooth
- Tooth in aberrant position causing bone loss on adjacent tooth/teeth
- Tooth/teeth impeding orthognathic surgery, reconstructive surgery, trauma surgery or other jaw surgery

Qualifying conditions specifically for removal of third molars only:

- Bone loss or caries in the adjacent second molar that cannot satisfactorily be treated without the removal of the third molar

- Periodontal disease in a second molar that was caused or exacerbated by the position of the adjacent third molar and cannot be managed without extraction of the third molar

General Criteria to Allow Surgical Extractions

- D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated; includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.
- D7220 Removal of impacted tooth soft tissue should be used when the tooth is not erupted to the occlusal plane and has soft tissue covering the occlusal surface of the tooth; requires mucoperiosteal flap elevation
- D7230 Removal of impacted tooth partially bony should be used when part of the crown is covered by bone above the height of contour and the tooth is clearly below the occlusal plane; requires mucoperiosteal flap elevation and bone removal.
- D7240 Removal of impacted tooth completely bony should be used when most or all of the crown is covered by bone above the height of contour and the tooth is clearly below the occlusal plane; requires mucoperiosteal flap elevation and bone removal.
- D7241 Removal of impacted tooth completely bony, with unusual surgical complications should be used when the tooth meets all of the criteria for D7240 and is unusually difficult or complicated due to factors such as the examples below, and requires a current preoperative diagnostic radiograph and, in some cases, the operation notes.
- The patient has an extensively compromised medical condition; meets ASA III criteria.
- The tooth is ankylosed.
- Nerve dissection is required.
- Separate closure of maxillary sinus is required.
- The tooth is in a significantly aberrant position.
- Horizontal impaction facing buccal/lingual (more than 45° from the arch form).
- More than one fourth of the roots and/or the crown of the tooth below the inferior alveolar nerve.
- Distoangular impaction with dilacerated roots curving distally.
- Vertical impaction with the occlusal surface of the tooth at the level of the apical one-third or higher of the adjacent tooth.

General Criteria Orthodontia

Primary dentition: Teeth developed and erupted first in order of time.

Transitional dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

All orthodontic treatment codes may be used more than once for the treatment of a patient depending on the circumstance. A patient may require more than one interceptive procedure or more than one limited procedure depending on their problem.

Kentucky Criteria for Orthodontic Treatment

KY Medicaid Members (aged 20 and younger) and KY CHIP Members (aged 18 and younger)

- Medicaid members (aged 20 and younger) and CHIP Members (aged 18 and younger) may qualify for orthodontic care under the program. Members must have a severe, dysfunctional, handicapping malocclusion.
- Minor tooth guidance, if a covered benefit, will be authorized on a selective basis to help prevent the future necessity for full-banded treatment. All appliance adjustments are incidental and included in the allowance for the tooth guidance appliance. Except for situations involving gingival stripping or other nonreversible damage, appliances for minor tooth guidance (D8010 through D8030) will be approved when they are the only treatment necessary. If treatment is not definitive, the movement will only be covered as part of a comprehensive orthodontic treatment plan.
- All orthodontic services require preauthorization. The member should present with either transitional or permanent dentition.
- Required documentation that must be submitted with a preauthorization of services per the KAR for D8060 or D8080 include:
    1. A MAP 396 (Kentucky Medicaid Program Orthodontic Evaluation form or equivalent)
    2. Panoramic film or intraoral complete series
    3. Images of properly trimmed and occluded orthodontic models or digital equivalent (such as OrthoCAD) – model views shall include:
        a. anterior view with teeth in occlusion;
        b. right and left lateral views with teeth in occlusion;
        c. maxillary and mandibular occlusal views;
        d. lingual view with teeth in occlusion showing the incisal edge of the mandibular incisors;
    4. Cephalometric radiograph with tracing
    5. Intraoral photographic images – views shall include
        a. anterior view with teeth in occlusion
        b. right and left lateral views with teeth in occlusion
        c. maxillary and mandibular occlusal views
    6. Extraoral photographic images – views shall include
        a. full face relaxed
        b. full face smiling
        c. profile relaxed

7. Avēsis Orthodontic Criteria Index Form

- Treatment should not begin prior to receiving notification from Avēsis indicating coverage or noncoverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the member or face possible termination of their provider agreement. Providers cannot bill prior to services being performed.
- If the case is denied, the prior authorization will be returned to the provider indicating that Avēsis will not cover the orthodontic treatment. However, an authorization will be issued for the payment of the pre-orthodontic visit (D8680), which includes treatment plan, radiographic, and/or photos, records and diagnostic models, for full-treatment cases only (D8060 or D8080), at the provider's contracted rate. This payment will be automatically generated for any case denied for full treatment.
- Note: the following codes are not payable to orthodontic providers for orthodontic treatment or diagnostic purposes: Examination codes D0120 – D0191 and radiographic codes D0210 – D0340 as these are considered inclusive in either "orthodontic records" as outlined above or included in active orthodontic treatment (including progress records) once a case is started.
- Kentucky Medicaid orthodontic treatment administered by Avēsis is paid in three separate payments:
    - Initial banding/bonding billed as CDT code D8080
    - Six-month payment billed as CDT code D8660. Member must have been in active treatment at least six months before submission for the second payment **AND** must have been seen for adjustment and observation at least three visits. A copy of member's chart notes showing at least three visits must be included with the submission.
    - Debanding/debonding and retention billed as CDT code D8999 which includes final records. Submission must include a copy of final records consisting, at a minimum, complete intraoral diagnostic images (photographs) or digital models or images of properly trimmed and occluded orthodontic models showing appropriate orthodontic relationships, such as Angle relationship, crowding, open or closed bite, etc.
- Avēsis does not pay for a lost or stolen retainer as a replacement unless Avēsis has previously paid CDT code D8999 for debanding/debonding and retention.

Billing for Orthodontic Treatment

The start and billing date of orthodontic services is defined as the date when the bands, brackets or appliances are placed in the member's mouth. The member must be eligible on this date of service.

If a member becomes ineligible during treatment and before full payment is made, it is the member's responsibility to pay the balance for any remaining treatment. You must notify the member of this requirement prior to beginning treatment.

To guarantee proper and prompt payment of orthodontic cases, please electronically file or mail a copy of the completed ADA form with the banding date filled in.

Once Avēsis receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit claims for periodic treatment visits (code D8670). The member must be eligible on the date of the visit.

Initial payments for orthodontics (code D8080) include pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, one set of retainers and 12 months of retainer adjustments (if retainer fees are not separate).

The maximum case payment for orthodontic treatment will be one initial payment (D8080) and seven quarterly payments thereafter, covering 23 periodic orthodontic treatment visits (D8670). Additional periodic orthodontic treatment visits beyond 23 will be your financial responsibility and not the member's.

Members may not be billed for broken, repaired or replacement of brackets or wires.

Payment of records for cases that are denied will be made automatically. There is no need to submit for the records payment (code D8660).

Payment of records/exams (code D8660) will NOT be paid prior to the case being reviewed by the consultant. Please do not submit separate claims for these procedures.

Please notify Avēsis should the member discontinue treatment for any reason.

Continuation of Orthodontic Treatment

Avēsis requires the following information for possible payment of continuation of care cases:

- The original banding date
- A detailed paid-to-date history, showing dollar amounts for initial banding and periodic orthodontic treatment fees.
- A copy of member's prior approval, including the total approved case fee, banding fee and periodic orthodontic treatment fees
- Photographs of the ORIGINAL diagnostic models (or OrthoCAD), or radiographs (optional), banding date, and a detailed payment history if the member started treatment under commercial insurance or fee-for-service

It is your responsibility, with the member, to get this required information. Cases cannot be set up for possible payment without complete information.

Cleft Palate Services

The Commission for Children with Special Health Care Needs (CCSHCN) will evaluate these members for orthodontic needs. The CCSHCN will generate an approval letter that must be submitted with the preauthorization in addition to the required diagnostic records.

Adjunctive General Services

Anesthesia

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthesia effects upon the central nervous system and not dependent upon the route of administration.

Avēsis Kentucky Anesthesia Guidelines

D9223 and D9243

Both D9223 and D9243 do not require prior authorization or post review from oral surgeons.

Both D9223 and D9243 require prior authorization and post review from all nonoral surgeons are required to submit a narrative detailing medical necessity. All nonoral surgeons are required to submit the anesthesia record for post review.

Medical necessity must be demonstrated based on the needs of the individual with respect to the provision of dental services provided under general anesthesia/deep sedation or intravenous sedation (see definitions from Kentucky 907 KAR 3:130 and CMS on Page 85 below).

1. Prior authorization required for nonspecialists.
2. What constitutes acceptable documentation for the condition of the beneficiary or the nature of the oral surgery to justify anesthesia/sedation?
    a. Child is than 7 years and more than one simple extraction or surgical extraction is performed (excluding D7111) (note: NO2 and/or oral sedation **do not** require prior authorization for children aged 9 and under)
        i. Required documentation: either a signed health history (signed by parent or guardian) with medication list or a signed physician statement to document medical necessity.

b. Beneficiary has documented medical conditions that preclude the use of local anesthesia, NO2 and/or oral sedation.
c. Severe infection at the injection site such as a quick spreading, life-threatening infection.
d. Beneficiaries with special needs, including intellectual disability, other mental health or physical conditions and who are unmanageable using local anesthesia, NO2 and/or oral sedation.
e. Multiple extractions in more than one quadrant (excluding D7111).
f. If the treatment is simple or surgical extractions (including impactions), tori removal or alveoloplasty (note: it is expected all surgical, restorative and periodontal treatment will be completed at one IV sedation visit whenever possible)
    i. two or more quadrants must require at least two teeth extracted per quadrant or
    ii. three or more quadrants must require at least one tooth extracted per quadrant, or
    iii. at least two impacted teeth or
    iv. at least two mandibular quadrants or one maxillary arch of tori removal or
    v. at least two quadrants of alveoloplasty or
    vi. hard tissue biopsy

3. What constitutes acceptable documentation to justify medical necessity?
    a. Chart notes documenting severe infection at the injection site.
    b. Severe cerebral palsy or other special-needs condition, physical or mental, resulting in the member being unmanageable for either surgical or restorative care.
    c. Documented failed attempt using local anesthesia, NO2 and/or oral sedation.
    d. Child referred to pediatric dentist because of behavior.
4. Examples of unacceptable documentation:
    a. Beneficiary unable to tolerate the procedure (must be specific)
    b. Beneficiary prefers or requests IV sedation or general anesthesia
    c. Beneficiary wants to be asleep
    d. Additional invoicing requirements
    e. Dental practitioners who routinely administer and bill managed care organizations (MCOs) for anesthesia/sedation when performing outpatient surgical procedures or tooth extractions regardless of medical necessity
5. Provider must bill for the surgery/surgical extractions/other care and the anesthesia/sedation on the same invoice
6. Any substantiating documentation to justify payment for the anesthesia must be included in the remarks section of the claim form or submitted as a separate narrative document

Note: a definitive diagnosis and secondary diagnosis along with documentation of the statements under the remarks section must be substantiated in the beneficiary's medical record. These claims are subject to review for medical necessity.

What is the definition for "Medically Necessary" in Kentucky Medicaid?

907 KAR 3:130. Medical necessity and clinically appropriate determination basis.

Section 2. Medical Necessity Determination. (1) The determination of whether a covered benefit or service is medically necessary shall:

Be based on an individualized assessment of the recipient's medical needs; and

Comply with the requirements established in this paragraph. To be medically necessary or a medical necessity, a covered benefit shall be:

Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;

Appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice;

Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the healthcare provider, or for cosmetic reasons;

Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;

Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard;

Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 1396d(r) and 42 C.F.R. Part 441 Subpart B for individuals under twenty-one (21) years of age; and

Provided in accordance with 42 C.F.R. 440.230.

(2) The department shall have the final authority to determine the medical necessity and clinical appropriateness of a covered benefit or service and shall ensure the right of a recipient to appeal a negative action in accordance with 907 KAR 1:563.

Section 3. Criteria to Establish Clinical Appropriateness. (1) The department shall utilize criteria to determine if a given Medicaid service or benefit is clinically appropriate.

(2) The criteria referenced in subsection (1) of this section shall be the nationally-recognized clinical criteria that meets the definition established in Section 1(1) of this administrative regulation.

Section 4. Medical Director Role in Service Denials. (1) If a request for a service is denied for failing to meet medical necessity or clinical appropriateness criteria, the department's medical director shall have the authority to reverse or approve the denial.

(2) The letter of denial shall include the specific clinical reason that the service was denied including any appropriate InterQual or other criteria. (27 Ky.R. 1713; eff. 2-1-2001; 33 Ky.R. 626; 1412; 1590; eff. 1-5-2007; TAm 1-13-2014.)

For children under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), the Centers for Medicare & Medicaid Services (CMS) defines medical necessity as follows:

"Services that fit within the scope of coverage under EPSDT must be provided to a child only if necessary to correct or ameliorate the individual child's physical or mental condition, i.e., only if 'medically necessary.' The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child … [and] all aspects of [the] child's needs, including nutritional, social development, and mental health and substance use disorders."

Additional EPSDT guidelines issued by the Kentucky Department of Medicaid Services:

Services provided to Kentucky Medicaid members under the traditional Dental or EPSDT Special Services Dental programs must be medically necessary and clinically appropriate as outlined below in the excerpt from provider letter A-04, dated Feb. 25, 2008. "Medically necessary" or "medical necessity" within the dental program means that the dental care and services furnished must:

1. Be necessary to protect, maintain or restore function (speech and mastication), appearance, growth and development of the oral-facial structures or to alleviate pain, infection, disfigurement and dysfunction.
2. Be individualized, specific and consistent with the need and the symptoms, or confirmed diagnosis of the condition or injury under treatment and not in excess of the member's needs.
3. Be consistent with generally accepted professional dental standards.
4. Be reflective of the level of service that can be safely furnished and for which no equally effective or more conservative or less costly treatment is available.
5. Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or for the convenience of the provider.

Kentucky Guidelines for EPSDT KAR 11.034

Section 5. Periodicity Schedule. The periodicity schedule, which is established in the manual incorporated by reference in this administrative regulation, shall define the age appropriate services and time frames for screenings. The periodicity schedule shall be recommended by the Department for Public Health and approved by the Department for Medicaid Services. An additional medical or dental assessment shall be provided if medically indicated. The periodicity schedule is incorporated by reference in the "Early and Periodic Screening, Diagnosis, and Treatment Services Manual."

Section 6. Diagnosis and Treatment. If referral for additional service is indicated, further diagnosis and medical treatment services shall be covered if the service or diagnosis:

(1) Is otherwise covered by the Medicaid program; or

(2)(a) Is not otherwise covered by the Medicaid program; and

(b) Meets the requirements for EPSDT special services as provided for in Section 7 of this administrative regulation.

Section 7. EPSDT Special Services. EPSDT special services shall include other healthcare, diagnostic services, preventive services, rehabilitative services, treatment, or other measures described in 42 U.S.C. 1396d(a), that are not otherwise covered under the Kentucky Medicaid Program and that are medically necessary, as defined in Section 9 of this administrative regulation, to correct or ameliorate a defect, physical or mental illness, or condition of a recipient.

Section 8. EPSDT Diagnostic and Treatment Provider and EPSDT Special Services Provider Participation Requirements. (1) An EPSDT diagnostic or treatment provider shall meet the requirements for participation in the Kentucky Medicaid Program as specified in Title 907 KAR for the particular diagnostic or treatment service rendered.

(2) Except as otherwise specified in Title 907 KAR, a provider seeking to provide an EPSDT special service, as established in Section 7 of this administrative regulation, shall first contact the department in writing or by telephone to apply for enrollment to become an EPSDT special services provider. In order to be enrolled, the provider shall supply documentation or other evidence which establishes that all of the following conditions are met:

(a) The provider shall:

1. Be licensed, certified or authorized by state law to provide the service; and

2. Not be suspended or otherwise disqualified.

(b) If the provider is out of state, the provider shall meet comparable requirements in the state in which he/she does business.

Section 9. Prior Authorization for EPSDT Diagnosis and Treatment Services and EPSDT Special Services. Except as otherwise provided for in this section or in 907 KAR Chapter 1 or 3, an EPSDT diagnosis or treatment service or an EPSDT special service which is not otherwise covered by the Kentucky Medicaid Program shall be covered subject to prior authorization if the requirements of subsections (1) and (2) of this section are met. The department shall review a request for a service to determine medical necessity without regard to whether the screen was performed by a Kentucky Medicaid provider or a non-Medicaid provider.

(1) A request for prior authorization for an EPSDT service established in Section 6(1) or 6(2) of this administrative regulation shall state that the request is for an EPSDT service, and shall be accompanied by the following information:

(a) The primary diagnosis and significant associated diagnoses;

(b) Prognosis;

(c) Date of onset of the illness or condition, and etiology if known;

(d) Clinical significance or functional impairment caused by the illness or condition;

(e) Specific types of services to be rendered by each discipline with physician's prescription if applicable;

(f) Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals if applicable;

(g) The extent to which healthcare services have been previously provided to address the defect, illness, or condition, and results demonstrated by prior care if applicable; and

(h) Other documentation necessary to justify the medical necessity of the requested service.

(2) Except as otherwise provided for in 907 KAR Chapter 1 or 3, a request for approval of a service shall meet the standard of medical necessity for EPSDT if the following applicable criteria are met:

(a) The service shall be to correct or ameliorate a defect, physical or mental illness, or condition;

(b) The service to be provided shall be medical or remedial in nature;

(c) The service shall be individualized and consistent with the recipient's medical needs;

(d) The service shall not be requested primarily for the convenience of the beneficiary, family, physician or another provider of services;

(e) The service shall not be unsafe or experimental;

(f) If an alternative medically accepted mode of treatment exists, the service shall be the most cost-effective and appropriate service for the child;

(g) A request for a diagnosis or treatment service in a community-based setting:

1. May not be approved if the costs would exceed those of equivalent services at the appropriate institutional level of care; and

2. Shall be individually assessed for appropriateness in keeping with the standards of medical necessity and the best interest of the child.

(h) The service to be provided shall be:

1. Generally recognized by the appropriate medical professionals as an accepted modality of medical practice or treatment;

2. Within the authorized scope of practice of the provider; and

3. An appropriate mode of treatment for the medical condition of the recipient.

(i) Scientific evidence, if available, shall be submitted consisting of:

1. Well-designed and well-conducted investigations published in peer-review journals, demonstrating that the service is intended to produce measurable physiological outcomes;

2. In the case of psychological or psychiatric services, measurable psychological outcomes, concerning the short- and long-term effects of the proposed service on health outcomes;

3. Opinions and evaluations published by national medical organizations, consensus panels and other technology evaluation bodies supporting provision of the benefit, shall also be considered if available.

(j) The predicted beneficial outcome of the service shall outweigh potential harmful effects;

(k) The services improve the overall health outcomes as much as, or more than, established alternatives.

(3) If reimbursement is being sought on a “by report” basis, a description of the service, the proposed unit of service, and the requested dollar amount shall be included with the request for authorization.

(4) A prior authorization request for an EPSDT service shall be reviewed for medical necessity without regard to the source of the referral to the service.

(5) A school-based health service provided in accordance with 907 KAR 1:715 which is included in an authorized Individual Education Program (IEP) shall be considered to be

medically necessary and shall not be subject to further Medicaid prior authorization requirements.

Kentucky Guidelines for EPSDT KAR 11.035

Section 1. Definitions.

(1) “Department” means the Department for Medicaid Services or its designated agent.

(2) “EPSDT” means early and periodic screening, diagnosis, and treatment in accordance with 42 C.F.R. 440.40(b), 441.56(b)-(c), 441.57, and 441.58.

(3) “EPSDT special services” means a service that is:

(a) Allowable under 42 C.F.R. 441.50 through 441.62 and 42 U.S.C. 1396d(r);

(b) Not otherwise covered under the Kentucky Medicaid Program; and

(c) Medically necessary in accordance with 907 KAR 3:130 to correct or ameliorate a defect, physical or mental illness, or condition of a recipient.

(4) “Medicaid physician fee schedule” means a list of current reimbursement rates for physician services established in accordance with 907 KAR 3:010, Section 3(1).

(5) “Recipient” means a Medicaid-eligible individual younger than 21, which includes the month in which the child becomes 21.

(6) “Usual and customary charge” means the uniform amount a physician charges to the public for a specific medical procedure or service.

Section 2. Reimbursement.

(1) A provider shall be reimbursed for a screening service in accordance with the payment provisions established through the appropriate Medicaid provider program.

(2) Payment for a screening service provided by an EPSDT enrolled screening clinic shall be the amount specified in the Medicaid physician fee schedule for the procedure code.

(3) Payment for a screening service shall not exceed the usual and customary charge of the provider for the service.

Section 3. Reimbursement of EPSDT Diagnosis and Treatment Providers.

The department shall reimburse an EPSDT diagnosis or treatment provider participating in compliance with 907 KAR 1:034, Section 8(1) as specified in 907 KAR Chapters 1 and 3 for reimbursement for the particular diagnosis or treatment service rendered.

Section 4. Reimbursement of EPSDT Special Services Providers.

(1) Except as specified in Section 5 of this administrative regulation, the department shall reimburse for an EPSDT special service which is similar to a service covered in

another Medicaid Program based on the payment methodology established for that provider program.

(2) Reimbursement for a special service that does not have a reimbursement rate established under subsection (1) of this section shall be based on a fee negotiated by the department adequate to obtain the service.

(3) The negotiated fee shall not exceed 100 percent of the usual and customary charges.

(4) If the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits.

(5) If an EPSDT special service is provided before prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.

Section 5. Reimbursement of School-based Health Services Providers.

(1) The department shall reimburse a school-based health service provider for a service included in an individualized education program which is provided to a Medicaid-eligible recipient based on a fee-for-service system designed to approximate cost for all participating providers in the aggregate without settlement to exact cost.

(2) Payment rates for a service shall be established using the following methodology:

(a) Interim payment rates for a service shall be based on annual cost data submitted in accordance with paragraph (b) of this subsection for the previous state fiscal year and shall be adjusted up or down as appropriate when final payment rates are established.

(b) Final payment rates shall be set based on the following:

1. Except as specified in subparagraphs 4 and 5 of this paragraph, a payment rate for a particular service shall be based on the lower of the mean or median of the participating providers' cost of providing the service;

a. The statewide mean and median cost for a service shall be based on the contracted hourly service cost and the cost associated with publicly employed professionals; and

b. The mean and median hourly cost shall be calculated, for each class of qualified professionals, from an array of hourly cost data falling within one standard deviation of the mean.

2. Cost for publicly employed professionals shall be computed in the following manner:

a. Salary, fringe benefits, and indirect overhead shall be included;

b. Annual professional salaries (including full-time equivalent employees) shall be converted to hourly wages using 185 work days per year and six work hours per day;

c. The applicable fringe benefit cost based on the actual percentage rate for classified and certified employees shall be added to the hourly salary wage; and

d. An indirect overhead cost consisting of 7 percent of the hourly wage shall be added to the hourly salary wage.

3. Payments for a professional service shall be based on units of service which are 15-minute increments;

4. Payments for medical transportation provided in accordance with 907 KAR 1:715, Section 3, shall be based on the average cost per mile of pupil transportation as calculated by the Department of Education;

5. Payments for assistive technology and medical equipment provided in accordance with 907 KAR 1:715, Section 3, shall be based on actual invoiced cost including shipping and handling expenses for the authorized equipment included in an individualized education program;

6. For each school year ending June 30, final payment rates shall be set using corresponding cost data available as of Sept. 1 for that school year; and

7. Final payment rates shall be the lower of the billed charge or the Medicaid rate on file for the date the service is provided.

(c) 1.) A school-based health services provider shall submit annual cost data to the department no later than Aug. 31 of each year, and 2.) If the cost data is not submitted within the specified period, the school-based health services provider shall be terminated from the program; and

(d) A school-based health services provider shall certify quarterly expenditures of state or local funds used to provide covered school-based health services to Medicaid-eligible children as specified in 702 KAR 3:285. (2 Ky.R. 109, eff. 9-10-1975; 5 Ky.R. 64, eff. 9-6-1978; 7 Ky.R. 410, eff. 12-3-1980; Recodified from 904 KAR 1:035, 5-2-1986; Ky.R. 1623, eff. 1-10-1992; 23 Ky.R. 1799, eff. 12-18-1996; 25 Ky.R. 933, 1382, eff. 12-16-1998; 30 Ky.R. 1859, 2035, eff. 3-18-2004; Recodified from 907 KAR 1:035, eff. 5-3-2011.)

Dental Services

At a minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. Each

state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.
https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

Benefit Exception Process

Avēsis requires consideration of written provider requests for a benefit exception under the EPSDT program if the member is aged 20 or younger. For members older than 20, benefit exceptions may be reviewed by Avēsis case by case.

If a member or a provider contacts Avēsis and requests coverage of a non-covered item or service as a benefit exception, the following procedure should be followed:

1. Requests for benefit exceptions must delineate the medical necessity for the exception with a Letter of Medical Necessity from an Avēsis Provider or a physician.
2. Letters of Medical Necessity must be submitted with the benefit exception request to Avēsis Dental Utilization Management.
3. Requests will be reviewed for medical necessity and appropriateness.
4. Avēsis must decide and notify the provider and member within two business days of receipt. If all the information is not available to make a decision, an extension of up to 14 additional days may be requested and approved if it is in the best interest of the provider. The provider must be notified of the extension and the reason. If additional information is requested, the provider shall be given up to 45 days to submit it.

Kentucky Guidelines for Professional Consultation

D9420 hospital or ambulatory surgical center call:

- Payable for all ages
- One per date of service per dentist or dental group, either D9410 or D9420
- Not payable with D0140, D1050, D0160, or D9110
- Only payable if submitted with place of service code 22 (on-campus outpatient hospital) or 24 (ambulatory surgical center)

Glossary

Administrative Appeals Hearing — A formal adjudicatory proceeding conducted by the administrative hearing tribunal of the Cabinet for Health and Family Services in accordance with KRS Chapter 13B.

Administrative Request — A prior authorization request that is received without any x-rays and/or chart notes.

Advisory Board Member — A dentist or dental specialist who participates on the Advisory Board established by Avēsis in certain states wherein dental benefits programs are administered.

Appropriate Radiographs — Radiographs that are clear, labeled to identify the area of the mouth, and showing the parts of the tooth or teeth to be treated. Digital radiographs must have a date stamp or some date identification.

Board Certified — Providers, whether consultants or participating providers, who specialize in areas of dentistry where there is a board certification process. Board certified providers have met all the requirements to be designated as board certified and Avēsis verifies this information with the applicable certification boards. (i.e., orthodontists, oral surgeons, pediatric dentists, etc.) Note: There is no board certification process for general dentists.

Clinical Request — A prior authorization request that is received with X-rays and/or chart notes.

Complaint — Any expression of dissatisfaction to a Medicaid health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicaid health plans such as: waiting times, the demeanor of healthcare personnel, the adequacy of facilities, the respect paid to enrollees, and the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Consultant or Dental Consultant — An independent dentist under contract with Avēsis or employed by Avēsis who reviews prior-authorization requests and/or appeals of adverse determinations, or participated in peer-to-peer discussions with participating providers to discuss claim denials or prior-authorization requests specific to a member's condition.

Dental Emergency — A situation where the member has or believes there is a current, acute dental crisis that could be detrimental to his or her health if not treated promptly.

External Independent Third-Party Review — A review performed by an independent third party outside the Medicaid managed care organization's internal appeal process, pursuant to administrative regulations promulgated by the department.

Fraud — The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true, and makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

Group Practice — A partnership, a corporation, or an assemblage of providers in a space-sharing arrangement in which the dental providers each maintain offices and the majority of their treatment facilities in a contiguous space.

Healthcare Durable Power of Attorney — A signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if he or she is unable to do so. A healthcare durable power of attorney can include instructions about any treatment the individual desires to undergo or avoid.

Inquiry — Any oral or written request to a health plan, provider or facility, without an expression of dissatisfaction (e.g., a request for information or action by an enrollee). *Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance or organization determination process.*

Living Will — A written document concerning the kind of medical care a person wants or does not want if he or she is unable to make his or her own decisions about care.

MCO — Managed Care Organization for which the Department of Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. sec. 438.2.

Medically Necessary — Except as otherwise defined for medical assistance and CHIP product regulatory requirements or by the applicable federal or state agency, medically necessary is defined as a covered benefit that will or is reasonably expected to prevent the onset of an illness, condition or disability; or will or is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

Primary Care Practitioner (PCP) — A specific practitioner or group under the scope of his/her licensure who is responsible for supervising, prescribing and providing primary care services; locating, coordinating, and monitoring dental or dental related care; and maintaining continuity of care on behalf of a member.

Prior authorization — A request made in advance for dental services to be performed by an Avēsis participating network dentist or dental specialist.

Provider — Any person or entity licensed in Kentucky as defined in KRS 304.17A-700(9) that provides covered services to enrollees.

Referral — A request for dental services to be performed by an Avēsis network specialist.

Forms

- Avēsis Provider Update Form
- Avēsis Locum Tenens Form
- Non-Covered Services Disclosure Form
- Electronic Funds Transfer Form
- Mastercard Enrollment Form
- Orthodontic Continuation of Care
- Avēsis Kentucky Anesthesia Guidelines
- Avēsis Children's Dental Outreach Policy
- Silver Diamine Consent Form
- Avēsis Silver Diamine Fluoride Guidelines
- Caries Risk Assessment Form (Age > 6)
- Caries Risk Assessment Form (Age 0 – 6)

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Avēsis Silver Diamine Fluoride Guidelines

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