MCNA & Humana – CareSource™

DENTAL
PROVIDER MANUAL

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I. INTRODUCTION

Humana – CareSource and MCNA's goal is to provide quality dental services to members and providers. MCNA has an organized network of private dental offices throughout the Commonwealth of Kentucky. Humana – CareSource and MCNA recognize the vital role the dental office plays in a successful dental plan. The purpose of the Provider Manual is to provide you with an explanation of administrative procedures, provisions and the role you play as a dentist. We appreciate your participation and look forward to partnering with you to improve the oral health of your patients and to grow your practice.

MCNA may make additions, deletions or changes to the policies and procedures described in this Provider Manual at any time and MCNA will give providers at least 30 days advance notice before implementation. As a participating provider your agreement requires you to comply with MCNA policies and procedures including those contained in this manual.

For the latest version of this manual in electronic format, please visit the Humana – CareSource Provider Portal at:

https://providerportal.caresource.com/KY/

or visit the MCNA website at:

https://portal.mcna.net/

II. MISSION

The MCNA mission is to deliver value to its clients and providers by providing access, quality and service excellence that improves the oral health outcomes of our members. Together, Humana – CareSource and MCNA are committed to facilitating great dental care for members.

III. CONTACT LIST

Communicating with Humana – CareSource

Humana – CareSource communicates with our Provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, website and Network Notifications.

Humana – CareSource Hours of Operation

PROVIDER SERVICES	M-F	8am-6pm	Provider Services
MEMBER SERVICES	M-F	7am-7pm	Member Services
24-Hour Nurse Advice Line	24/7/365		Triage

Phone

To help us direct your call to the appropriate professional for assistance, you will be instructed to select the menu option(s) that best fits your needs. ***Please note that our menu options are subject to change.*** We also provide telephone based self-service applications that allow you to verify Member eligibility.

Phone Numbers

Provider Relations.....1-855-852-7005

Provider Services.....1-855-852-7005

Dental Prior Authorizations 1-877-375-6262

Claims Inquiries 1-855-852-7005

Credentialing.....1-855-852-7005

Member Services.....1-855-852-7005

24-Hour Nurse Triage Line 1-866-206-9599

Fraud, Waste and Abuse Hotline 1-855-852-7005

TTY for the Hearing Impaired.....1-800-648-6056 or 711

Fax Numbers

Case Management Referral 1-888-211-9858

Credentialing.....1-502-508-0521

Fraud, Waste and Abuse 1-800-418-0248

Dental Prior Authorizations 1-954-628-3331

Provider Appeals.....1-855-262-9793

Provider Maintenance (e.g., office changes, adding/deleting providers…1-800-626-1686)

How to Communicate by Mail

Dental Prior Authorizations:
MCNA Dental
200 West Cypress Creek Rd., Suite 500
Ft. Lauderdale, FL 33309

Provider Appeals:
Humana – CareSource
Attn: Provider Appeals - Clinical
P.O. Box 823
Dayton, OH 45401-0823

Member Appeals & Grievances:
Humana – CareSource
Attn: Grievance/Appeals
P.O. Box 221529
Louisville, KY 40204

Claims:
Humana – CareSource
Attn: Claims Department
P.O. Box 824
Dayton, OH 45401-0824

Fraud, Waste and Abuse:
Humana – CareSource
Attn: Special Investigations Department
P.O. Box 1940
Dayton, OH 45401-1940

Information reported to us can be reported ***anonymously*** and is kept ***confidential*** to the extent permitted by law.

IV. HUMANA – CARESOURCE ONLINE PROVIDER PORTAL

Provider Portal

The Humana – CareSource secure, online Provider Portal, located at https://providerportal.caresource.com/KY, makes it easier for you to work with us 24/7. The Provider Portal has critical information and tools to save your practice time. Simply enter your Username and Password (if already a registered user), or submit your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our Members.

Provider Portal – Value to You

We encourage you to take advantage of the following time saving tools:

- **Claims History** – View dental claims history
- **Claim Status** – Check medical/dental claims status
- **Prior Authorizations** – Enter and view authorizations
- **Coordination of Benefits** (COB) – View and enter COB for members
- **Explanation of Payment** (EOP) – View on the Portal with the option to print
- **Eligibility Termination Dates** - View the Member's termination date (if applicable) under the eligibility tab
- **Case Management Referrals** – The case management form is now automated on our portal for efficiency in enrolling Members
- **Care Treatment Plans** – Access member treatment plans
- **Provider Information Change** - Demographic Change, add an affiliation, add a Provider
- **Member Profile** - Comprehensive view of patient medical/pharmacy utilization

Portal Registration – Sign up today!

If you are not registered with Humana – CareSource's Provider Portal, follow these easy steps to get started:

- Click on the "Register Now" button and complete the 3-step registration process. Note: you will need to have your Tax ID number
- Click the "Continue" button
- Note the User Name and Password you create so that you can access the Portal's many helpful tools
- If you do not remember your username/password, please call the Provider Services Department at 1-855-852-7005.

V. MCNA ONLINE PROVIDER PORTAL

The MCNA Portal, available at https://portal.mcna.net/ offers dental providers the following functionality:

- Check member eligibility
- Submit preauthorization requests and option to upload documents
- Check status of preauthorizations

VI. VERIFY MEMBER ELIGIBILITY

The Member ID card is used to identify a Humana – CareSource Member; it does not guarantee eligibility or benefits coverage. Members may disenroll from Humana – CareSource and retain their previous ID card. Likewise, members may lose Medicaid eligibility. Therefore, it is important to **verify member eligibility prior to every service.**

You can verify eligibility through either of the following **provider portals:** https://providerportal.caresource.com/KY or https://portal.mcna.net/

Using the Humana – CareSource secure Provider Portal, you can check member eligibility up to 24 months after the date of service. Click on "Member Eligibility" on the left. You can search by date of service plus one of the following:

- Member name and date of birth, case number
- Medicaid (MMIS) number
- Humana – CareSource Member ID number

You can also submit multiple Member ID numbers in a single request.

For assistance, please call Humana – CareSource Provider Services: 1-855-852-7005

You may also call the Humana – CareSource automated member eligibility verification system from touch-tone phones and follow the appropriate menu options. The automated system, available 24 hours a day, will prompt you to enter the Member ID number and the month of service to check eligibility.

Using the MCNA Provider Portal, click the "Manage Your Subscribers" button at the top of the page, and then select "Verify Eligibility." To find the subscriber you are looking for, you must have the date of birth and at least one of the following:

- Member ID number
- Member last name

When you have finished entering the subscriber's information, click the "Search for Subscriber" button to proceed. If a subscriber is found and enrolled in a plan your office serves, the remaining fields will be automatically populated and green check marks will appear next to each field.

Dental Benefits defined by Kentucky State Rules:

907 KAR 1:026 - *Dental Services* http://www.lrc.ky.gov/kar/907/001/026.htm
907 KAR 1:626 - *Reimbursement of Dental Services* http://www.lrc.ky.gov/kar/907/001/626.htm

VII. ADMINISTRATION OVERVIEW

Appointments and Access to Care

Providers must provide the same availability to Humana – CareSource members as is done for all other patients.

The Dental Provider Agreement outlines appointment availability standards. These standards will be monitored via the MCNA Quality Management Program:

Emergency Care – patient must have access 24 hours a day, 7 days a week to relieve pain or prevent worsening of a condition. The dentist must be available to the member or arrange for another dentist to provide services

Urgent Care – must be seen immediately or within 48 hours (swelling, bleeding, fever, infection)

Routine Care – patient must have access within 21 days of request

Hygiene appointments –within 6 weeks of request

Routine symptomatic – cases shall be seen within 2 weeks

The Dentist or his or her covering credentialed dentist must respond to a member within 30 minutes after notification of an emergency or urgent call.

Appropriate access to care is an essential part of the MCNA Quality Management Program. Access to care is monitored by the MCNA Provider Relations Department. Periodically, a written inquiry or phone call may be generated by a Provider Services Representative to obtain information concerning the next available appointment.

Transfer of Dental Records

Please request that the member authorize release of his or her dental records to you from practitioners who treated the member prior to visiting your office.

There will be no charge for the copying of charts and/or radiographs subject to Kentucky's state requirements and MCNA policies. All copies must be provided to the Humana – CareSource member within five (5) days of the request.

Termination of Dental Contract

MCNA may terminate the provider from the network for misrepresentation(s) made on his/her application. Causes for termination with a 90-day notice include but are not limited to:

- Failure to meet participating criteria
- Failure to provide requested dental records

Causes for immediate termination include but are not limited to:

- Expulsion, disciplinary action, or barred from participating in other state's Medicaid Program or the Medicare Program;
- Loss or suspension of the provider's professional liability coverage;
- Failure to satisfy some or all of the credentialing requirements of MCNA;
- Failure to cooperate with or abide by MCNA's Quality Management Program;
- Commit one or more acts of fraud in connection with the provision of Dental Services and/or;
- Conduct that is detrimental to MCNA's business reputation.

Providers who wish to terminate participation with Humana – CareSource must provide MCNA with a 90-day notice of termination in writing, with a mailed certified return receipt, which includes the final termination date.

Provider Responsibilities

Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations.

Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission.

If suspected cases are discovered, an oral report should be made immediately, by telephone or otherwise, to a representative of the local Department for Social Services office or by calling the Abuse Hotline at (800) 752-6200. To facilitate reporting of suspected child abuse and neglect cases, legislation affecting the reporting of child abuse (KRS 620.030) is printed on the reverse side of the Child Abuse Reporting Form (DSS--115). These forms may be obtained from the local Department for Social Services office.

Adult abuse is defined by KRS. 209.020 as “the infliction of physical pain, mental injury, or injury of an adult.” The statute describes an adult as “(a) a person 18 years of age who because of mental or physical dysfunction is unable to manage his [or her] own resources or carry out the activity of daily living or protect himself [or herself] from neglect or a hazardous or abusive situation without assistance from others and who may be in need of protective services; or (b) a person without regard to age who is the victim of abuse and neglect inflicted by a spouse.”

Fraud, Waste and Abuse

Health care fraud, waste and abuse hurts everyone including members, providers, taxpayers and Humana – CareSource. As a result, we have a comprehensive Fraud, Waste and Abuse program in our Special Investigations Unit. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

Definition of Terms:

Fraud — is defined as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes acts that constitutes fraud under applicable federal or state law.” (42 CFR Part 455.2)

Waste — involves taxpayers not receiving reasonable value for money in connection with government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight. (U.S. Department of Defense, Office of Inspector General).

Abuse — is defined as “Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.” (42 CFR Part 455.2)

Improper Payment — are payments that should not have been made or were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative or other legally applicable requirements. Includes payment to an ineligible

recipient, payments for an ineligible good or service, duplicate payments, payments for a good or service not received (except for such payments where authorized by law) and payments that do not account for credit for applicable discounts. (Improper Payments Elimination and Recovery Act [IPERA]).

Examples of Member Fraud, Waste and/or Abuse:

- Inappropriately using services such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions
- Sharing their ID cards
- Non-disclosed other health insurance coverage
- Changing prescription forms to get more than the amount of medication prescribed by their physician
- Obtaining unnecessary equipment and supplies
- Members receiving services or picking up prescriptions under another person's ID (identity theft)
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Examples of Provider Fraud, Waste and /or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower reimbursement rates
- Billing for tests or services not provided
- Intentionally using improper medical coding to receive a higher reimbursement
- Purchasing drugs from outside the U.S.
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking Member IDs resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using enrollee lists for the purpose for submitting fraudulent claims
- Drugs billed for inpatients as if they were outpatients
- Payments stemming from kickbacks or Stark Violations
- Retaining overpayments made in error by Humana – CareSource
- Preventing Members from accessing covered services resulting in underutilization of services offered

Examples of Pharmacy Fraud, Waste and /or Abuse:

- Prescription drugs not dispensed as written
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed

- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted or illegal drugs
- Billing for prescriptions not filled or picked up

It is also important for you to tell us if a company employee acts inappropriately. Some examples are:

- Receiving gifts or kickbacks from vendors for goods or services
- Inappropriately marketing our company to potential members
- Behaving in an unethical or dishonest manner while performing company business

We routinely monitor our claims data and review medical records for billing aberrancies. When found, an investigation is initiated and, if warranted, a corrective action is taken.

Corrective Actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Reporting to one or more applicable state and federal agencies
- Legal action

Refer to your Provider Agreement for specific information on each of type of provider termination/suspension. Also, refer to the Fair Hearing Plan for the information on the appeal process. The Fair Hearing Plan is available at **caresource.com/KY**, and search for "Fair Hearing Plan."

Federal and State Fraud Laws

The Federal False Claims Act allows everyday people to bring "whistleblower" lawsuits on behalf of the government — known as "qui tam" suits — against businesses or other individuals that defraud the government through programs, agencies or contracts. Using the False Claims Act, you can help reduce fraud against the federal government.

The False Claims Act addresses those who:

a. Knowingly present, or cause to present, a false or fraudulent claim for payment or approval
b. Knowingly make, use or cause to be made or use, a false record or statement material to a false or fraudulent claim
c. Conspires to commit a violation of other sections of the False Claims Act
d. Has possession, custody or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property
e. Is authorized to make or deliver a document certifying receipt of property used, or to be used by the Government, and intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true.
f. Defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true
g. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a Member of the Armed Forces, who lawfully may not sell or pledge property
h. Knowingly makes, used, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government

A violation of the Federal Anti-Kickback Statute constitutes a false and fraudulent claim under the Federal False Claims Act.

“Knowingly” means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

An example would be if a health care provider, such as a hospital, dentist, or physician, knowingly “upcodes” or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

Penalties (in addition to amount of damages) may range from $5,500 to $11,000 per false claim, plus three times the amount of money the government is defrauded. In addition to monetary penalties, the provider may be excluded from participation in the Medicaid or Medicare program.

The time period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct; or
- Within three years after the date the Government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.

Kentucky Law:

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 3 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 2 to 6 months upon the first offense, 6 months to 1 year for second offense, and 1 to 5 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 or 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 a 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 at Kentucky Revised Statutes §§205.8451-205.8483.

Other Fraud, Waste and Abuse Laws:

- Under the **Federal Anti-Kickback Statute**, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for an

item or service for which payment may be made in whole or in part under a federal health care program. 42 U.S.C. §1320a-7b.

- Under the **Federal Stark Law**, and subject to certain exceptions, physicians are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family Member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs. 42 U.S.C. §1395(a) and §1903(s).
- As part of the **Health Insurance Portability and Accountability Act (HIPAA)**, the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, money or property owned by or under the custody or control of federal health care programs. 18 U.S.C. §1347.

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 on **caresource.com/KY.**

Prohibited Affiliations / 42 C.F.R. § 438.610:

Humana – CareSource is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended or otherwise excluded from participating in federal procurement and non-procurement 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 health care programs. If you become aware that you or your office management staff possesses a prohibited affiliation, you must notify us *immediately* utilizing the contact information in the reporting process section.

Disclosure of Ownership, Debarment and Criminal Convictions:

Before Humana – CareSource enters into or renews an agreement with your practice or corporate entity, you must disclose debarments or suspension status and criminal convictions

related to federal health care programs for yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by using the contact information in the reporting section below.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations (CFR) 42 CFR 455.100-106 for more information and definitions of relevant terms.

How to Report Fraud, Waste or Abuse:

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, please contact our Special Investigations Unit. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting **anonymously**:

Call: 1-855-852-7005 and follow the appropriate menu option for reporting fraud

Write:

Humana – CareSource
Attn: Special Investigations Unit
P.O. Box 1940
Dayton, OH 45401-1940

Options for reporting that are **not anonymous:**

- **Fax:** 1-800-418-0248
- **Email:** fraud@caresource.com

Note: Most email systems are not protected from third parties. This means people may access your email without you knowing or saying it's okay. Please do not use email to tell us information that you think is confidential, such as your social security number, member ID number or medical diagnoses. Instead, please use the form or phone number above. This can help protect your privacy.

Or you may choose to use the Fraud, Waste and Abuse Reporting Form located at **CareSource.com/KY.**

When you report fraud, waste or abuse, please give as many details as you can, including names and phone numbers. You may remain ***anonymous***, but if you do we will not be able to call you back for more information. Your reports will be kept ***confidential*** to the extent permitted by law.

A Roadmap to Avoid Medicare and Medicaid Fraud and Abuse:

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of Inspector General's website at:

http://oig.hhs.gov/compliance/physician-education/index.asp.

Thank you for helping Humana – CareSource keep fraud, waste and abuse out of health care.

VIII. CLAIMS AND PAYMENTS

Claims Submissions

In general, Humana – CareSource follows claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. For expedited claims processing and payment delivery, please ensure all addresses and phone numbers on file with Humana – CareSource are up to date.

Billing Methods

Humana – CareSource accepts claims in a variety of formats, including paper and electronic claims.

We encourage providers to submit routine claims electronically to take advantage of the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training or cost

Electronic Funds Transfer

Humana – CareSource now offers Electronic Funds Transfer (EFT) as a payment option. Visit the Provider Portal for additional information about the program and to enroll in EFT.

Providers who elect to receive EFT payment will receive an EDI 835 (Electronic Remittance Advice). Providers can download their Explanation of Payment (EOP) from the Provider Portal or receive a hard copy via the mail.

Benefits of EFT:

Simple - Receive fully reconciled remittances electronically; eliminate paper checks and EOPs, which will increase efficiency with payment processing.

Convenient - Available 24/7; works in conjunction with Practice Management Systems. In addition, Humana – CareSource offers free training for providers.

Reliable - Claim payments are electronically deposited into your bank account.

Secure - Access your account through Humana – CareSource's secure Provider Portal to simply complete the enrollment form and fax it back to InstaMed®, who will view (and print if needed) remittances and transaction details with providers to enroll in EFT.

Electronic Claims Submission

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business data in standard formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). Our EDI system complies with HIPAA standards for electronic claims submission.

EDI Clearinghouses

To submit claims electronically, providers must work with an electronic claims clearinghouse. Humana – CareSource currently accepts electronic claims from Kentucky providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claims submission.

Please provide the clearinghouse with the Humana – CareSource payer ID number: KYCS1

Clearinghouse	Phone	Website
Emdeon™	1-800-845-6592	www.emdeon.com
Quadax	1-866-422-8079	www.quadax.com
Relay Health	1-800-778-6711	www.relayhealth.com
CPS (Emdeon)	1-888-255-7293	www.cpsedi.com

Note: Providers can also use the Availity® portal to check member eligibility and claims status.

File Format

Humana – CareSource accepts electronic claims in the 837 ANSI ASC X12N (004010A1) file format for professional and hospital claims.

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This is in preparation to implement ICD-10 CM codes in 2013. The new standard is the HIPAA 5010 format. All trading partners and payers must now be 5010 compliant.

Transactions covered under the 5010 requirements:

- 837 Claims Encounters
- 276/277 Claim Status Inquiry
- 835 Electronic Remittance Advice
- 270/271 Eligibility
- 278 Prior Authorization Requests
- 834 Enrollment
- 820 Payment Order / Remittance Advice
- NCPDP Version D

NPI and Tax ID Numbers

Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out when to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Location of provider NPI, TIN and member ID Number on professional claims:

On 5010 (837P) **professional** claims, the Provider NPI should be in the following location:

- Medicaid: 2010AA Loop – Billing Provider Name
- 2010AA Loop – Billing Provider Name
    - Identification Code Qualifier – NM108 = XX
    - Identification Code – NM109 = Billing Provider NPI
- 2310B Loop – Rendering Provider Name
    - Identification Code Qualifier – NM108 = XX
    - Identification Code – NM109 = Rendering Provider NPI

The Billing Provider TIN (Tax Identification Number) must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

Institutional Claims

On 5010 (837I) **institutional** claims, the Billing Provider NPI should be in the following location:

- 2010AA Loop – Billing Provider Name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing Provider NPI

The Billing Provider TIN (Tax Identification Number) must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On **all** electronic claims, the Humana – CareSource member ID number should go on:

- 2010BA Loop – Subscriber Name
- NM109 = Member ID Number

Paper Claims

For the most efficient processing of your claims, Humana – CareSource recommends you submit all claims electronically. Paper claim forms are encouraged for services that require clinical documentation or other forms to process.

If you submit paper claims, please submit claims on one of the following claim form types:

- CMS-1500, formerly HCFA 1500 form — AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental claim form
- CMS-1450 (UB-04), formerly UB-92 form for Facilities

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA). We cannot accept handwritten claims or Super Bills. Detailed instructions for completing each form type are available at the websites below.

- CMS-1500 Form Instructions www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf
- UB-04 Form Instructions: www.nucc.org

All claims (EDI and paper) must include the following information:

- **Patient (member) Name**
- **Patient Address**
- **Insured's ID Number** — Be sure to provide the complete Humana – CareSource member ID number of the patient.
- **Patient's Birth Date** — Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- **Place of Service** — Use standard CMS (HCFA) location codes.
- **ICD-9 diagnosis code(s)**
- **HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.**
- **Units, where applicable** (Anesthesia claims require minutes).
- **Date of Service** — Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- **Prior Authorization Number, where applicable** — A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required a prior authorization.
- **National Provider Identifier (NPI) - Please refer to sections for Professional and Institutional claim information.**
- **Federal Tax ID Number or Physician Social Security Number** — Every provider practice (e.g., legal business entity) has a different tax ID number.
- **Signature of Physician or Supplier** — The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

Instructions for NDC on Paper Claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit National Drug code (NDC) (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use 3 spaces between the NDC number and the units on paper forms

What to Include on Claims that Require NDC

1. NDC and unit of measure (e.g., pill, milliliter (cc), international unit or gram)
2. Quantity administered – number of NDC units
3. NDC unit price – detail charge divided by quantity administered
4. HCPCS codes that will require NDCs on professional claims (submitted on the 837P format)

Tips for Submitting Paper Claims

For the most efficient processing of your claims, Humana – CareSource recommends you submit all claims electronically.

Humana – CareSource uses optical/intelligent character recognition (OCR/ICR) systems to capture claims information that increases efficiency, improves accuracy and results in faster turnaround time.

To Ensure Optimal Claims Processing Timelines:

- EDI claims are generally processed more quickly than paper claims
- If you submit paper claims we require the most current form version as designated by CMS, NUCC and the ADA
- No handwritten (including printed claims with any handwritten information) claims or Super Bills will be accepted
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website
- Fonts should be 10 to 14 point (capital letters preferred) with printing in black ink
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form
- Federal tax ID number or physician SSN is required for all claim submissions

Please send all paper claim forms to Humana – CareSource at the following address:

Humana – CareSource
Attn: Claims Department
P.O. Box 824
Dayton, OH 45401-0824

Claim Submission Timely Filing

Claims must be submitted within **365 days** of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim. If this

happens, providers have **365 days** from the date of service or discharge to submit a corrected claim or file a claim appeal.

Claims Processing Guidelines

- Providers have 365 days from the date of service or discharge to submit a claim. If the claim is submitted after 365 days, the claim will be denied for timely filing.
- If you do not agree with the decision of the processed claim, you will have 365 days from the date of service or discharge to file an appeal.
- If the claims appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a member has other insurance and Humana – CareSource is secondary, the provider may submit for secondary payment within 365 days of the original date of service.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required timeframe, the claim will be denied for timely filing.

Searching for Claims Information Online

Claim status is updated daily on our Provider Portal, and you can check claims that were submitted from the previous 24 months. You can search by member ID number, member name, date of birth or claim number.

Additional Claims Enhancements on the Provider Portal:

- Claims History Available Up to 24 Months from Date of Service
- Reason for Payment/Denial
- Check Numbers/Date
- Procedure/Diagnostic
- Claims Payment Date

Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following five code sets when submitting health care claims electronically. Humana – CareSource also requires HIPAA compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on health care providers and health plans. Local or proprietary codes are no longer allowed.

- *International Classification of Diseases*, 9th Edition, Clinical Modification (ICD-9-CM). Available from the U.S. Government Printing Office at (202) 512-1800, (202) 512-2250 (fax) and from many other vendors.
- *Current Procedural Terminology*, 4th Edition, (CPT-4). Available at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml.
- *HCFA Common Procedure Coding System* (HCPCS). Available at http://www.cms.hhs.gov/default.asp Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org.
- *National Drug Codes* (NDC). Available at **http://www.fda.gov/.**

Procedures That Do Not Have a Corresponding CPT Code

If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:

- A full, detailed description of the service provided.
- A report, such as an operative report or a plan of treatment.
- Other information that would assist in determining the service rendered.

For example, CPT code 84999 is an unlisted lab code that would require additional explanation.

Additional Coding / Claim Submission Guidelines

- Drug injections that do not have specific J code descriptions (J9999 and J3490) and any assigned HCPC J code that is not listed on the Medicaid fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Abortion Sterilization and Hysterectomy procedures — Consent forms must be attached (please go to the Supplemental/Form Section of this Provider Manual for these forms)
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus any other documentation that will assist in determining reimbursement
- Coordination of Benefits (COB) paper claims require a copy of the Explanation of Payment (EOP) from the primary carrier or the primary carrier's payment information for EDI claims

Code Editing

Humana – CareSource uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately and efficiently.

Humana – CareSource's code editing software finds coding conflicts or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and

diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the health care provider.

Humana – CareSource's clinical editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Humana – CareSource seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, claims that are denied based upon the use of a certain code, the relationship between two or more codes and the unit counts or the use of modifiers. This review will take into consideration all previously mentioned Commonwealth, Medicare, CCI and national commercial standards when considering the appeal. In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the Humana – CareSource appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current Humana – CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Humana – CareSource Provider Coding and Reimbursement Guidelines

Humana – CareSource strives to be consistent with Commonwealth, Medicare, and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received either via hard copy or electronically. We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA compliant code sets (HCPC, CPT, ICD-9). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers are honored as an aspect of a provider contract. When referenced in a contract, Commonwealth reimbursement rules as set forth and followed, depending on the state at issue. In addition, the Center for Medicare & Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. Humana

– CareSource strives to follow the prevailing NCCI National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the following link for details:

http://chfs.ky.gov/dms/fee.htm

Humana – CareSource uses coding industry standards, such as the AMA CPT manual, CCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCs code or modifier usage

Explanation of Payment (EOP)

Explanation of Payments (EOP) are statements of the current status of your claims that have been submitted to Humana – CareSource and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated depending on your claims activity. Providers who receive EFT payments will receive an ERA (Electronic Remittance Advice) and can access a “human readable” version on the Provider Portal.

Information Included on EOPs

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA compliant remark code indicating the reason the claim was denied. It is the provider’s responsibility to resubmit claims with the correct or completed information needed for processing.

Check Claim Status Online

Please remember that you can track the progress of your submitted claims through our Provider Portal.

Other Coverage – Coordination of Benefits (COB)

Coordination of Benefits

Humana – CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately, and in general we are required to comply with the federal regulations that Medicaid programs serve as the payer of last resort.

While we try to maintain information as accurately as possible, we rely on numerous sources of information that are updated periodically, and some information may not always be fully reflected on our Provider Portal. Please ask Humana – CareSource members for all health care insurance information at the time of service.

Search COB on the Provider Portal by:

- Member Number
- Case Number
- Medicaid Number/MMIS Number
- Member Name and Date of Birth

You can check COB information for members who have been active with Humana – CareSource within the last 12 months.

Claims involving COB will not be paid until a completed Explanation of Benefits/Payment or EDI payment information form has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full ($0 balance) must still be submitted to Humana – CareSource for processing. This is due to regulatory requirements.

COB Overpayment

If a provider receives a payment from another carrier after receiving payment from Humana – CareSource for the same items or services, this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider, or providers can issue refund checks to Humana – CareSource for any overpayments. Providers should not refund monies received from a third party to a member.

Workers' Compensation

Claims indicating that a member's diagnosis was caused by the member's employment will not

be paid. The provider will be advised to submit the charges to Workers' Compensation for reimbursement.

Third-Party Liability / Subrogation – Claims indicating the provided services were the result of an injury will be considered as a case of possible subrogation. All third-party liability will be determined. Humana – CareSource will pay the provider for all covered services. Then, we will pursue recovery from third parties involved.

Member Billing Policy

State and federal regulations prohibit health care providers from billing Humana – CareSource members for services provided to them except under limited circumstances. Humana – CareSource monitors this activity based on reports of billing from members. We will implement a stepped approach in working with our providers to resolve any member billing issues that include notification of excessive member complaints and education regarding appropriate practices. Failure to comply with regulations after intervention may result in potential termination of your agreement with Humana – CareSource.

Regulations on Billing Members

Please remember regulations state that health care providers must hold members harmless in the event that Humana – CareSource does not pay for a covered service performed by the provider unless MCNA denies prior authorization of the service, and you notify the member in writing that the member is financially responsible for the specific service. This must be done prior to providing the service and the member must sign and date the notification. We appreciate your adherence to these requirements.

In compliance with federal and state requirements, Humana – CareSource members cannot be billed for missed appointments. Humana – CareSource encourages members to keep scheduled appointments and call to cancel, if needed. Humana – CareSource provides transportation for many doctor's visits to help ensure our members make it to needed medical appointments. Please call our Case Management Department if you are concerned about Humana – CareSource members who miss appointments.

Providers should call Provider Services for guidance before billing members for any services. You can reach Provider Services by calling 1-855-852-7005.

IX. MEMBER SERVICES

Member Support Services and Benefits

Humana – CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

Medicaid New Member Identification Cards and Kits

Each new member household receives a new member kit, a welcome letter, and an ID card for each person in the family who has joined Humana – CareSource. The new member kits are mailed separately from the ID card and new member welcome letter.

Medicaid new member kits contain:

- A current provider directory that lists health care providers and facilities participating with Humana – CareSource.
  Note: Members will receive a provider directory unless they have indicated at the time of enrollment that they do not want one. A current list of providers can be found at any time on Humana – CareSource's website.
- A member handbook, which explains plan services and benefits and how to access them.
- A health assessment survey.
- Humana – CareSource's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).
- Other preventive health education materials and information.

Member Services

Humana – CareSource provides assistance to members with questions or concerns about services or benefits. Members can contact our Member Services department by calling 1-855-852-7005 (TTY for the hearing impaired: 1-800-648-6056). Representatives are available by telephone Monday through Friday, 7 a.m. to 7 p.m., except on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the day after and Christmas Eve and Christmas Day. If the holiday falls on a Saturday, the company will be closed on the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

Interpreter Services — Non-Hospital Providers

Humana – CareSource offers sign and language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. We can also provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services are available at **no cost** to the member or health care provider. As a provider, you are required to identify the need for interpreter services for your Humana – CareSource patients and offer assistance to them appropriately. To arrange services, please contact Provider Services at **1-855-852-7005** (TTY: 1-800-648-6056 or 711). We ask that you let us know of members in need of interpreter services, as well as members that may receive interpreter services through another resource.

EPSDT Program

The Early Periodic Screening Diagnosis and Treatment (EPSDT) service is a federally mandated program developed for children through the age of 20 who are Medicaid recipients. **All children through age 20 who are Humana – CareSource members should receive EPSDT exams.** The program is designed to provide comprehensive preventive health care services at regular intervals. EPSDT stresses health education to children and their caretakers in the areas of health maintenance and early intervention and treatment of problems discovered during exams.

Member Rights and Responsibilities

As a Humana – CareSource provider you are required to respect the rights of our members. Humana – CareSource members are informed of their rights and responsibilities via their member handbook. The list of our member's rights and responsibilities are listed below.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Members have the right to:

A. Respect, dignity, privacy, confidentiality and nondiscrimination.

B. A reasonable opportunity to choose a PCP and to change to another provider in a reasonable manner.

C. Consent or refuse treatment and active participation in decision choices.

D. Ask questions and receive complete information relating to the member's medical condition and treatment options, including specialty care.

E. Voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and request a state fair hearing from the contractor and/or the department.

F. Timely access to care that lacks communication or physical access barriers.

G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643.

H. Assistance with medical records in accordance with applicable federal and state laws.

I. Timely referral and access to medically indicated specialty care.

J. Be free from forms of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

K. Receive information about Humana – CareSource, our services, our practitioners and providers and member rights and responsibilities.

L. Receive all services that Humana – CareSource must provide, and receive them in a timely manner.

M. Ensure that their medical record information will be kept private.

N. Receive information about their health. This information may also be available to someone whom they have legally approved to have the information or whom they have said should be reached in an emergency when it is not in the best interest of their health to give it to them.

Humana – CareSource may not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.

Members of Humana – CareSource are also informed of the following responsibilities:

A. Become informed about member rights.

B. Abide by the Humana – CareSource and Department of Medicaid Services' policies and procedures.

C. Become informed about service and treatment options.

D. Actively participate in personal health and care decisions and practice healthy lifestyles.

E. Report suspected fraud and abuse.

F. Keep appointments or call to cancel.

G. Use only approved providers.

H. Keep scheduled provider appointments, be on time, and if you have to cancel, call 24 hours in advance.

I. Follow the advice and instructions for care you have agreed upon with your health care providers.

J. Carry their ID card and do not let anyone else use their ID card.

K. Always present their ID card when receiving services.

L. Notify their county caseworker and Humana – CareSource of a change in your phone number or address.

M. Contact their PCP after going to an urgent care center or after getting medical care outside of Humana – CareSource's covered counties or service area.

N. Let us know if they have other health insurance coverage.

O. Provide the information that Humana – CareSource and their health care providers need in order to provide care for you.

Member Privacy

Members are notified of Humana – CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Humana – CareSource's Notice of Privacy Practices includes a description of how and when member information is used and

disclosed within and outside of the Humana – CareSource organization. The notice also informs members on how they may obtain a statement of disclosures or request their medical claim information. Humana – CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically in regards to protected health information (PHI) of members.

As a provider, please remember to follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Member Grievance & Appeals Procedures

Members have the right to file a grievance or appeal. They also have the right to request a state hearing once they have exhausted their appeal rights. As a Humana – CareSource provider we may contact you to obtain documentation when a member has filed a grievance or appeal or has requested a state hearing. State and federal agencies require Humana – CareSource to comply with all requirements, which include aggressive resolution timeframes.

Members are encouraged to call or write to Humana – CareSource to let us know of any complaints regarding Humana – CareSource or the health care services they receive. Members or providers, when designated as the authorized representative by the member, may file a grievance or appeal with Humana – CareSource. Detailed grievance and appeal procedures are explained in the member handbook. Members or providers can contact Humana – CareSource **1-855-852-7005** (TTY: 1-800-648-6056 or 711) to learn more about these procedures.

Member Grievances

When a member informs us that they are dissatisfied with Humana – CareSource or one of our providers, it is a grievance. Humana – CareSource investigates all grievances. If the grievance is about a provider, Humana – CareSource calls the provider's office to gather information for resolution. Humana – CareSource responds to all grievances within 30 calendar days.

Member Appeals

Members have the right to appeal an action or decision made by Humana – CareSource. An action for the purpose of an appeal may include:

- the denial or limited authorization of a requested service, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service;
- the denial, in whole or in part, of payment for a service;
- the failure of Humana – CareSource to provide services in a timely manner, as defined by the Department of Medicaid Services or its designee; or
- the failure of the Humana – CareSource to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

Members have the right to appeal the decisions or actions listed above if they contact Humana – CareSource within 30 calendar days of receiving the notice of action. Humana – CareSource will respond to the appeal within 30 calendar days of when it was received. An appeal will be expedited when it is determined the resolution time for a standard appeal could serious jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. Expedited appeals will be resolved within three working days of the receipt of the request.

State Fair Hearings — Once members have exhausted their appeal rights they can request a state fair hearing if Humana – CareSource makes a decision to deny, reduce, suspend or stop care for a member. Members have 30 days from receiving Humana – CareSource's final decision to file a state fair hearing.

If Humana – CareSource proposes to reduce, suspend or terminate a service already approved, members may request continuation of benefits until a state fair hearing is held; however, the member may be liable for the cost.

Members may request a state fair hearing through the Department of Medicaid Services. They can submit their request in writing, by fax, or in person to:

Kentucky Department for Medicaid Services
Division of Administration and
Financial Management
275 East Main St., 6W-C
Frankfort, KY 40621
Fax number: (502) 564-6917

For questions, they can call 1-800-635-2570.

How to Submit Appeals

There are three ways to submit appeals: through our Provider Portal, by fax or in writing.

Provider Portal: https://providerportal.caresource.com/KY

Fax: 1-855-262-9793

Writing:

Humana – CareSource
Attn: Provider Appeals – Clinical
P.O. Box 823
Dayton, OH 45401

X. UTILIZATION MANAGEMENT

Utilization Management (UM) is the process of influencing the continuum of care by evaluating the necessity and efficiency of health care services and affecting patient care decisions through assessments of the appropriateness of care. The UM department helps to assure prompt delivery of medically-appropriate dental care services to Humana – CareSource members and subsequently monitors the quality of care.

All participating providers are required to obtain prior authorization from MCNA. MCNA is available Monday through Friday, 9:00 a.m. to 5:00 p.m. EST (except designated holidays and weekends). All requests for authorization of services may be received during these hours of operation by calling 1-877-375-6262.

MCNA provides the opportunity for the provider to discuss a decision with the Dental Director, to ask questions about a UM issue or to seek information from the dental reviewer about the UM process and the authorization of care by calling 1-877-375-6262. After business hours or on holidays a provider may leave a message and a representative will return the call the next business day.

MCNA will not enter into contractual arrangements that reward participating providers or other individuals who may conduct utilization review activities for issuing denial of coverage of service or other financial incentives for utilization decision making. Quality of care will not be affected by financial and reimbursement related processes and decisions.

MCNA complies with the following requirements:

- Compensation for utilization management activities ARE NOT structured to provide inappropriate incentives for denials, limitations or discontinuation of authorization of services.
- Compensation programs for MCNA Dental Plans, consultants, dental directors or staff who make clinical determinations DOES NOT include incentives for denial of medically necessary services.
- Continuous monitoring of the potential effects of incentive plans on access and/or quality of care.

XI. PRIOR AUTHORIZATION OF CARE

Prior authorization of care may be requested through the mail or online at https://portal.mcna.net/ Requests are reviewed against MCNA approved criteria such as the Medicaid guidelines, the American Academy of Pediatric Dentistry Guidelines (available at www.aapd.org) and the American Dental Association Guidelines (available at www.ada.org). The provider may call MCNA's Provider Relations Department for a copy of the criteria.

Failure to submit a request for prior authorization and supporting documentation will result in non-payment to the provider. Per the Dental Provider Agreement the provider must hold Humana – CareSource, MCNA, the member and the State of Kentucky harmless if coverage is denied for failure to obtain prior authorization, whether before or after service is rendered.

ORTHODONTIC SERVICES ARE ONLY COVERED WHEN THE PATIENTS CONDITION MEETS THE COMMONWEALTH OF KENTUCKY MEDICAID SERVICES ORTHODONTIC PROGRAM CRITERIA FOR SEVERE HANDICAPPING MALOCCLUSION (907 KAR 1:026 SECTION 13). IF THIS CONDITION APPLIES, PLEASE SUBMIT THE PREAUTHORIZATION WITH STUDY MODELS, RECORDS, X-RAYS, RATIONALE AND PHOTOGRAPHS FOR DENTAL DIRECTOR REVIEW. ALL ORTHODONTIC PROCEDURES REQUIRE PRE-AUTHORIZATION.

For further information regarding orthodontic services, please refer to the Orthodontic Services and the Criteria for Severe Handicapping Malocclusion form in the Forms section of this manual.

Prior authorization requests may be submitted electronically at https://portal.mcna.net/ or mailed to our office at:

MCNA
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

Faxed authorization requests or authorization requests submitted through a clearinghouse will not be accepted.

To support MCNA's ongoing effort to "Go Green," providers registered on our web portal will only receive determination notices for authorizations through the web portal.

Services That Require a PreAuthorization

D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS (COVERED ONLY FOR PREGNANT WOMEN)
D5913	NASAL PROSTHESIS*
D5914	AURICULAR PROSTHESIS*
D5919	FACIAL PROSTHESIS*
D5931	OBTURATOR PROSTHESIS, SURGICAL
D5932	OBTURATOR PROSTHESIS, DEFINITIVE
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE*
D5952	SPEECH AID PROSTHESIS, PEDIATRIC*
D5953	SPEECH AID PROSTHESIS, ADULT*
D5954	PALATAL AUGMENTATION PROSTHESIS*
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE*
D5988	SURGICAL SPLINT*
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT*
D7140	SIMPLE EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT- THIRD MOLARS ONLY
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH – FOR PRIMARY TEETH AND THIRD MOLARS
D7220	REMOVAL OF IMPACTED TOOTH, SOFT TISSUE – PRIMARY TEETH AND THIRD MOLARS
D7230	REMOVAL OF IMPACTED TOOTH, PARTIAL BONE – PRIMARY TEETH AND THIRD MOLARS
D7240	REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY – PRIMARY TEETH AND THIRD MOLARS
D7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY WITH UNUSUAL SURGICAL COMPLICATIONS – PRIMARY TEETH AND THIRD MOLARS
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION (REQUIRES STUDY MODELS)
D8210	REMOVABLE APPLIANCE THERAPY (REQUIRES STUDY MODELS)
D8220	FIXED APPLIANCE THERAPY (REQUIRES STUDY MODELS)
D8660	PRE-ORTHODONTIC TREATMENT VISIT (REQUIRES STUDY MODELS)

D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S)
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT (REQUIRES STUDY MODELS)

*Procedures limited to Kentucky Board Certified Prosthodontist.

MCNA requires a preauthorization for the following dental procedures: D7210, D7220, D7230, D7240 and D7241 when reported on tooth letters A through T or AS through TS. Additionally, MCNA requires a preauthorization on all extractions of tooth numbers 1, 16, 17 and 32.

All EPSDT procedures require submission of the preauthorization form, X-rays, rationale and/or charting prior to treatment. The preauthorization form must be completed and sent to MCNA or submitted online.

A completed preauthorization Form is valid for three months or 90 days from the date of the authorization. In certain circumstances, a specific expiration date may be given.

Non-Emergency Treatment Authorization

Services should not begin before authorization has been received for non-emergency care. If treatment is provided prior to determination of coverage the provider does so at his/her own financial risk. The provider will be financially responsible and cannot balance bill the member if coverage is denied.

The provider should complete and submit the Preauthorization Form along with related X-rays, narratives or other supporting documentation as requested by MCNA. For electronic submissions the supporting documentation needed, including X-rays, must be included electronically. The preauthorization form can be found in the Forms section of this manual and on Humana – CareSource's website at https://providerportal.caresource.com/KY/ or the MCNA website at: https://portal.mcna.net/

Upon receipt of the Preauthorization Form, the UM staff date stamps the form and verifies the member's eligibility and benefits as well as the dentist's and dental specialist's network affiliation. Additional information may be requested and collected from the dentist's office as necessary.

Once a determination has been made, the UM staff will mail the Preauthorization Form to the dentist with the authorization decision. There will be an authorization number assigned for service and this number must be submitted with the claim after services are rendered.

Emergency Treatment Authorization

Humana – CareSource ensures that members have access to emergency care, without prior authorization, and to services and treatment as provided through the state agreement and defined in federal and state regulations. Humana – CareSource ensures that members have the right to access emergency dental care services, consistent with the need for such services.

Should you need to refer a member on an emergency basis please contact MCNA at **1-877-375-6262** for assistance with coordination of the member's care.

Authorization prior to emergency treatment may not be possible. In those instances the provider is required to submit the same documentation with the claim post-treatment as is needed in the submission of a request for prior authorization. Claims submitted without this documentation will be denied.

EPSDT

Early Periodic Screening, Diagnosis and Treatment Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program developed to ensure that the Medicaid population younger than the age of 21 is monitored for preventable and treatable conditions. Only EPSDT certified dental providers can submit EPSDT dental procedures.

Authorization Requirements for EPSDT

All EPSDT Special Services require preauthorization by MCNA. Indicate "EPSDT" on the preauthorization form and submit with X-rays and/or charting to MCNA. Requests for preauthorization must be made on an ADA form with supporting documentation explaining the rationale for treatment. Requests for EPSDT preauthorization may be submitted electronically to https://portal.mcna.net/ or mailed to our office at:

MCNA
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

All preauthorization and claims for EPSDT services must be submitted separately from non-EPSDT services on a separate ADA claim form. Please indicate on claims EPSDT services to ensure processing.

How to Become an EPSDT Provider

If providers are already enrolled in the Medicaid program and want also to become an EPSDT Special Services provider, they must complete the one page EPSDT Special Services Short Form (MAP-814).

For more information, please visit http://chfs.ky.gov/dms/epsdt.htm

For questions on enrollment, requirements or claims, please contact Provider Services at 1-855-852-7005 or visit the website http://chfs.ky.gov/dms/epsdt.htm.

Should you have any questions regarding this process, please contact Humana – CareSource's Provider Relations at 1-855-852-7005.

Denials

An authorization request for a service may be denied for failure to meet guidelines, protocols, dental policies or failure to follow administrative procedures outlined in the Provider Contract or this Provider Manual.

Medical-Necessity Denials

Utilization Management utilizes dental policies, protocols, and industry standard guidelines to render review decisions. Requests not meeting the guidelines, protocols, or policies are referred to a Chief Dental Director for clinical review. MCNA's Clinical Reviewers render all denial decisions. The Chief Dental Director is available to discuss any decision rendered with the attending dental provider. To speak with the Chief Dental Director, please contact Utilization Management department at 1-877-375-6262.

XII. TREATMENT

Use of Specialists

Members have direct access to dental specialists. A referral is not necessary.

Second Opinion

The dentist should discuss all aspects of the patient's treatment plan prior to beginning treatment. Make sure all of member's concerns and questions are answered. If the patient indicates she/he would like a second opinion, inform the member they may do so and that Humana – CareSource will cover the cost of a second opinion if they see a dentist within the MCNA network of participating dentists. The dentist must provide copies of the chart, radiographs and any other information to the dentist performing the second opinion upon request.

Preventive Treatment

Patients should be encouraged to return for a recall visit as frequently as indicated by his/her individual oral status and within plan time parameters. It is important that each dental office has a recall procedure in place. The following should be accomplished at each recall visit:

- Update medical history
- Review of oral hygiene practices and necessary instruction provided
- Complete prophylaxis and periodontal maintenance procedures
- Topical application of fluoride if indicated
- Sealant application if indicated

Below are the American Academy of Pediatric Dentistry's recommendations for treatment of pediatric members by age.

Periodicity and Anticipatory Guidance Recommendations
Dental Health Guidelines – Ages 0-18 Years
Recommendations for Preventive Pediatric Dental Care
(AAPD Reference Manual 2002-2003)

(AAPD/ADA/AAP guidelines) Periodicity Recommendations					
Age (1)	Infancy 6-12 Months	Late infancy 12-24 Months	Preschool 2-6 Years	School Aged 6-12 years	Adolescence 12-18 Years
Oral Hygiene counseling (2)	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Patient
Injury, Prevention Counseling (3)	X	X	X	X	X
Dietary counseling (4)	X	X	X	X	X
Counseling for non-nutritive habits (5)	X	X	X	X	X
Fluoride Supplementation (6,7)	X	X	X	X	X
Assess oral growth and development (8)	X	X	X	X	X
Clinical oral exam	X	X	X	X	X
Prophylaxis and topical fluoride treatment (9)	X	X	X	X	
Radiographic assessment (10)		X	X	X	
Pit and Fissure Sealants		If indicated on primary molars	First permanent molars as soon as possible after eruption	Second permanent molars and appropriate premolars as soon as possible after eruption	
Treatment of dental disease	X	X	X	X	X
Assessment and treatment of developing malocclusion		X	X	X	
Substance abuse counseling			X	X	
Assessment and/or removal of third molars			X		
Referral for regular periodic dental care			X		
Anticipatory guidance (11)	X	X	X	X	X

Decision Making Criteria

MCNA follows the generally accepted dental standards of the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org)

The procedure codes used by MCNA are described in the American Dental Association's Code Manual. Requests for documentation of these codes are determined by community accepted dental standards for authorization such as treatment plans, narratives, radiographs and periodontal charting. As appropriate, the State will define the requirements for dental procedures.

These criteria are approved and annually reviewed by MCNA's Dental Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute.

The criteria are changed and enhanced as needed. MCNA appreciates your input regarding the criteria used for decision making. Please contact MCNA at **1-877-375-6262** to comment or make suggestions. MCNA also complies with the Center for Medicare and Medicaid Services (CMS) national coverage decisions and written decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered. A copy of the criteria is available to providers upon request to MCNA at **1-877-375-6262.**

Guidelines for Chronic Dental Conditions

The Clinical Practice Guidelines are based on the enrolled membership and dictates the provision of acute and chronic dental care services to assist dentists and members in making appropriate dental care decisions to improve quality of care. Practice Guidelines are developed based on the following criteria:

- Reasonable, sound, scientific medical evidence
- Prevalence of dental conditions
- Extent of variation present in current clinical practice patterns
- Magnitude of quality of care issues based on existing patterns of clinical practice
- Ability to impact on practice patterns
- Consider the needs of the members
- Strength of evidence to support best clinical practice management strategies
- Ability to achieve consensus on optional strategy

MCNA has adopted the American Academy of Pediatric Dentistry (AAPD) Policy on Use of Fluoride and the Policy on Early Childhood Caries (ECC); Classifications, Consequences and Preventive Strategies (www.aapd.org).

XIII. NETWORK

Participating Dentist Criteria

The Dentist Criteria lists a variety of requirements that the participating Dentist must meet. These requirements include standards regarding your office's physical attributes, practice coverage, patient access, office procedures, office records, insurance and professional qualifications and work history. These criteria are used in our credentialing and re-credentialing process and are attached to the current MCNA provider agreements. The criteria shall apply to each applicant for participation and to dentists participating with MCNA and shall be enforced by MCNA as required by Medicaid.

Applicability

A. The dentist must satisfactorily document evidence meeting the criteria listed for at least six months prior to application unless the applicant has entered clinical practice or completed a residency or a fellowship program within the past six months or unless the dentist is a current participant with the MCNA network.

B. Each participating dentist must continue to meet the defined Dentist Criteria while participating in MCNA.

C. All MCNA participating dentists in a group practice must meet MCNA credentialing criteria. If all of the dentists in the group do not meet the criteria, the group cannot participate.

D. To participate in the Medicaid program, the dentist must be credentialed, must execute a Provider Agreement with <who the agreement is with> and agree to provide services to Medicaid members of MCNA.

E. All dental providers are re-credentialed every three years.

On-Site Office Survey

The office site survey has two components; a prospective survey for new or applying offices, and ongoing for participating offices. Each review highlights essential areas of office management and dental care delivery. During the site survey (which may or may not be scheduled), the following areas will be evaluated:

A. General Information – The name of the practice, address, name of principal owner and associates, license numbers, staffing information, office hours, list of foreign languages spoken in the office, availability of appointments and method of providing 24 hour

coverage (e.g., answering machine answering services, etc.), the name of the covering dentist when the office is closed or on vacation.

B. Practice History – The office provides information regarding malpractice suites, settlements and disciplinary actions, if applicable.

C. Office Profile – Indicates services they routinely perform.

D. Facility Information – Includes location, accessibility (including handicap accessibility), a description of the interior office such as the reception area, operatories and lab, type of infection control, radiographic equipment and other equipment.

E. Risk Management – Includes review of personal protective equipment (such as gloves, masks, handling of waste disposal, sterilization and disinfection methods), training programs for staff, radiographic procedures and safety, occupational hazard control (regarding amalgam, nitrous oxide and hazardous chemicals), medical emergency preparedness training and equipment.

F. Recall System – Includes review of procedures for assuring patients are scheduled for recall examinations and follow-up treatment.

G. Verification that all MCNA participating dental providers in a group practice are credentialed by MCNA.

Credentialing/Re-Credentialing

Credentialing is the review of qualifications and other relevant information pertaining to a dental care professional who seeks acceptance into MCNA's provider network. The Credentialing Program follows the recommended CMS categories, which include:

- Initial Credentialing – Written application; verification of information from primary and secondary sources; confirmation of eligibility for payment under Medicare and/or Medicaid, if applicable, and site visits as appropriate.
- Monitoring – Includes monitoring of lists of practitioners who have been sanctioned and/or had grievances filed against them and of practitioners who opt-out of accepting federal reimbursement from Medicare and/or Medicaid. Monitoring is done on a regular basis between credentialing and re-credentialing cycles.
- Re-credentialing – Re-evaluation of provider's credentials at least every three years through a process that updates information obtained in initial credentialing, considers performance indicators such as those collected through the QM program, the utilization management system, the grievance system, enrollee satisfaction surveys and other activities of the organization.

Confirmation of eligibility for payment under Medicaid is verified against the DMS provided MCO network file for all currently active Medicaid providers as determined by DMS. The Credentialing Program requires all providers with a MAID number to complete the Dental Credentialing Form and the MAP 347 form.

All original documents must be mailed to:

MCNA
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

For providers applying for a MAID number, MCNA requires a completed MAP 811 Individual with Addendum E and the MAP 347 forms. For groups applying for a new MAID number, MCNA requires a completed MAP 811 Non Credentialed and MAP 347 forms. Additionally, MCNA will:

- Verify Kentucky license through appropriate licensing agency
- Review federal and state sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and State Medicaid Agencies)
- Review monthly reports released by the Office of Inspector General and local Medicaid Agencies to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid

All providers are required to complete the Dental Credentialing Form.

The Credentialing Program establishes the selection criteria for qualification as a participating provider. The criteria are clearly outlined in the credentialing application and is reviewed and approved by the Credentialing Committee.

Additionally, current copies of the following documents must be attached for Initial Credentialing as well as for Re-Credentialing. These documents are required as components of the selection criteria and will be verified with Primary and Secondary Sources:

- Kentucky Dental License
- Medicare/Medicaid (CMS) Provider Number
- Controlled Substance Registration Certificate from the Drug Enforcement State (DEA)
- Professional Liability Insurance Face Sheet
- Curriculum Vitae
- Dental School Diploma
- Board Certificate or Evidence of adequate training
- Completed W-9 Form
- Signed Provider Agreement/Contract
- Signed Provider Application

It is the provider's responsibility to submit renewal certification documentation or changes in information to MCNA within 10 business days of any change.

Credentialing Committee Appeals

In the event an applicant is credentialed with restrictions or denied, the Credentialing Committee offers an opportunity to appeal.

An appeal must be requested in writing and must be reviewed by the Committee within 30 days of the date the Committee gave notice of its decision.

A copy of MCNA's credentialing policies can be obtained by contacting the Credentialing Department at 1-877-375-6262.

Peer Review Committee

Peer review of professional competency or conduct may result in a proposed adverse action for "medical disciplinary cause or reason" affecting a provider's continued participation with MCNA.

A "medical disciplinary cause or reason" means an aspect of a provider's competence or professional conduct that is reasonably likely to be detrimental to the delivery of patient care. The Chief Dental Director may immediately initiate corrective action against a provider for identified medical disciplinary cause, or other reasons where the Dental Director reasonably believes that the failure to take such action may result in imminent danger to the health of any individual.

MCNA's Peer Review Committee meets as necessary to objectively and methodically assess, evaluate and resolve issues related to the quality and appropriateness of care, safety and service and determines appropriate actions to be taken relating to a contracted participating provider's professional competency or conduct and quality of care issues. The Peer Review Committee also monitors the results of the improvement strategy that is implemented and ensures appropriate re-evaluation.

The Committee consists of at least three qualified dentists, one of whom (at a minimum) must be a participating provider who is not otherwise involved in network management and/or who is a clinical peer of the participating provider in question.

The Peer Review Committee convenes and makes a decision to either suspend or terminate the provider from participating. The provider is notified of the Committee's decision as it is related to a quality of care and competency issues or professional conduct via certified letter is sent within

three calendar days of the meeting.

XIV. OFFICE POLICIES AND PROCEDURES

Office Standards

Each Dentist's office must:

A. Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.
B. Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
C. Be accessible to all patients, including but not limited to its entrance, parking and bathroom facilities.
D. Have offices that are clean, presentable and have a professional appearance.
E. Be a non-smoking facility and have a no-smoking sign prominently displayed in the waiting room.
F. Have clean and properly equipped patient toilet and hand washing facilities.
G. Have a waiting room that will accommodate at least four patients.
H. Have treatment rooms that are clean, properly equipped and contain functional, adequately supplied hand-washing facilities.
I. Have at least one staff person (in addition to the Dentist) on duty during normal office hours.
J. Provide a copy of current licenses and certificates for all dentists, dental hygienists and other non-dentist dental professionals practicing in the office, including state professional licenses and certificates, Federal Drug Enforcement and State Controlled Drug Substance licenses and certification (where applicable).
K. Keep a file and make available to Humana – CareSource and MCNA state-required practices and protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in the office.
L. Have appropriate, safe X-ray equipment. Radiation protection devices, including, without limitation, lead aprons shall be available and used according to professionally recognized guidelines (e.g., Food and Drug Administration) and appropriately visible signs warning pregnant women of potential exposure.

M. Use appropriate sterilization procedures for instruments; use gloves and disposable needles; maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state and local laws and regulations including, but not limited to, those mandated by OSHA and as advocated by the American Dental Association (ADA) and state and local societies.
N. Comply with all applicable federal, state and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.
O. Make appointments in an appointment book (or an electronic equivalent acceptable to MCNA). Appointments should be made in a manner that will prevent undue patient waiting time and in compliance with the access criteria listed in this manual.
P. Have documented emergency procedures, including procedures addressing treatment, evacuation and transportation plans to provide for the safety of members.
Q. Upon request provide patients with a copy of their rights and responsibilities as listed in the manual.
R. Provide translation assistance service available to patients whose native language is different from English.
S. Have a functional recall system in place for notifying members of the need to schedule dental appointments. The recall system must include the following requirements for all enrolled members:
    a. The system must include either written or verbal notification.
    b. The system must have procedures for scheduling and notifying members of routine checkups, follow-up appointments and cleaning appointments.
    c. The system must have procedures for the follow up and rescheduling of missed appointments.

Humana – CareSource and MCNA encourage its providers to make efforts to decrease the number of “no shows.” It is suggested the provider contact the member prior to the appointment either by phone or in writing to remind them of the time and place of the appointment. Follow-up phone calls or written information should be provided encouraging the member to reschedule the appointment in the event the appointment is missed.

Sterilization and Infection Control

Patient and staff members must be protected from infectious and environmental contaminants.

OSHA requirements:

A. All personnel should wash with bacterial soap before all oral procedures.
B. OSHA approved clean gloves should be worn.
C. All instruments should be thoroughly scrubbed and debrided before sterilization.
D. All instruments and equipment that cannot be sterilized, including operating light chair switches, hand pieces, cabinet working surfaces and water/air syringes and their tips should be disinfected using approved techniques after each use.
E. ADA approved sterilization solutions should be utilized.
F. All equipment should be monitored using process indicators with each load and spore testing on a weekly basis.
G. Handling of all environmental waste, including the disposal of waste and solutions, must be in compliance with all applicable federal, state and local laws and regulations.

Medical Emergencies

All office staff shall be prepared to deal with medical emergencies through the implementation of the following guidelines:

A. The dentist and at least one other staff member must have current CPR training.
B. The dental office must have a formal medical emergency plan and staff members must understand their individual responsibilities. All emergency numbers must be posted.
C. Patients with medical risk shall be identified in advance.
D. All dental offices must have a portable source of oxygen with a positive demand valve, blood pressure cuff and stethoscope.

Dental Records Standards

Humana – CareSource and MCNA dentists must ensure that dental records are maintained for each member enrolled. The record shall include the quality, quantity, appropriateness and timeliness of services performed as follows.

The following dental record standards must be included/followed in each member's records as appropriate:

A. Significant illness and medical conditions indicated on the problem list.
B. Relevant psychological and social conditions, mental/behavioral health and substance abuse history documented.
C. Medication allergies and adverse reactions prominently noted in the medical record (i.e., NKA and NKDA).
D. Documentation of a medication list and/or prescribed therapies.
E. Medication strength, dose, amount and number of refills documented.
F. Documentation that the member was given directions on how to use medication(s).
G. Documentation of written denials for service and the reason for the denial(s).
H. Dental history easily identified and includes serious accidents, operations and illnesses.
I. All entries must indicate the chief complaint or purpose of the visit, the objective findings of the practitioner, diagnosis and proposed treatment.
J. Documentation of working diagnoses consistent with clinical findings.
K. Documentation for treatment plans consistent with diagnoses.
L. Documentation for encounter forms or treatment notes have a notation, when indicated, regarding follow-up care, calls or visits with times of return noted in weeks, months or as needed.
M. Unresolved problems from previous office visits, referrals, diagnostic testing and status of preventive dental screenings addressed in subsequent visits.
N. Consent forms maintained in the dental record.
O. Documentation of requested consultation and the date, time and consultant notes included in the record.
P. If a consultation is requested, evidence of review for over or under utilization.
Q. Documentation for labs and/or other studies that were ordered as appropriate.

R. Consults and/or imaging reports reviewed and initialed by the ordering dental provider documented.

S. Progress notes, lab results, X-ray/imaging studies, hospital records (i.e., ER reports and discharge summaries), physical therapy reports, etc., included in the record if applicable.

T. Documentation to reflect follow-up care post-emergency for indicated emergency services.

U. Evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.

V. Evidence of member identification information, with each page reflecting the member's name or identification.

W. One-time identification of personal/biographical data, including social security number, date of birth, age, gender, marital status, home and work telephone number, home and work address, mailing address (if different from home), school/employer name and emergency contact's name and telephone number (if no phone contact name and number were provided).

X. Documentation of the parent, caregiver or guardian if the member is less than 18 years of age.

Y. One-time identification of race, ethnicity and language spoken.

Z. Entries signed by the provider by first and last name credentials. (Note: Electronic signature is acceptable.)

AA. Entry date on entries.

BB. Evidence of reportable diseases and conditions and if it was reported to the local Department for Public Health.

CC. Documentation of whether the member executed an advance medical directive if the member is 18 years of age and older.

DD. Identification and history of nicotine, alcohol use or substance abuse if the member is 12 years of age or older.

EE. Dental record documentation should be maintained in detail and is legible to persons besides the writer of the documentation.

Record Content and Format

Dental charts must include the following components:

A. General patient information, medical history, and periodic updates
B. Permanent display of all medical alerts and allergies, along with names and phone numbers of related health care professionals
C. Documentation of all healthcare professionals that have been contacted, along with comments or recommendations from these providers
D. Dental history, existing restorations
E. Clinical examination including head, neck, oral cancer screening and TMJ examination
F. Radiographs
G. Diagnosis
H. Treatment plan(s) and where applicable, alternate treatment plan(s)
I. Dated and signed consent form
J. Referral information, along with reason for referral
K. Progress note
L. Anesthesia/analgesia notations
M. Termination, completion or discharge notes
N. Patient comments/dissatisfaction

Access to Dental Records

As a Humana – CareSource and MCNA contracted dentist, you are required to ensure that an accurate and complete patient dental record is established and maintained and allow Humana – CareSource and MCNA's authorized personnel, its designated representatives, review organizations and government agencies on site access to such records during regular business hours. If requested, you must provide Humana – CareSource and MCNA with all information required under the Participating Provider Agreement, including but not limited to records, reports and other information related to your performance of obligations under the agreement, according to timelines, definitions, formats and instructions specified by Humana –CareSource and MCNA. In addition, you are required to provide the following entities or their designees with prompt, reasonable, and adequate access to the Participating Provider Agreement and any

records, books, documents, and papers that are related to the agreement and/or your performance of responsibilities under the agreement:

- MCNA authorized personnel
- Commonwealth and/or Federal regulatory agencies
- Humana - CareSource authorized personnel

You must also provide access to the location or facility where such records, books, documents and papers are maintained and you must provide reasonable comfort, furnishings, equipment and other conveniences necessary to fulfill any of the following described purposes:

- Audits and investigations;
- Contract administration;
- The making of copies, excerpts, or transcripts: and
- All other purposes Humana – CareSource and MCNA deems necessary for contract enforcement or to perform our regulatory functions.

XV. DENTAL CARE SERVICES

Code	Description	Age Limitation	Benefit Limits
D0140	Limited oral evaluation - problem focused	All	Not reimbursable on the same day as D0150. Trauma related injuries only. May only be billed in conjunction with D0220, D0230, D0270, D0272, D0274, D0330, D2330, D2331, D2332, D2335, D7140, D7130, D7210, D7250, D7530, D7910 and D9240.
D0150	Comprehensive oral evaluation - new or established patient	All	Coverage for a comprehensive oral evaluation shall be limited to one per twelve month period, per recipient, per provider. A second comprehensive oral evaluation is allowed six months after the initial evaluation if the evaluation is provided in conjunction with a prophylaxis to an individual less than twenty one years of age. A comprehensive oral evaluation shall not be covered in conjunction with the following: 1. A limited oral evaluation for trauma related injuries; 2. Space maintainers; 3. Root canal therapy; 4. Denture relining; 5. Transitional appliances; 6. A prosthodontic service; 7. Temporomandibular joint therapy; 8. An orthodontic service; 9. Palliative treatment; or 10. Hospital call.
D0210	Intraoral - complete series (including bitewings)	All	One per patient per dentist or dental group every 12 months.
D0220	Intraoral - periapical first film	All	Not to be billed in the same 12 months as a D0210. Total of 14 (D0220 and D0230) per patient per dentist or dental group every 12 months.
D0230	Intraoral - periapical each additional film	All	Not to be billed in the same 12 months as a D0210. Total of 14 (D0220 and D0230) per patient per dentist or dental group every 12 months.

D0270	Bitewing - single film	All	Total of four bitewing x-rays per patient per dentist or dental group every 12 months. Not to be billed in the same 12 months as a D0210.
D0272	Bitewings - two films	All	Total of four bitewing x-rays per patient per dentist or dental group every 12 months. Not to be billed in the same 12 months as a D0210.
D0274	Bitewings - four films	All	Total of four bitewing x-rays per patient per dentist or dental group every 12 months. Not to be billed in the same 12 months as a D0210.
D0330	Panoramic film	All	One per patient per dentist or dental group every 24 months. Part of D8660 for orthodontic patients. Preauthorization required for ages 0 - 5.
D0340	Cephalometric X-ray	0-20	One per patient per dentist or dental group every 24 months. Part of D8660 for orthodontic patients. Authorization required for ages 0 - 5.
D1110	Prophylaxis – 21 and over	21 and older	One per 12 months.
D1110	Prophylaxis – 14 through 20	14-20	Two per 12 months.
D1120	Prophylaxis – 13 and under	0-13	Two per 12 months.
D1203	Topical application of fluoride (including prophylaxis) - child	0 - 20	Two per 12 months. Fluoride must be applied separately from prophylaxis paste.
D1351	Sealant - per tooth	5 - 20	One per 48 months. Maximum of three times. Covered on occlusal surfaces on first or second permanent molars only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Repair, replacement, or reapplication of the sealant within the four-year period is the responsibility of the dentist.
D1510	Space maintainer - fixed - unilateral	0 - 20	Limit of two (D1510, D1515, D1520 or D1525) per 12 months.
D1515	Space maintainer - fixed - bilateral	0 - 20	Limit of two (D1510, D1515, D1520 or D1525) per 12 months.
D1520	Space maintainer – removable – unilateral	0 - 20	Limit of two (D1510, D1515, D1520 or D1525) per 12 months.

D1525	Space maintainer - removable – bilateral	0 - 20	Limit of two (D1510, D1515, D1520 or D1525) per 12 months.
D2140	Amalgam - one surface, primary or permanent	All	Limited to once per 12 months on the same tooth and surfaces.
D2150	Amalgam - two surfaces, primary or permanent	All	Limited to once per 12 months on the same tooth and surfaces.
D2160	Amalgam - three surfaces, primary or permanent	All	Limited to once per 12 months on the same tooth and surfaces.
D2161	Amalgam - four or more surfaces, primary or permanent	All	Limited to once per 12 months on the same tooth and surfaces.
D2330	Resin-based composite - one surface, anterior	All	Limited to once per 12 months on the same tooth and surfaces.
D2331	Resin-based composite - two surfaces, anterior	All	Limited to once per 12 months on the same tooth and surfaces.
D2332	Resin-based composite - three surfaces, anterior	All	Limited to once per 12 months on the same tooth and surfaces.
D2335	Resin-based composite - four surfaces, anterior	All	Limited to once per 12 months on the same tooth and surfaces.
D2391	Resin-based composite - one surface, posterior	All	Limited to once per 12 months on the same tooth and surfaces.
D2392	Resin-based composite - two surfaces posterior	All	Limited to once per 12 months on the same tooth and surfaces.
D2393	Resin-based composite - three surfaces, posterior	All	Limited to once per 12 months on the same tooth and surfaces.
D2394	Resin-based composite - four or more surfaces, posterior	All	Limited to once per 12 months on the same tooth and surfaces.
D2930	Prefabricated stainless steel crown - primary tooth	0 - 20	
D2931	Prefabricated stainless steel crown - permanent tooth	0 - 20	
D2932	Prefabricated resin crown	0 - 20	

D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	0 - 20	Limited to anterior primary teeth
D2951	Pin retention - per tooth, in addition to restoration	0 - 20	Limited to permanent molars; used in conjunction with D2160, D2161, D2931, or D2932. Lifetime maximum of two per molar. Limit of one per tooth per date of service.
D3110	Pulp cap - direct (excluding final restoration)	0 - 20	No Authorization required. Must send preoperative X-rays.
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0 - 20	Shall not be billed in conjunction with D3310, D3320, or D3330 on the same day.
D3310	Root canal - anterior (excluding final restoration)	0 - 20	Once per tooth per lifetime. Please submit preoperative and postoperative x-rays when submitting a claim for this procedure. Preauthorization is required if three or more root canal procedures are scheduled within six months.
D3320	Root canal - bicuspid (excluding final restoration)	0 - 20	Once per tooth per lifetime. Please submit preoperative and postoperative x-rays when submitting a claim for this procedure. Preauthorization is required if three or more root canal procedures are scheduled within six months.
D3330	Root canal - molar (excluding final restoration)	0 - 20	Once per tooth per lifetime. Please submit preoperative and postoperative x-rays when submitting a claim for this procedure. Preauthorization is required if three or more root canal procedures are scheduled within six months.
D3410	Apicoectomy/periradicular surgery - anterior	All	Once per lifetime. Preauthorization requires X-rays and a narrative.

D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	All	Once per lifetime. Preauthorization requires X-rays and a narrative.
D3425	Apicoectomy/periradicular surgery - molar (first root)	All	Once per lifetime. Preauthorization requires X-rays and a narrative.
D3426	Apicoectomy/periradicular surgery (each additional root)	All	Once per lifetime. Preauthorization requires X-rays and a narrative.
D4210	Gingivectomy/gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	All	One per 12 months. A minimum of four teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes. Preauthorization requires X–rays, perio-charting, narrative attached and intraoral pictures.
D4211	Gingivectomy/gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	All	One per 12 months. One to three teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes. Preauthorization requires x-rays, perio-charting, narrative attached and intraoral pictures
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	All	One per 12 months. A minimum of three teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1201. One per three months for patients diagnosed with AIDS. Preauthorization requires perio-charting, narrative attached and intraoral pictures.
D4355	Full mouth debridement	All	Covered for pregnant women only. One per pregnancy. Preauthorization requires perio-charting
D5520	Replace missing or broken teeth - complete denture (each tooth)	0 - 20	One per 12 months per denture per patient.
D5610	Repair resin denture base	0 - 20	Three per 12 months per patient.
D5620	Repair cast framework	0 - 20	Three per 12 months per patient.
D5640	Replace broken teeth - per tooth	0 - 20	One per 12 months per patient per dentist.

D5750	Reline complete maxillary denture (laboratory)	0 - 20	One per 12 months per denture per patient. Not covered within six months of placement.
D5751	Reline complete mandibular denture (laboratory)	0 - 20	One per 12 months per denture per patient. Not covered within six months of placement.
D5820	Interim partial denture (maxillary)	0 - 20	One per 12 months per patient.
D5821	Interim partial denture (mandibular)	0 - 20	One per 12 months per patient.
D5913	Nasal prosthesis	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5914	Auricular prosthesis	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5919	Facial prosthesis	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5931	Obturator prosthesis, surgical	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5932	Obturator prosthesis, definitive	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5934	Mandibular resection prosthesis with guide flange	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5952	Speech aid prosthesis, pediatric	0 - 13	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5953	Speech aid prosthesis, adult	14 - 20	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5954	Palatal augmentation prosthesis	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5955	Palatal lift prosthesis, definitive	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5988	Surgical splint	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D5999	Unspecified maxillofacial prosthesis, by report	All	Covered for Prosthodontists only. Preauthorization and X-rays required.
D7111	Extraction, coronal remnants - deciduous tooth	All	

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	All	Preauthorization narrative and X-rays required for third molars.
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	All	Includes cutting of gingiva and bone, removal of tooth structure and closure. Preauthorization and X-rays required on primary teeth and third molars.
D7220	Removal of impacted tooth - soft tissue	All	Preauthorization and X-rays required on primary teeth and third molars.
D7230	Removal of impacted tooth - partially bone	All	Preauthorization and X-rays required on primary teeth and third molars.
D7240	Removal of impacted tooth - completely bony	All	Preauthorization and X-rays required on primary teeth and third molars.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	All	Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position. Preauthorization and X-rays required on primary teeth and third molars.
D7250	Surgical removal of residual roots (cutting procedure)	All	Will not be paid to the dentists or group that removed the tooth.
D7260	Oroantral fistula closure	All	
D7280	Surgical access of unerupted tooth	0 - 20	
D7310	Alveoloplasty in conjunction with extractions - per quadrant	All	Once per lifetime. Minimum of three extractions in the affected quadrant. Usually in preparation for a prosthesis. **An Oral Surgeon cannot render this service. Oral Surgeons must submit claims under medical benefits.**
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	All	Once per lifetime. No extractions performed in an edentulous area. **An Oral Surgeon cannot render this service. Oral Surgeons must submit claims under medical benefits.**
D7410	Excision of benign lesion up to 1.25 cm	All	
D7472	Destruction of torus platinus	All	Once per lifetime.

D7473	Removal of torus mandibularis	All	Once per lifetime.
D7510	Incision and drainage of abscess - intraoral soft tissue	All	
D7520	Incision and drainage of abscess - extraoral soft tissue	All	
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	All	Shall not pertain to removal of sutures or teeth.
D7880	Occlusal orthotic device, by report	0 - 20	Once per lifetime.
D7910	Suture of recent small wounds up to 5.0 cm	All	Shall not be billed in conjunction with any other surgical procedure. It shall not pertain to repair of surgically induced wounds.
D7960	Frenulectomy - (frenectomy or frenotomy) - separate procedure	All	Once per lifetime. Limited to one per date of service. Preauthorization intraoral pictures and X-rays required.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	0 - 20	Initial Payment
D8210	Removable appliance therapy	0 - 20	This appliance is not to be used to control harmful habits. Limit of two (D8210, or D8220) per 12 months.
D8220	Fixed appliance therapy	0 - 20	This appliance is not to be used to control harmful habits. Limit of two (D8210, or D8220) per 12 months.
D8660	Preorthodontic treatment visit	0 - 20	Used to pay for records. Final records will be paid only if member is age 20 and under and still eligible for benefits on date of service. Member cannot be billed for final records. Requires preauthorization, all models, X-rays, wax bites, treatment plan must be submitted. $112 total, $56 for denied orthodontic services.

D8680	Orthodontic retention (removal of appliances, constructions and placement of retainer(s))	0 - 20	Post treatment intraoral and extraoral facial frontal and profile pictures, copy of treatment card/notes with dates of service for all appointments, adjustments, repairs, oral hygiene, instructions given to the patient and efforts to reschedule missed appointments.
D8999	Unspecified orthodontic procedure, by report	0 - 20	Six month payment. Requires preauthorization, and chart notes of six **MONTHLY ADJUSTMENTS (MAP 559) after completed banding.**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	All	Not allowed with any other services other than radiographs. One per patient per dentist or dental group per date of service.
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	0 - 20	"This procedure code shall not be used for billing local anesthesia or nitrous oxide." (Kentucky State Dental Manual page 4.11).
D9420	Hospital call	All	No other procedures may be billed in conjunction with D9420. Not applicable for nursing home visits (D0150 or D9110). One per patient per dentist or dental group per date of service. Cannot bill conjunctively.

Services performed primarily for aesthetic purposes are not covered.

Orthodontic services are only covered when the patient's condition meets the commonwealth of Kentucky Medicaid Services Orthodontic Program Criteria for Severe Handicapping Malocclusion (907 KAR 1:026 Section 13). If this condition applies, please submit the preauthorization form with study models, wax bite (or electronic equivalent), records, X-rays, rationale, and orthodontic criteria form for dental director review. **All orthodontic procedures require preauthorization.**

No benefit is provided for the extraction of non-infected primary teeth when normal loss is imminent. This includes extraction of asymptomatic teeth, which show no signs of infection, including, but not limited to the removal of third molars and/or ortho-related procedures (all orthodontic procedures require preauthorization).

Humana – CareSource will pay for a full mouth series X-ray (D0210) once every 12 months. An alternate benefit of a full mouth series X-ray (D0210) will be applied when an office submits a combination of periapical and bitewing X-rays exceeding the reimbursable value of the full mouth series x-ray.

Please refer to 907 KAR 1:026 for Dental Service and 907 KAR 1:626 for Reimbursement of dental services or you may go to www.lrc.state.ky.us for more information.

XVI. ORTHODONTIC SERVICES

Members under the age of 21 may qualify for orthodontic care under the program. Members must have a severe, dysfunctional and handicapping malocclusion. Orthodontic services are only covered when the patient's condition meets the Commonwealth of Kentucky Medicaid services orthodontic program criteria for severe handicapping malocclusion (907 KAR 1:026 Section 13).

Since a case must be dysfunctional to be accepted for treatment, members whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is not usually dysfunctional in spite of aesthetic considerations.

All orthodontic services require prior authorization. Members should present with a fully erupted set of permanent teeth. At least 1/2 to 3/4 of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

Diagnostic study models (trimmed) with wax bites or the OrthoCad electronic equivalent, rationale, photographs and treatment plan must be submitted with the request for prior authorization of services along with the Criteria for Severe Handicapping Malocclusion Form located in the Forms section.

MCNA will not return Orthodontic models. We require you to make two sets of models and send us the duplicate set.

Treatment should not begin prior to receiving notification from Humana – CareSource indicating coverage or non-coverage 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 Humana – CareSource or the member and may face possible termination of their Provider agreement. Providers cannot bill prior to services being performed. Payment of record/exam (code D8660) will not be paid prior to the case being reviewed by the dental consultant.

General Billing Information for Orthodontics

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. Members must be eligible for coverage on the date of service. Members cannot be billed for final records.

To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:

- Electronically file or mail a copy of the completed ADA form with the date of service (banding date for code D8080 and D8660).
- For payment for the 6th adjustment, submit code D8999 with the date of service of the 6th adjustment. (Please submit MAP 559 form. If submission is made after one year, please include MAP 557 and narrative.)
- Submit code D8680 for retention when patient has been debanded. This closes the case, and there is **NO** payment as this was paid in advance in the comprehensive procedure.
- Payments for orthodontics (code D8080) include pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, one set of retainers, and 12 months of retainer adjustments.

The maximum case payment for orthodontic treatment will be one initial payment (D8080), initial and final records (D8660), one payment for the six periodic orthodontic treatment visits (D8999), and retention (D8680). Members may not be billed for broken, repaired or replacement of brackets or wires.

Once a case has been denied, you cannot resubmit for consideration until there has been a significant change in the patient's occlusion which would qualify the patient for treatment under one or more of the criteria established under Kentucky's Medicaid regulation 907 KAR 1:026 for disabling malocclusion.

Requirements for Procedure Code D8999

After six adjustments, when submitting for D8999, please include a copy of the treatment card/notes or Kentucky MAP Form 559 to substantiate you have adjusted the patient's braces a minimum of six times. In accordance with Kentucky's Medicaid regulation 907 KAR 1:026, the first six treatment visits must be performed within 12 months from the date of banding. If this scenario occurs, please indicate the rationale for performing the treatment visits after 12 months of the date of banding.

After debanding, when submitting for payment of D8680, the following documentation must accompany your claim:

- Post-treatment intraoral and extraoral facial frontal and profile pictures; and
- Copy of treatment card/notes with dates of service for all appointments for adjustments and repairs, oral hygiene, instructions given to the patient and efforts to reschedule missed appointments.

Every effort should be made to work with patients to make sure their oral hygiene care is sufficient before banding occurs. After banding, oral hygiene should be a top priority with added emphasis at every visit. Please refer patients to their primary care dental office for regular exams and restorative needs.

In the event you deem it necessary to dismiss a patient, please be aware that Humana – CareSource will recoup payment for the balance of treatment not performed. This will be done on a prorated basis.

Kentucky Orthodontic Service Coverage Limitations - 907 KAR 1:026 Section 13

1) Coverage of an orthodontic service shall:
   a) Be limited to a recipient under age twenty-one; and
   b) Require prior authorization.
2) The combination of space maintainers and appliance therapy shall be limited to two per twelve-month period, per recipient.
3) Space maintainers and appliance therapy shall not be covered in conjunction with comprehensive orthodontics.
4) The department shall only cover new orthodontic brackets or appliances.
5) An appliance for minor tooth guidance shall not be covered for the control of harmful habits.
6) In addition to the limitations specified in subsection (1) of this section, a comprehensive orthodontic service shall:
   a) Require a referral by a dentist; and
   b) Be limited to:
      i) The correction of a disabling malocclusion; or
      ii) Transitional or full permanent dentition unless for treatment of a cleft palate or severe facial anomaly.
7) A disabling malocclusion shall exist if a patient:
   a) Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors;
   b) Has a true anterior open bite that does not include:
      i) One or two teeth slightly out of occlusion; or
      ii) Where the incisors have not fully erupted;

c) Demonstrates a significant antero-posterior discrepancy (Class II or III malocclusion that is comparable to at least one full tooth Class II or III, dental or skeletal);

d) Has an anterior crossbite that involves:

i) More than two teeth in crossbite;

ii) Obvious gingival stripping; or

iii) Recession related to the crossbite;

e) Demonstrates handicapping posterior transverse discrepancies which:

i) May include several teeth, one of which shall be a molar; and

ii) Is handicapping in a function fashion as follows:

(1) Functional shift;

(2) Facial asymmetry;

(3) Complete buccal or lingual crossbite; or

(4) Speech concern;

f) Has a significant posterior open bite that does not involve:

i) Partially erupted teeth; or

ii) One or two teeth slightly out of occlusion;

g) Except for third molars, has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention;

h) Has extreme overjet in excess of eight to nine millimeters and one of the skeletal conditions specified in paragraphs (a) through (g) of this subsection;

i) Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures, and does not include simple loss of teeth with no other affects;

j) Has a congenital or developmental disorder giving rise to a handicapping malocclusion;

k) Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach; or

l) Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation.

8) Coverage of comprehensive orthodontic treatment shall not be inclusive of orthognathic surgery.

9) If comprehensive orthodontic treatment is discontinued prior to completion, the provider shall submit to the department:

a) A referral form, if applicable; and

b) A letter detailing:

i) Treatment provided, including dates of service;

ii) Current treatment status of the patient; and

iii) Charges for the treatment provided.

10) Remaining portions of comprehensive orthodontic treatment may be authorized for prorated coverage upon submission of the prior authorization requirements specified in Section 15(2) and (7) of this administrative regulation if treatment:

a) Is transferred to another provider; or

b) Began prior to Medicaid eligibility.

XVII. FEE SCHEDULES

Members 20 Years of Age and Younger

Diagnostic		
D0140	Limited oral evaluation	$33.00
D0150	Comprehensive oral evaluation	$26.00
D0210	Intraoral complete series	$63.70
D0220	Intraoral-periapical – first film	$10.40
D0230	Intraoral-periapical – each additional	$7.80
D0270	Bitewing – single film	$9.10
D0272	Bitewings -– two films	$18.20
D0274	Bitewings – four films	$29.90
D0330	Panoramic film	$39.00
D0340	Cephalometric x-ray	$61.10

Preventative		
D1110	Prophylaxis	$48.10
D1120	Prophylaxis-child	$48.10
D1203	Topical application of fluoride	$15.00
D1351	Sealant – per tooth	$19.50
D1510	Space maintainer – fixed-uni	$135.20
D1515	Space maintainer – fixed-bilateral	$262.60
D1520	Space maintainer – removable-uni	$134.00
D1525	Space maintainer – removable-bi	$202.00

Restorative		
D2140	Amalgam -– one surface	$49.40
D2150	Amalgam – two surfaces	$65.00
D2160	Amalgam – three surfaces	$76.70
D2161	Amalgam – four or more surfaces	$93.60
D2330	Composite – one surface, anterior	$57.20
D2331	Composite -– two surfaces, anterior	$71.50
D2332	Composite – three surfaces, anterior	$85.80
D2335	Composite – four or more surfaces, anterior	$101.40
D2391	Composite – one surface posterior	$57.20
D2392	Composite – two surface posterior	$71.50
D2393	Composite – three surface posterior	$85.80
D2394	Composite – four or more surfaces posterior	$101.40
D2930	Crown – prefab stainless steel	$119.60
D2931	Crown – prefab steel crown	$133.90
D2932	Crown – prefab resin	$113.10
D2934	Prefab esthetic coated SS CR-primary	$119.60
D2951	Pin retention – per tooth	$13.00

Endodontics		
D3110	Pulp cap – direct	$17.00
D3220	Pulpotomy	$67.60
D3310	Root canal – anterior	$274.30
D3320	Root canal – bicuspid	$344.50
D3330	Root canal – molar	$481.00
D3410	Apicoectomy – anterior	$201.50
D3421	Apicoectomy – bicuspid first root	$201.50
D3425	Apicoectomy – molar first root	$201.50
D3426	Apicoectomy – per tooth (each additional root)	$197.00

Periodontics		
D4210	Gingivectomy/oplasty – four or more teeth per quad	$336.70
D4211	Gingivectomy/oplasty – one to three teeth per quad	$135.20
D4341	Scaling and root planing – per quad	$101.40
D4355	Full mouth debridement (Pregnant Women Only)	$68.50

Prosthodontics, removable		
D5520	Replace missing/broken teeth – complete denture	$40.30
D5610	Repair – partial denture base	$61.10
D5620	Repair cast framework partial denture	$97.50
D5640	Replace broken teeth – per tooth/denture	$36.40
D5750	Reline – complete denture – max - lab	$128.70
D5751	Reline – complete denture – mand - lab	$128.70
D5820	Interim partial denture – max	$319.80
D5821	Interim partial denture – mand	$336.70
D5913	Nasal prosthesis *	$2,036.00
D5914	Auricular prosthesis *	$1,881.00
D5919	Facial prosthesis*	$3,408.00
D5931	Obturator (temporary)	$1,121.90
D5932	Obturator (permanent)	$1,992.00
D5934	Mandibular resection prosthesis *	$1,660.00
D5952	Speech aid-pediatric (13 and under) *	$2,036.00
D5953	Speech aid-adult (14 and over) *	$2,036.00
D5954	Palatal augmentation prosthesis *	$1,550.00
D5955	Palatal lift prosthesis *	$1,836.00
D5988	Oral surgical splint *	$896.00
D5999	Unlisted maxillofacial prosthetic proc *	B/R

*** Procedures limited to Kentucky Board Certified Prosthodontist.**

Oral Surgery		
D7111	Coronal remnants- primary tooth	$49.40
D7140	Extraction – erupted tooth or exposed root	$49.40
D7210	Extraction – surgical	$93.60
D7220	Impaction – soft tissue	$127.40
D7230	Impaction – partially bony	$179.40
D7240	Impaction – completely tooth	$215.80
D7241	Impaction-completely bony – surg comp	$222.30
D7250	Surgical removal of residual roots	$107.90
D7260	Oroantral fistula closure	$135.20
D7280	Surgical access of unerupted tooth	B/R
D7310	Alveoplasty w/ extractions per quad (general dentists)	$101.40
D7320	Alveoplasty w/o extraction per quad (general dentists)	$101.40
D7410	Excision benign lesion – 1.25	$87.10
D7472	Removal of turus palatines upper arch (one per lifetime)	$302.47
D7473	Removal of turus palatines lower quadrants (one each quad lifetime)	$209.28
D7510	Incision & drainage – intraoral	$67.60
D7520	Incision & drainage extraoral	$80.60
D7530	Removal of foreign body	$201.50
D7910	Suture of small wounds – 5.0 cm	$67.60
D7960	Frenulectomy	$167.60

Orthodontics		
D8080	Comprehensive Orthodontic Treatment	See below
D8210	Removable appliance therapy	$362.00/PA
D8220	Fixed appliance therapy	$259.00/PA
D8660	Pre-orthodontic treatment visit	$112 approved, $56 denied
D8680	Retention	$0
D8999	Unspecified procedure	See below

Orthodontics:

1. Patient's condition must meet the criteria established in 907 KAR 1:026, Section 13(7).
2. A service for an early phase of moderately severe or severe disabling malocclusion: $1,367 for an orthodontist; or $1,234 for a general dentist.
3. A service for a moderately severe disabling malocclusion: $1,825 for an orthodontist; or $1,659 for a general dentist.
4. A service for a severe disabling malocclusion: $3,000 total for an orthodontist; or $2,674 total for a general dentist.
5. After reimbursement for records ($112 for approved cases and $56 for denied cases), reimbursement for comprehensive orthodontic treatment shall consist of two payments. The first payment shall be two-thirds of the prior authorized payment amount. The second payment shall be one-third of the prior authorized payment amount and not be billed until six monthly visits are completed following the banding date. The two payments shall be inclusive of all services associated with the comprehensive orthodontic treatment including debanding.

Adjunctive General		
D9110	Palliative treatment	$27.30
D9241	IV conscious sedation	$158.60
D9420	Hospital call	$67.60

Members 21 Years of Age and Older

Diagnostic		
D0120	Periodic oral evaluation	$16.00
D0140	Limited oral evaluation (trauma related)	$33.00
D0150	Comprehensive oral evaluation	$26.00
D0210	Intra-oral complete series	$49.00
D0220	Intraoral-periapical – 1st film	$8.00
D0230	Intraoral-periapical – each additional	$6.00
D0270	Bitewing – single film	$7.00
D0272	Bitewings – two films	$14.00

D0274	Bitewings – four films	$23.00
D0330	Panoramic film	$39.00
D0340	Cephalometric x-ray	$47.00

Preventative		
D1110	Prophylaxis	$37.00

Restorative		
D2140	Amalgam – one surface	$38.00
D2150	Amalgam – two surfaces	$50.00
D2160	Amalgam – three surfaces	$59.00
D2161	Amalgam – four or more surfaces	$72.00
D2330	Composite – one surface, anterior	$44.00
D2331	Composite – two surfaces, anterior	$55.00
D2332	Composite – three surfaces, anterior	$66.00
D2335	Composite – four or more surfaces, anterior	$78.00
D2391	Composite – one surface posterior	$44.00
D2392	Composite – two surfaces posterior	$55.00
D2393	Composite – three surfaces posterior	$66.00
D2394	Composite – four or more surfaces posterior	$78.00
D2951	Pin retention – per tooth	$13.00

Endodontics		
D3410	Apicoectomy – anterior	$155.00
D3421	Apicoectomy – bicuspid first root	$155.00
D3425	Apicoectomy – molar first root	$155.00
D3426	Apicoectomy – per tooth (each additional root)	$197.00

Periodontics		
D4210	Gingivectomy/oplasty – four or more teeth per quad	$259.00
D4211	Gingivectomy/oplasty – one to three teeth per quad	$104.00
D4341	Scaling and root planing – per quad	$78.00
D4355	Full mouth debridement (Pregnant Women Only)	$68.50

Prosthodontics, removable		
D5913	Nasal prosthesis *	$2,036.00
D5914	Auricular prosthesis *	$1,881.00
D5919	Facial prosthesis *	$3,408.00
D5931	Obturator (temporary)	$863.00
D5932	Obturator (permanent)	$1,992.00
D5934	Mandibular resection prosthesis *	$1,660.00
D5953	Speech aid – adult (14 and over) *	$2,036.00
D5954	Palatal augmentation prosthesis *	$1,550.00
D5955	Palatal lift prosthesis *	$1,836.00
D5988	Oral surgical splint *	$896.00
D5999	Unlisted maxillofacial prosthetic proc *	B/R

*** Procedures limited to Kentucky Board Certified Prosthodontist.**

Oral Surgery		
D7111	Coronal remnants – primary tooth	$38.00
D7140	Extraction – erupted tooth or exposed root	$38.00
D7210	Extraction – surgical	$72.00
D7220	Impaction – soft tissue	$98.00
D7230	Impaction – partially bony	$138.00
D7240	Impaction – completely bony	$166.00
D7241	Impaction – completely bony- surgery comp	$171.00
D7250	Surgical removal of residual roots	$83.00
D7260	Oroantral fistula closure	$104.00
D7280	Surgical access of unerupted tooth	B/R
D7310	Alveoplasty w/extractions per quad (general dentist)	$78.00
D7320	Alveoplasty w/o extraction per quad (general dentist)	$78.00
D7410	Excision benign lesion – 1.25	$67.00
D7472	Removal of torus Palatines Upper Arch (one per lifetime)	$302.47
D7473	Removal of torus Palatines Lower Quad (one each quad per lifetime)	$209.28
D7510	Incision & drainage – intraoral	$52.00
D7520	Incision & drainage extraoral	$62.00
D7530	Removal of foreign body	$155.00
D7910	Suture of small wounds – 5.0 cm	$52.00
D7960	Frenulectomy	$129.00

Adjunctive General		
D9110	Palliative treatment	$21.00
D9420	Hospital call	$52.00

XVIII. EPSDT PROCEDURE CODES

Code	Code Description
D0140	LIMITED ORAL EXAM - PROBLEM FOCUSED
D0150	COMPREHENSIVE ORAL EVALUATION
D0160	EXTENSIVE ORAL EVAL - PROBLEM FOCUSED
D0170	RE-EVALUATION LIMITED PROBLEM
D0210	INTRAORAL - COMPLETE SERIES
D0220	INTRAORAL - PERIAPICAL - FIRST FILM
D0230	INTRAORAL - PERIAPICAL - EACH ADDITIONAL FILM
D0240	INTRA ORAL X-RAY OCCLUSAL FILM
D0272	BITEWINGS - TWO FILMS
D0273	BITEWINGS - THREE FILMS
D0274	BITEWINGS - FOUR FILMS
D0330	PANORAMIC FILM
D0360	CONE BEAM CT - CRANIOFACIAL DATA CAPTURE
D0363	CONE BEAM - THREE-DIMENSIONAL IMAGE
D0460	PULP VITALITY TEST
D0470	DIAGNOSTIC CAST
D1110	PROPHYLAXIS - ADULT
D1120	PROPHYLAXIS - CHILD
D1201	TOPICAL APPLICATION OF FLUORIDE (including prophylaxis) - child
D1203	TOPICAL APPLICATION OF FLUORIDE (prophylaxis not included) - child
D1351	SEALANT - PER TOOTH
D1510	SPACE MAINTAINER - FIXED - UNILATERAL
D1515	SPACE MAINTAINTER - FIXED - BILATERAL
D1520	SPACE MAINTAINTER - REMOVABLE - UNILATERAL
D1525	SPACE MAINTAINER - REMOVABLE - BILATERAL
D1550	RE-CEMENT SPACE MAINTAINER
D2331	RESIN - BASED COMPOSITE - TWO SURFACES ANTERIOR
D2390	RESIN - BASED COMPOSITE - CROWN, ANTERIOR
D2410	DENTAL GOLD FOIL ONE SURFACE
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES
D2643	DENTAL ONLAY PORCELIN 3 SURF
D2644	ONLAY - PORCELAIN/CERAMIC - FOUR OR MORE SURFACES
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE
D2750	CROWN - PORCELAIN FUSED TO HIGH METAL NOBLE
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASED METAL
D2752	CROWN PORCELAIN FUSED TO NOBLE METAL
D2783	CROWN 3/4 PORCELAIN/CERAMIC
D2790	CROWN - FULL CAST BOLD NOBLE METAL
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL
D2792	CROWN - FULL CAST NOBLE METAL
D2920	DENTAL RECEMENT CROWN
D2930	PRE-FAB STAINLESS STEEL CROWN - PRIMARY TOOTH
D2933	GROSS PULPAL DEBRIDEMENT
D2940	SEDATIVE FILLING
D2950	CORE BUILDUP, INCLUDING ANY PINS
D2952	CAST POST/CORE IN ADDITION TO CROWN
D2954	PRE-FAB POST & CORE IN ADDITION TO CROWN
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY

D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY
D3120	PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH
D3230	PULPAL THERAPY ANTERIOR PRIMARY TOOTH
D3240	PULPAL THERAPYPOSTERIOR PRIMARY TOOTH
D3310	COMPLETE ROOT CANAL THERAPY - ANTERIOR
D3330	ROOT CANAL THERAPY THREE CANALS
D3331	NON-SURG TX ROOT CANAL OBS
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR
D3346	RETREATMENT OF ROOT CANAL - ANTERIOR
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VISIT
D3352	APEXIFICATION/RECALCIFICATION - INTERIM MEDICATION REPLACEMENT VISIT
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT
D3430	RETROGRADE FILLING
D3999	UNSPECIFIED ENDODONTIC PRECEDURE, BY REPORT
D4240	GINGIVAL FLAP PROC W/ PLANING
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE
D4261	OSSEOUS SURGL - THREE TEETH PER QUAD
D4263	BONE REPLCE GRAFT FIRST SITE
D4265	BIO MTRLS TO AID SOFT/OS REG
D4266	GUIDED TISSUE REGENERATION
D4271	SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY)
D4273	SUBEPITHELIAL TISSUE GRAFT
D4275	SOFT TISSUE ALLOGRAFT
D4275	SOFT TISSUE ALLOGRAFT
D4321	PROVISIONAL SPLINTING - EXTRACORONAL
D4355	FULL MOUTH DEBRIDEMENT
D4381	LOCALIZED DELIVERY OF CHEMOTHERAPEUTIC AGENTS VIA CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH
D4910	PERIODONTAL MAINTENANCE
D5110	COMPLETE DENTURE - MAXILLARY
D5120	COMPLETE DENTURE - MANDIBULAR
D5130	IMMEDIATE DENTURE - MAXILLARY
D5140	IMMEDIATE DENTURE - MANDIBULAR
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE
D5213	MAXILLARY PARTIAL DENTURE - Cast Metal framework with resin denture bases
D5214	MANDIBULAR PARTIAL DENTURE - Cast Metal framework with resin denture bases
D5225	MAXILLARY PART DENTURE FLEX
D5226	MADIBULAR PART DENTURE FLEX
D5281	REMOVABLE PARTIAL DENTURE
D5730	DENTURE RELN CMPLT MAXIL CH
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)
D5860	OVERDENTURE - COMPLETE BY REPORT
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC
D5933	OBTURATOR PROSTHESIS, MODIFICATION
D5951	FEEDING AID

D5952	SPEECH AID PROSTHESIS, PEDIATRIC
D5986	FLUORIDE APPLICATOR
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS BY REPORT
D6010	SURGICAL PLACEMENT OF IMPLANT (INDOSTEAD IMPLANTS)
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT ODONTICS
D6053	RIMPLNT/ABTMNT SPPRT
D6056	PREFABRICATED ABUTMENT
D6057	CUSTOM ABUTMENT - INCLUDES PLACEMENT
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO MTL CROWN (HIGH NOBLE MTL)
D6060	ABUTMENT SUPPORTED PORCELAIN fused to Metal Crown
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN
D6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD
D6094	ABUTMENT SUPPORTED CROWN - TITANIUM
D6199	UNSPECIFIED IMPLANT PROCEDURE
D6210	PONTIC - CAST HIGH NOBLE METAL
D6212	PONTIC - CAST NOBLE METAL
D6240	PONTIC - PORCELIN FUSED TO HIGH NOBLE METAL
D6241	PONTIC - PORCELIN FUSED TO PREDOMINANTLY BASE METAL
D6242	PONTIC - PORCELIN FUSED TO NOBLE METAL
D6245	PONTIC - BRIDGE PORCELAIN/CERAMIC
D6250	BRIDGE RESIN W/HIGH NOBLE
D6545	RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS
D6548	PORCELAIN/CERAMIC RETAINER
D6609	ONLAY PORC/CRMC >=3 SURFACES
D6720	CROWN-RESIN WITH HIGH NOBLE METAL
D6740	CROWN PORCELAIN/CERAMIC
D6750	CROWN PORCELAIN FUSED TO HIGH NOBLE METAL
D6751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
D6752	CROWN - PORCELAIN FUSED TO NOBLE METAL
D6792	CROWN FULL CAST NOBLE METAL
D6793	PROVISIONAL RETAINER CROWN
D6930	DENTAL RECEMENT BRIDGE
D6970	CAST POST & CORE/BRG
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT
D7261	REMOVABLE PARTIAL DENTURE
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF DISPLACED TOOTH
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH
D7281	EXPOSURE TOOTH AID ERUPTION
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION
D7283	PLACE DEVICE IMPACTED TOOTH
D7286	BIOPSY OF ORAL TISSUE SOFT
D7292	SCREW RETAINED PLATE
D7292	SCREW RETAINED PLATE
D7293	TEMP ANCHORAGE DEV W FLAP
D7294	TEMP ANCHORAGE DEV W/O FLAP
D7473	REMOVAL OF TORUS MANDIBULARS
D7620	MAXILLA-CLOSED REDUCTION
D7620	CLSD REDUCT SIMPL MAXILLA FX
D7670	ALVEOLUS-CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT

D7911	COMPLICATED DENTAL SUTURE WOUND TO 5 CM
D7950	MANDIBLE GRAFT
D7953	BONE REPLACEMENT GRAFT
D7971	EXCISION PERICORONAL GINGIVA
D7972	SURGICAL REDUCTION OF FIRBROUS TUBEROSITY
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
D8210	REMOVABLE APPLIANCE THERAPY
D8220	FIXED APPLIANCE THERAPY (INCLUDE ADJUSTMENTS)
D8680	ESSIX APPLIANCE
D8690	ORTHODONTIC TREATMENT (ALTERNATIVE BILLING TO A CONTRACT FEE)
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER
D8693	REBOND/CEMENT/REPAIR RETAINER
D9220	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 30 MINUTES
D9221	DEEP SEDATION/GENERAL ANESTHESIA - EACH ADDITIONAL 15 MINUTES
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - FIRST 30 MINUTES
D9242	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - EACH ADDITIONAL 15 MIN
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION
D9310	PROFESSIONAL CONSULTATION
D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS
D9610	THERAPEUTIC DRUG INJECTION, BY REPORT
D9630	OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT
D9920	BEHAVIOR MANAGEMENT, BY REPORT
D9940	OCCLUSAL GUARD, BY REPORT
D9952	COMPLETE OCCLUSAL ADJUSTMENT
D9971	ODONTOPLASTY 1 - 2 TEETH; INCLUDES REMOVAL OF ENAMEL PROJECTIONS
D9973	EXTERNAL BLEACHING PER TOOTH
D9974	INTRNL BLEACHING PER TOOTH

XIX. FORMS

The following pages include forms that can be completed and submitted directly to MCNA.

MAP 559 Form

KENTUCKY MEDICAID PROGRAM
SIX MONTH ORTHODONTIC PROGRESS
PATIENT IN ACTIVE TREATMENT

DATE _____

PROVIDER NAME _____ PROVIDER NUMBER _____

PROVIDER TOTAL FEE (FOR TREATMENT) _____

STREET ADDRESS _____

CITY, STATE AND ZIP _____

PHONE NUMBER _____

PATIENT'S NAME _____ M.A.I.D. # _____

PRIOR AUTHORIZATION # (INITIAL SUBMISSION) _____

BANDING DATE (START OF TREATMENT) _____
MONTH DAY YEAR

DATE	TREATMENT (SPECIFY EXACT PROCEDURE)

☐ TREATMENT IS PROGRESSING WELL AND IS ON SCHEDULE. (PLEASE LIST PATIENT VISITS ABOVE, LISTING DATE SEEN AND BRIEF DESCRIPTIONS OF TREATMENT.)

☐ TREATMENT IS BEHIND SCHEDULE. (IF CHECKED, PLEASE GIVE A BRIEF EXPLANATION OF CIRCUMSTANCES. PLEASE LIST ALL ATTEMPTS TO CONTACT PATIENT BY DATE, METHOD AND RESULT.)

DESCRIBE PROGRESS AS IT RELATES TO ORIGINAL TREATMENT PLAN.

_____

_____

ACCORDING TO MY RECORDS THE PATIENT IS:

KEEPING HIS / HER APPOINTMENTS	YES ☐	NO ☐
PRACTICING GOOD ORAL HYGIENE	YES ☐	NO ☐
TAKING CARE NOT TO BREAK THE ORTHODONTIC APPLIANCES	YES ☐	NO ☐

_____
SIGNATURE OF ORTHODONTIST

Please complete and submit for processing to the following address:

MCNA Dental
200 West Cypress Creek Road
Suite 500
Fort Lauderdale, FL 33309

Preauthorization Form

USE THIS FORM OR THE STANDARD ADA FORM

Patient Information ☐ **EPSDT**

Name (First, Middle, Last)	Date of Birth	Subscriber ID
Address	City, State, Zip Code	
Telephone #	Group Name	Plan Type

General Dentist Information

Are x-rays included with this form? **Yes** **No**

Facility/Office ID#	Dentist Name	Telephone #
Address	City, State, Zip Code	

Specialist Information (not required) Circle Specialty **Endo** **Perio** **Oral Surgery** **Pedo** **Ortho**

Facility/Office ID#	Dentist Name	Telephone #
Address	City, State, Zip Code	

Treatment Plan

Area or Tooth #	Surface	ADA Code	Description of Service	Fee

For EPSDT, please include the rationale

Orthodontic benefits:

Services are limited to those circumstances where the child's condition creates a disability and impairment to their physical development. **Not covered for cosmetic purposes.**

Kentucky Medicaid Services Orthodontic Program Criteria for Disabling Malocclusion

Patient Information

Name (First, Middle, Last)	Date of Birth	Subscriber ID
Address	City, State, Zip Code	
Telephone #	Group Name	Plan Type

First Review ☐ Second Review ☐ Third Review ☐ Appeal C&G ☐

Models ☐ Orthocad ☐ Ceph Films ☐ X-Rays ☐ Photos ☐ Narrative ☐

#	ABBREVIATION	CRITERIA	YES	NO
1	DO	Deep impinging overbite that shows palatal impingement with the majority of lower incisors		
2	AO	True anterior openbite (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted)		
3	AP	Demonstrates a significant antera-posterior discrepancy (Class II and Class III malocclusions that is comparable to at least one full tooth Class II and Class III dental or skeletal)		
4	AX	Anterior crossbite (Involves more than two teeth and in crossbite, or there is obvious gingival stripping or recession related to the crossbite)		
5	PX	Handicapping posterior transverse discrepancies (may involve several teeth, one of which must be a molar AND is handicapping in some functional fashion such as a functional shift, facial asymmetry, or complete buccal or lingual crossbite, speech concerns, etc)		
6	PO	Significant posterior openbites (Not involving partially erupted teeth or one or two teeth slightly out of occlusion)		
7	IMP	Impacted teeth that will not erupt into the arches without orthodontic or surgical intervention (Does not include third molars)		
8	OJ	Extreme overjet (in excess of 8-9 mm) but must also include one of the other above skeletal concerns to be considered		
9	TR	Trauma-Injury resulting in severe misalignment of the teeth or alveolar structures creating a handicapping malocclusion-simple loss of teeth with no other affects would not be approved		
10	CDD	Congenital or developmental disorder giving rise to a handicapping malocclusion		
11	FAC	Significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach		
12	ANO	Developmental anodontia-several congenitally missing teeth resulting in a handicapping, malocclusion and/or arch deformation		

Comments

Orthodontic Continuation of Care Form

MCNA Dental Plans
Orthodontic Continuation of Care Form

Member ID Number: _____

Member Name (Last/First): _____

Date of Birth (MM/DD/YYYY): _____

Name of Previous Vendor that Issued Original Approval:

_____

Banding Date (MM/DD/YYYY): _____

Case Rate Approved By Previous Vendor: _____

Amount Paid for Dates of Service that Occurred Prior to MCNA: _____

Amount Owed for Dates of Service that Occurred Prior to MCNA: _____

Balance Expected for Future Dates of Service: _____

Number of Adjustments Remaining: _____

Additional Information Required:

- ☐ Completed ADA Claim Form listing services to be rendered.
- ☐ If member is transferring from an existing Medicaid Program, a copy of the original orthodontic approval and a copy of any remittance advice from the state showing payments for this treatment.
- ☐ If ember is transferring from a commercial insurance program, please enclose the original diagnostic models (or OrthoCad equivalent). Radiographs are optional.

Mail To:

MCNA Dental Plans
Attn: Continuation of Care
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

Questions:

Contact MCNA by phone at **(877) 375-6262**.