


The Avēsis Medicaid Provider Manual

for the State of Mississippi

Welcome

Dear Doctor:

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

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

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

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

Provider Services Number

(833) 282-2419

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

If you require assistance or information that is not included within this document, please contact our Provider Services Department. This office is typically staffed Monday through Friday from 7:00 a.m. until 8:00 p.m. (ET), excluding observed holidays. We look forward to a successful relationship with you and your practice.

Sincerely,

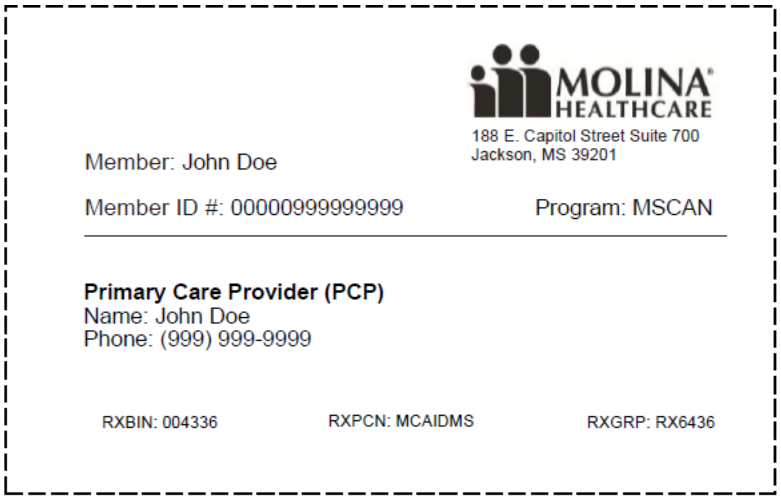
Michael K. Exler, DDS, FAGD
Vice President, National Dental Director

Table of Contents

Quick Reference Guide for the State of Mississippi

Avēsis Executive Offices 10324 South Dolfield Road Owings Mills, MD 21117-3991 (410) 581-8700 (800) 643-1132	Avēsis Corporate Offices 10400 North 25th Avenue, Suite 200 Phoenix, AZ 85021-1696 (602) 241-3400 (800) 522-0258
EFT Avēsis Third Party Administrators, Inc. Attention: Finance P.O. Box 316 Owings Mills, MD 21117	Appeals Avēsis Third Party Administrators, Inc. Attention: Dental Appeals P.O. Box 38300 Phoenix, AZ 85069-8300
Pre-Authorization Avēsis Third Party Administrators Attention: Dental Pre-Authorization P.O. Box 38300 Phoenix, AZ 85069-8300	Post Review Avēsis Third Party Administrators Attention: Dental Post Review P.O. Box 38300 Phoenix, AZ 85069-8300
Dental Claims Avēsis Third Party Administrators Attention: Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300	Corrected Claims Avēsis Third Party Administrators Attention: Dental Corrected Claims P.O. Box 38300 Phoenix, AZ 85069-8300
Provider/Customer Services (833) 282-2419 Monday – Friday, 8:00 a.m. – 6:00 p.m. EST, except observed holidays	Avēsis Provider Portal/Website www.Avēsis.com Avēsis IVR: (866) 234-4806
Avēsis Mississippi State Dental Director Dr. Jimmy Hollingsworth	
Molina PLAN TBD Healthcare Customer Service TBD	Molina PLAN TBD Healthcare Member Services TBD
Molina PLAN TBD Healthcare 24-Hour Nurse Line TBD	Molina PLAN TBD Healthcare Special Needs Assistance TBD

Sample ID Card



Members should present a Molina Healthcare Plan ID card. Medical Assistance Members may also present their Medical Assistance card. Providers are responsible for verifying eligibility and benefits prior to an appointment.

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

- Call the Interactive Voice Response (IVR) at (866) 234-4806
- Visit www.Avēsis.com
- Call Avēsis Provider Services at (833) 282-2419

Language Assistance

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

Attention: If you speak [insert language here}, free language support services are available to you. Call (833) 282-2419.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (833) 282-2419.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (833) 282-2419.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (833) 282-2419.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (833) 282-2419.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para TTY: (833) 282-2419.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (833) 282-2419.

Persian/Farsi:

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

تماس بگیرید.(833) 282-2419 فراهم می باشد. با

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (833) 282-2419.

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε TTY: (833) 282-2419.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (833) 282-2419.

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (833) 282-2419.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (833) 282-2419。

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。（833) 282-2419 まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (833) 282-2419 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (833) 282-2419.

Program Overview

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

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

Using this Provider Manual

Our Dental Provider Manual is intended to be a comprehensive reference tool to help you and your office team efficiently service our members.

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

Provider Rights and Responsibilities

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

- Communicate openly and freely with Avēsis
- Communicate openly and freely with members
- Suggest dental treatment options to members
- Recommend non-covered services to members

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

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

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

Member Rights and Responsibilities

Avēsis members have the right to:

- Communicate openly and freely with Avēsis and their dentists and other oral health providers without fear of retribution
- Expect privacy according to HIPAA (Health Insurance Portability and Accountability Act) and other state or federal guidelines
- Be treated with respect, courtesy, and dignity
- Be treated the same as all other patients in the practice
- Be treated without discrimination based on race, religion, color, sex, national origin, or disability
- Be informed of their oral health status and examination findings
- Participate in choosing treatment options

- Receive information on treatment options in a manner that they can understand, including receiving materials translated into their primary language, upon request
- Know whether treatment is medically necessary
- Know whether the treatment is experimental and give his/her consent
- Refuse any treatment, except as provided by law
- Be provided with a phone number in case of an emergency
- Obtain non-covered services only when a disclosure form is signed by all parties
- Submit a complaint against a provider, without fear of retribution
- Be informed of any appeals filed on their behalf
- Change providers
- File grievance issues with Avēsis
- Access their records to review and/or change

Members shall, to the best of their ability:

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

- Choose a mutually agreed upon treatment plan with options they believe are in the best interest of their oral health
- Have the opportunity to ask about a fee associated with any non-covered service before the service is rendered
- Use best efforts to not miss or be late for an appointment
- Cancel scheduled appointment in advance, if unable to make it
- Provide emergency contact information
- Follow home care instructions
- Call the dentist of record in the event of an emergency
- Report suspected, fraud, waste, and abuse

Treating Beneficiaries

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

Role of the General/Pediatric Dentist

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

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

- Diagnostic and preventive care
- Extractions (D7140)
- Endodontic therapy on anterior and bicuspid teeth

- Non-surgical periodontal services, e.g., scaling and root planing, full mouth debridement, etc.
- Restorative dentistry

Non-covered services

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

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

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

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

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

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

Non-Covered Services Disclosure Form

To download the Non-Covered Services Disclosure form:

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

Verifying Eligibility

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

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

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

Setting Up Your Provider Username and Password

To register your new account:

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

OPTION 1: Internet

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

OPTION 2: Provider Services

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

You can also check member eligibility using the IVR (interactive voice response) system. You may, but do not need to, talk with a customer service representative when checking eligibility. When you use IVR or talk with the customer service representative, you will receive a real-time response.

Prior Authorization

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

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

A request for prior authorization must include:

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

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

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

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

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

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

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

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

- Online through the provider portal at www.Avēsis.com
- Electronically in a HIPAA-compliant data file
- On paper via postal service using the current ADA claim form.
  Avēsis Third Party Administrators, Inc.
  Attention: Dental Prior authorization
  PO Box 38300
  Phoenix, AZ 85069-8300

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

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

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

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

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

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

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

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

Medical Necessity

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

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

Expedited Prior Authorization

Avēsis will provide notice of decision for expedited authorizations for services no later than 24 hours after receipt.

Post-Treatment Review

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

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

The post-treatment review process is as follows:

- Following receipt of a claim for a procedure or diagnostic code that requires post-treatment review, Avēsis will send a letter to the provider within two business days of receipt, requesting additional information in support of the medical necessity of the claim.

Diagnostic Codes

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

- Upon receipt of the requested information, we will review the file and make a determination based upon guidelines and screening criteria established for the procedure/service.
- Within 30 calendar days of receipt of all required information, we will notify the provider and/or member, as appropriate, of the decision in writing.
- If the post-treatment review is approved, the provider will then have to submit a standard claim to be paid.
- If the request does not meet the screening criteria or guidelines established for the procedure/service, the request will immediately be turned over to the Dental Advisory Board member or state dental director for review.
- In situations where an adverse determination may be made, the state dental director or member of the dental advisory board may first contact the provider to discuss all the case specifics and review all the supporting information available. Where appropriate, special circumstances that may require deviating from established norms will be taken into consideration.
- If it is the decision of the state dental director or advisory board to deny the claim, written notification of the adverse determination shall be communicated to the provider and member within 30 calendar days. This notification shall include:
    - Date of the determination
    - Principal reason(s) for the determination
    - Source of the criteria used to make the determination

- Notification that the provider and/or member can obtain a copy of the actual benefit provision or clinical protocol on which the adverse determination was based
- Instructions for initiating an appeal of the adverse determination.

- Adverse determination notifications shall be signed by the state dental director and include contact information for Avēsis.
- Notifications of adverse determinations, whether for pre- or post-service reviews, will include a statement that the decision is based on appropriate care and service guidelines and that there is no reward for issuing denials nor are incentives offered to encourage inappropriate utilization.
- Review personnel will be qualified to speak with providers to obtain diagnosis and/or treatment information and shall be supervised by the Vice President/National Dental Director for Avēsis.
- Personnel may use pre-established screening criteria that have been reviewed and approved for purposes of approving the requested treatment or materials. Screening criteria shall be periodically evaluated and updated by the Vice President/National Dental Director for Avēsis and Dental Advisory Board.
- You are responsible for submitting all the necessary documentation for the review process. This includes:
  - Completed 2012 ADA claim form
  - Pre-treatment radiographs necessary for proper diagnosis and treatment
  - Any other material required for proper diagnosis and treatment such as periodontal charts or ortho models
  - Documentation of index criteria used to determine orthodontic necessity
- Post-treatment review material may be submitted:
  - Electronically via the secure provider portal on our website, www.Avēsis.com
  - Mail sent to:
    Avēsis Third Party Administrators, Inc.
    Attention: Dental Post-Treatment Review
    PO Box 38300
    Phoenix, AZ 85069-8300

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

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

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

Inter-Rater Reliability

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

Facilitated by NCQA standard of "8 and 30", this process involves the review of clinical prior authorization requests from the previous quarter. The file sampling procedure involves reviewing of initial sample of eight files, then reviewing an additional sample of 22 files if any of the original eight fails the review (a total of 30 records).

Dental consultants review the first eight cases and make a determination. Their results are compared to one another to determine whether each consultant came to the same conclusion, and the results are presented at a team meeting. If they are in 100 percent agreement, they are finished.

If there is not 100 percent agreement among the dental consultants in the disposition of the case, the dental consultants will review the remaining 22 files. When inappropriate or extreme discrepancies exist between the determinations made in the actual clinical case and the recommendations made by the reviewers during the IRR activity, further interventions will be determined by the chief dental officer. For example, Avēsis may decide to update clinical guideline criteria or provide additional training to the dental consultants or UR processors. In certain instances, auditing of a case may be necessary.

After each IRR session, the Chief Dental Officer or a designee will report the outcomes of the IRR to the Quality Management Committee.

Emergency Care

According to Mississippi Code Ann. § 43-13-121, Medicaid defines a dental emergency as a condition that requires treatment and that causes pain and/or infection of the dental apparatus and/or contiguous structures.

Mississippi Medicaid provides palliative dental services for non-EPSDT eligible beneficiaries. Palliative services are defined as the treatment of symptoms without treating the underlying cause, and frequently refer to treatment of pain without further treatment**.** Emergency care for the relief of pain and infection, emergency extractions and dental care related to the treatment of an acute medical or surgical condition are covered. Palliative treatment may be provided for relief of pain when no other Medicaid services are provided.

Palliative (emergency) treatment cannot be billed with another therapeutic (definitive) procedure but can be billed with diagnostic procedures. Palliative (emergency) treatment of dental pain - minor procedure must be authorized prior to billing. Authorization is a condition for reimbursement and is not a guarantee of payment. Authorization requests may be submitted prior to or within thirty (30) days of the date of service. The authorization request must be submitted to the Utilization Management/Quality Improvement Organization (UM/QIO) along with the appropriate documentation. The beneficiary cannot be billed if the dental provider chooses to render services for palliative (emergency) treatment of dental pain prior to submitting an authorization request or if approval is not given. The UM/QIO will make the determination of medical necessity using the criteria set forth by DOM, and a TAN will be assigned. If a claim is submitted without a TAN, no reimbursement will be paid. Retroactive authorization after the thirty (30) day period will be allowed only in cases where beneficiary was approved for retroactive eligibility and is not applicable to any other situation. All terms of DOM's reimbursement and coverage criteria are applicable.

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

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

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

Avēsis shall permit treatment of all dental services necessary to address a dental emergency for a member without prior authorization. However, elective dental services not necessary for

relieving pain and/or preventing immediate damage to dentition default to the standard prior authorization process.

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

(a) render services in the dental office to treat the emergency, or

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

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

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

Prior Authorization for Emergencies

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

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

Claims and accompanying information must be submitted within 30 calendar days of the issuance of temporary referral approval number. The beneficiary cannot be billed if the dental provider chooses to render services for palliative (emergency) treatment of dental pain prior to submitting an authorization request or if approval is not given. The UM/QIO will make the

determination of medical necessity using the criteria set forth by DOM, and a TAN will be assigned. If a claim is submitted without a TAN, no reimbursement will be paid. Retroactive authorization after the thirty (30) day period will be allowed only in cases where beneficiary was approved for retroactive eligibility and is not applicable to any other situation. All terms of DOM's reimbursement and coverage criteria are applicable.

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

Referrals

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

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

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

Specialist Treatment

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

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

Out-of-Network Care

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

There may be exceptions in the event the member is out of state and requires emergency treatment. Your members should be instructed to contact your office if they are experiencing a

dental emergency, so they can receive instruction on how to manage the condition until they can get to your office.

Office Accessibility

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

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

After-Hours Accessibility

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

Transfer of Care

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

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

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

OR

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

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

Continuity of Care

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

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

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

Locum Tenens

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

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

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

When approved, the participating Avēsis provider can submit claims to receive payment for the covered benefits for services provided by the locum tenens provider. The

Locum Tenens Form

To download a copy of the Locum Tenens form:

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

locum tenens provider must hold a valid professional license within their practicing state. The existing provider's malpractice insurance is used to cover the locum tenens provider.

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

Clinical Coordination

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

Patient Outreach

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

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

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

Missed Appointments

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

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

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

Pregnant Women

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

Patients with Special Needs

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

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

Cultural Competency and Language Services

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

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

The Avēsis Cultural Competency Program

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

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

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

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

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

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

Language Assistance

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

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

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

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

Translation vs. Interpretation

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

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

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

Deaf or Hard of Hearing Patients

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

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

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

Free Access to TRS

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

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

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

Your Provider Relations Representative can provide you or your office staff with additional suggestions and ideas for improving the linguistic accessibility of your office.

Functional Illiteracy

A person with functional illiteracy is someone with basic education but whose reading and writing skills are inadequate for everyday needs. Health illiteracy is the degree to which individuals lack the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[1] In fact, the most recent National Assessment of Adult Literacy (2006) reports that 22 percent of adults have basic health literacy, while 14 percent have below basic health literacy.[2]

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

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

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

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

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

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

Cultural Competency Training

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

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

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

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

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

Required Annual Cultural Competency Training

To gain access to the required training course:

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

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

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

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

Cultural Competency Grievances

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

Telephone: (410) 413-9309
Fax: (844) 344-7112
Mail: Compliance
10324 S. Dolfield Road
Owings Mills MD 21117
Email: compliance@Avēsis.com

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

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

Recordkeeping

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

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

- Administration documentation
    - Patient's identification number on all pages
    - Signed HIPAA confidentiality statement
    - Signed consent to permit Avēsis to access medical records upon request
    - Claims and billing records
    - The name and telephone number of the member's PCP
- Medical documentation
    - The original handwritten personal signature, initials, or electronic signature of practitioner performing the service, and initialed by the dentist, if s/he did not perform the service
    - Current health history
    - Complete medical history
    - Current prescription and non-prescription medications, including quantities and dosages
    - Medication allergies and sensitivities, or reference "No Known Allergies" (NKA) to medications prominently on the record
    - Any disorders and/or diseases
    - Initial examination data
    - Tobacco, alcohol, and substance abuse history for patients aged 14 and older
    - A physical assessment, including member's current complaint, if relevant
    - Diagnosis that is reasonably based on the history and/or examination
    - Documentation that problems from previous visits were addressed

- Treatment plan consistent with the diagnosis, signed by the provider and adult member, parent/guardian, or minor member
- Progress notes
- Date for return or follow-up visit
- All radiographs taken during the member's previous dental visits (dated and labeled)
- Copies of all authorizations or referrals
- Copies or notations regarding any drugs prescribed

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

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

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

Confidentiality of Records

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

Records Audit

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

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

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

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

Quality

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

- Quality standards
- Quality assurance
- Utilization review

We welcome participation from you and other network providers who seek to review and/or contribute to either of these efforts. Participating network providers are expected to agree, respond to, and/or otherwise comply with Avēsis' Quality Improvement Program as it relates to quality assurance, utilization review, and member grievances. Network providers may also be subject to the quality assurance, utilization review, and grievance programs of the health plan for which Avēsis provides benefit administration.

Avēsis Quality Standards

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

- Dental Professional Standards of Care
- Standards for Member Records
- Standards for Member Contact and Appointments
- Standards for Member Contact Information and Outreach
- Standards for Member Appointments
- Standards for Infection Control
- Standards for Radiation Protection

- Standards for Treatment Planning
- Standards for Services Not Covered Under the Member's Plan
- Standards for Submitting Claims

The following sections address these individually.

Dental Professional Standards of Care

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

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

Standards for Member Records

Each member must have an individual record that is maintained at the dental office. The record should meet the requirements defined in the Recordkeeping section of this manual (see page 36). The records must be available for review by an Avēsis staff member during any facility review. If computerized, the records shall be non-changeable; however, the system shall permit adding to the original record. All files must be properly backed up for protection, in accordance with any applicable HIPAA requirements. The provider shall confirm that all records conform to applicable industry standards.

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

Standards for Member Contact and Appointments

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

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

Standards for Member Contact Information and Outreach

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

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

Standards for Member Appointments

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

Standards for Infection Control

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

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

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

Standards for Radiation Protection

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

Standards for Treatment Planning:

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

Standards for Services Not Covered Under the Member's Plan

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

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

Standards for Submitting Claims

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

Quality Assurance Program

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

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

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

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

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

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

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

The QAP is reviewed and updated annually by the Avēsis Quality Oversight Committee. The Committee is composed of senior staff of Avēsis and clinical staff, including the Chief Dental Officer and state dental director. Members of each state's Dental Advisory Board are also permitted to participate.

Utilization Management (UM)

The goals and objectives of the Avēsis UM program include:

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

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

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

Statistical Provider Review

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

The following items formulate the basis of the review:

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

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

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

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

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

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

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

Wait Time Review

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

Providers found to have excessive wait times will be notified that they did not meet wait time standards. Their office will be randomly tested during the next survey cycle. If they do not meet wait time standards the second time, they will receive a call from Provider Relations. During this call, the Provider Relations Representative will work with the office to try to understand the root cause of the wait time issues, so they can be addressed. If the provider's office fails a third wait time review survey, a Provider Relations Representative will visit the office to provide one-on-

one education about the wait time standards and to try additional ideas for addressing the issue. At this time, Avēsis will need to contact the health plan sponsor or state Medicaid agency.

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

Site Reviews

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

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

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

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

Fraud, Waste, and Abuse

CMS defines fraud as:

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

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

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

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

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

Anti-Fraud Training

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

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

Required CMS MLN Training

To gain access to the required training course:

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

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

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

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

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

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

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

Reporting Suspected Fraud, Waste, and Abuse

All our providers and their office staff are also expected to be alert to possible fraud, waste, and abuse and report any suspicious activity to Avēsis. The Avēsis fraud hotline number is (410) 413-9309. You may leave a message on the hotline's voice mail anonymously, as the hotline is not answered in real time. Or you may leave your contact information so that we may provide you with updates on the investigation. Upon receipt of a report of suspected fraud, waste, or abuse, Avēsis will work with relevant plan fraud units and the applicable state/federal fraud, waste, and abuse authorities to investigate.

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

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

- The Mississippi Division of Medicaid has established a hotline to report suspected fraud and abuse committed by any person or entity providing services to medical assistance recipients. When calling the hotline, callers may remain anonymous and may call after hours and leave a voicemail if they prefer at (800) 880-5920. An online fraud and abuse complaint form may be found at https://medicaid.ms.gov/wp-content/uploads/2017/04/fraud-and-abuse-complaint-form.pfd or report via mail:

  Mississippi Division of Medicaid
  550 High Street, Suite 1000
  Jackson, Mississippi 39201

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

- It is Molina Healthcare of Mississippi's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the Federal False Claims Act or any state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, you may contact Risk Management. Reporting fraud, waste or abuse can be anonymous or not.

  Acceptance of improper payments is a form of Fraud, Waste and Abuse. This includes payments that should not have been made or were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative other legally applicable requirements. It 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]).

Refer to 42 CFR Part 455; Miss. Code Ann.§§ 43-13-121, 43-13-129 for more information.

Federal Laws and Statues Affecting Providers

Anti-Kickback Statute

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

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

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

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

Accessing the LEIE and EPLS

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

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

State Exclusions Databases:

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

State of Mississippi Laws and Regulations

The State of Mississippi does not have its own False Claims Act, but has the following laws regarding fraudulent and false claims:

Mississippi Code Ann. §§ 43-13-209, -211, -213, -215 & -225

- A fine up to three times the Government's damages

- A civil fine ranging from $5,000 to $11,000 for each false or fraudulent claim submitted
- The costs of the civil action against the entity that submitted the false claims.

Mississippi code Ann. § 43-13-215 (2013)

The Medicaid Fraud Control Act – A person who violates any provision of Sections 43-13-205 through 43-13-213 shall be guilty of a felony, and, upon conviction thereof, shall be punished by imprisonment for not more than five years, or by a fine of not more than Fifty Thousand Dollars ($50,000), or by both. Sentences imposed for convictions of separate offenses under this article may run consecutively.

The complete set of Mississippi laws governing Medicaid fraud and abuse may be found in Mississippi Code Ann. §§ 43-13-2014 through 233.

Suspected Child or Adult Abuse or Neglect

Cases of suspected or adult abuse or neglect might be uncovered ruing 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 of Social Services office or by calling the Mississippi Department of Child Protection Services Hotline at (800) 222-8000 or the Mississippi Department of Human Services Adult Protective Services at (800) 227-7308. For more information on reporting child abuse, please refer to Section 43-21-105 and Section 43-21-353 of the Mississippi Code. You can also report child abuse online at **https://reportabuse.mdcps.ms.gov/**.

Adult abuse is defined by Section 43-47-5 of the Mississippi Code as "the commission of a willful act, or the willful omission of the performance of a duty, which act or omission contributes, tends to contribute to, or results in the infliction of physical pain, injury or mental anguish on or to a vulnerable person, the unreasonable confinement of a vulnerable person, or the willful deprivation by a caretaker of services which are necessary to maintain the mental or physical health of a vulnerable person. For more information on reporting adult abuse, please visit **http://www.mdhs.ms.gov/adults-seniors/adult-protective-services/**.

Claims, Billing and Payment

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

Clean Claims

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

A clean claim is one that includes all following information:

- Patient's plan ID number
- Patient's name, date of birth, and gender
- Patient's address (street or P.O. box, city, zip)
- Subscriber's name
- Patient's relationship to subscriber
    - Subscriber's address, if different from patient (street or P.O. box, city, zip)
    - Subscriber's policy number, if different from patient
    - Subscriber's birthdate and gender, if different from patient
- Health plan name
- Disclosure of any other health benefit plans
- Patient's or authorized person's signature or notation that the signature is on file with the provider
    - Subscriber's or authorized person's signature or notation that the signature is on file with the provider, if different from the patient
- Date(s) of service
- Place of service codes
- CDT code for the service, including arch, tooth number, quadrant, and tooth surface, as applicable
- ICD10 code, if applicable

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

The claim must be accompanied by all necessary documentation.

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

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

Claims Timelines

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

- File claim no longer than 180 calendar days from the date of service
- Correct a claim no longer than 90 calendar days from the explanation of benefit date
- Denied claims may be filed within the appropriate time frame but denied may be resubmitted to the Avēsis within 90 calendar days from the date of denial
- Providers who submit claims that are denied due to insufficient information must be notified that claim cannot be paid within 30 calendar day of the adjudication of the claim.
- Member EOBs must be sent within 30 calendar days of claim adjudication

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

How to Submit Claims

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

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

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

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

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

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

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

Including Documentation with Your Claim

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

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

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

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

Claims Review Process

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

- Medically Necessary Services: Medically necessary dental services must be appropriate and consistent with the standard of care for dental practices. The nature of the diagnosis and the severity of the symptoms must not be provided solely for the convenience of the dental professional or facility or other entity. Furthermore, any omission of services has the potential to adversely affect the member's condition. There must be no other

effective and more conservative or substantially less costly treatment available. Furthermore, for certain procedures requiring prior authorization as set forth herein, the procedure is medically necessary to prevent or minimize the recurrence and progression of periodontal disease in recipients who have been previously treated for periodontitis; prevent or reduce the incidence of tooth loss by monitoring the dentition and any prosthetic replacements of the natural teeth; and increase the probability of locating and treating, in a timely manner, other diseases or conditions found within the oral cavity.

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

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

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

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

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

Checking Claim Status

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

Checking Claim Status

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

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

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

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

- Patient's name
- Date of service
- Patient's date of birth
- Member's name
- Member's ID number
- Member's group number
- Claim number

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

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

Claims Payment

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

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

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

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

Lesser of Billed Charges or Fee Schedule

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

Receiving Payment

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

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

Electronic Funds Transfer (EFT)

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

Initiating EFT Payment Arrangements

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

Card Payment Services (CPS)

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

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

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

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

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

- Enter the Avēsis 6-digit bank identifying number (BIN) of 556766. This BIN will always be the same
- Enter the unique 10-digit transaction payment number supplied on the remittance advice

Terminal Entry Example

BIN number 556766

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

Unique CVC code (e.g., 321)

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

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

- Enter the unique, 3-digit transaction security code supplied on the remittance advice
- Enter the exact amount of the payment
- Enter the transaction expiration date expressed as MMYY

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

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

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

Explanation of Payment (EOP)

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

Overpayment

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

- Sending a check or money order: If you elect to send a check or money order, you must do so within 45 calendar days of receiving notification of the overpayment. The check must be made out to Avēsis and mailed to P.O. Box 38300, Phoenix, AZ 85069-8300. The check or money order must be accompanied by all COB documentation.
- Recoupment: Recoupment refers to the withholding of all or a portion of a future payment until an overpayment refund obligation is met. If no check or money order is received within 45 calendar days of notification of an overpayment, Avēsis will initiate the recoupment process with your practice. You will be notified in writing.

Member Billing

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

service or procedure will not be covered by this insurance and that s/he will be liable for payment.

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

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

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

Coordination of Benefits

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

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

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

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

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

Claims Correction

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

Corrected claims may be submitted by mail or the secure provider portal on our website. The corrected claim should

Submitting a Corrected Claim

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

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

include the ADA 2012 claim form with the corrected information and the words "CORRECTED CLAIM" at the top of the form.

Avēsis Provider Network

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

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

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

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

Network Enrollment Requirements

Dentists are enrolled in our provider network if they:

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

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

- For each individual dentist or facility who shall receive payment for services rendered to members, the following contracting paperwork is required:
    - Completed and signed Avēsis Provider Agreement
    - Signed W-9 (any version prior to 2014 will not be accepted)
    - Disclosure of ownership form, as required by the applicable state
    - ADA survey regarding the accessibility of your office for members with special

needs or hearing impairments, in addition to details on your practice's ability to treat developmentally disabled patients.

    - Copy of IRS approval of Tax Identification Number letter

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

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

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

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

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

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

Incomplete Submissions

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

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

Correcting Information in Your Network Enrollment Package

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

Credentialing Details

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

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

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

- A Completed and signed agreement
- Provider information, including:
    - Date of birth

- Social security number
- Professional education and training
- Board certification, if any
- Work history for the last five years
- Proof of professional liability insurance

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

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

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

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

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

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

State Medicaid Exclusions Databases:

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

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

Providers who want to participate in the Medicare Advantage program cannot opt-out of Medicare. Medicare Opt-Out lists are maintained for each Medicare region. These Opt-Out lists

shall also be checked at least quarterly. If a provider has opted out of Medicare, the provider may not provide services to Medicare Advantage members.

Re-credentialing Details

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

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

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

The Credentialing Committee reviews all re-credentialing files.

Credentialing Timelines

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

Credentialing Denials

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

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

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

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

Credentialing Denial Appeals Process

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

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

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

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

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

Delegated Credentialing

Typically, Avēsis performs the primary credentialing functions, but on occasion, we delegate all or portions of credentialing to another group or entity. At a minimum, a delegated entity must

meet the requirements for credentialing and re-credentialing outlined in the full Avēsis credentialing policies and procedures in addition to the relevant requirements of NCQA and our health plan partners. Avēsis retains the right to deny or terminate network participation to any provider covered by a delegated credentialing arrangement.

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

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

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

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

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

Practice Information in the Avēsis Database

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

Documentation stored on file includes:

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

Changing Practice Information

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

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

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

Practice Update Form

To download a copy of the Practice Update form:

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

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

Provider and Practice Support Tools

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

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

Provider Portal

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

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

Forms available through the portal include:

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

Learning Through the Avēsis Provider Portal

To access learning resources on the provider portal:

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

Provider Educational Programming

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

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

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

Educational programming may be delivered in myriad ways, including:

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

Avēsis Dental Advisory Board

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

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

- Establishing lines of communication between Avēsis and the provider stakeholder communities
- Facilitating access to the local provider network for Avēsis' recruitment staff
- Educating Avēsis on market specific considerations

- Elevating care delivery and/or operating issues that are affecting the local provider community
- Understanding, providing feedback and/or recommending network related policy or procedural changes
- Incorporating Plan feedback into network provider relations

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

Role of the State Dental Director

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

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

Leaving the Network

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

Voluntary Termination

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

Involuntary Termination

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

- The failure of a provider to maintain or obtain a license to practice medicine in the state where services are provided

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

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

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

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

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

Termination Appeals

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

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

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

Suspension

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

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

Complaints, Grievances and Appeals

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

Submitting Complaints and Grievances

Request Complaints and Grievances in writing to:

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

may have. Of course, you may always file a complaint or appeal. Information on that process follows.

Complaints

According to State of Mississippi, a complaint is an expression of dissatisfaction, regardless of whether identified by the member as a "complaint," received by any employee of the contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

Any complaint not resolved within one calendar day shall be treated as a grievance. A complaint includes, but is not limited to, inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information.

Avēsis is not delegated for member complaints, however, the following outlines the processes:

A member or authorized representative may file a complaint either orally or in writing with Avēsis within 30 calendar days of the date of the event causing the dissatisfaction.

Avēsis shall have procedures for receiving, responding to, and documenting resolution of member complaints within one calendar day of receipt do not require a formal written response or notification.

Avēsis shall contact the member within twenty-four hours of the initial contact via telephone if Avēsis is unavailable for any reason or the matter cannot be readily resolved during the initial contact.

Any complaint that is not resolved within one calendar day shall be treated as a grievance, in accordance with requirements set forth.

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

A provider may submit a complaint within 30 calendar days of the date of the event causing dissatisfaction.

Grievances

If a complaint cannot be resolved within one calendar day, then it is called a grievance.

A grievance may be filed by a provider within 30 calendar days of the date of the event causing dissatisfaction. Avēsis will confirm receipt of the received grievance within five calendar days of receipt of the filed grievance to the provider.

Avēsis will make a determination and notify the provider within 30 calendar days of filed grievance. Avēsis may extend the time frame up to fourteen calendar days if more information is required to make determination.

Avēsis is not delegated for member grievances, but the following outlines the processes:

- A member or authorized representative may file within five days.
- Avēsis must provide written notice that the grievance has been received and the expected date of its resolution.
- Resolution must be reached within 30 days of the date the grievance is received.
- Or as expeditiously as the member's health condition requires and must include a resolution letter to the grievant.
- Avēsis may extend the time frame up to 14 days if the member requests an extension.
- Avēsis must give the member written notice of the reason for the extension within two days of the decision.

Appeals

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

Member/Clinical Appeal

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

and grievance procedures comply with Federal and State regulations and meet appropriate accreditation standards.

Members receive instructions on how to file an appeal or grievance in their plan documents. Members may contact the Member Services number on their ID cards for assistance.

Provider Appeal

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

1. A written request for the claim to be reviewed including the justification for the service to be reimbursed within 30 days of receipt of the adverse determination should be submitted.

2. Avēsis must provide a notice of receipt and expected date of resolution within 10 days of receiving the appeal.

3. If more information is required to make determination, Avēsis may extend the time frame up to fourteen calendar days.

Medically Necessary Appeals – appeals involving adverse determination findings that there was no medically necessary reason to pay the claim. Avēsis has the following time frames for making a determination:

1. A written notice of appeal to Avēsis involving adverse determination findings that there was no medically necessary reason to pay the claim. The appeal should include documentation in support of the appeal not previously provided.

2. The Avēsis Mississippi State Dental Director will review the appeal, and if necessary speak directly with the provider. If the State Dental Director made the initial determination, the appeal will be reviewed by a member of the Avēsis Dental Advisory Board.

3. A member may file an appeal within 60 days of receiving notice of adverse benefit determination.

4. A provider may file an appeal within 30 calendar days of receiving an Avēsis notice of adverse benefit determination.

5. Avēsis will provide a notice of receipt and expected date of resolution within 10 days of receiving the appeal to the member/provider.

6. Avēsis will respond within 30 days of receipt of the initial appeal with written notification of the determination to the member/provider.

Avēsis is not delegated for member appeals, but the following outlines both processes:

- A member may file an appeal within 60 days of receiving notice of adverse benefit determination.
- Avēsis has 30 days to resolve the appeal.
- The Avēsis Mississippi State Dental Director will review the appeal, and if necessary speak directly with the provider. If the State Dental Director made the initial determination, the appeal will be reviewed by a member of the Avēsis Dental Advisory Board.
- Avēsis will provide a notice of receipt and expected date of resolution within 10 days of receiving the appeal.

Expedited Resolution of Appeal

In the case where a member's health could be seriously jeopardized, Avēsis will resolve an appeal within 72 hours according to Mississippi regulations and may extend the time frame up to fourteen days if the member requests an extension.

State Administrative Hearing

A provider may request a state administrative hearing within 30 calendar days of the final decision by Avēsis for an appeal.

Avēsis has 90 calendar days from the date the provider filed for direct access to a state administrative hearing.

Avēsis is not delegated for member state administrative hearings, but the following outlines the processes:

A member may request a state fair hearing within 120 days if they are unhappy with their adverse benefit determination.

Appeal summary must be provided at least 10 days before the date of hearing. Member must have exhausted all grievance and appeal procedures prior to requesting a state fair hearing.

Appeals must be requested in writing by the member or the member's representative within 120 days of receipt of notice of adverse benefit determination unless an acceptable reason for delay exists.

The state fair hearing decision shall be final and not subject to an appeal by Avēsis.

Clinical Criteria

Providers may also refer to the Mississippi Division of Medicaid Provider Billing Handbook available at https://www.medicaid.ms.gov/wp-content/uploads/2014/11/Provider-Billing-Handbook.pdf and the Provider Reference Guide available at https://medicaid.ms.gov/providers/administrative-code/.

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

Sources for Information about Evidence-based Dentistry

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

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

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

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

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

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

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

For certain procedures requiring prior authorization, the procedure is medically necessary to prevent or minimize the recurrence and progression of periodontal disease in recipients who have been previously treated for periodontitis; prevent or reduce the incidence of tooth loss by monitoring the dentition and any prosthetic replacements of the natural teeth; and increase the probability of locating and treating, in a timely manner, other diseases or conditions found within the oral cavity.

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

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

EPSDT is medical assistance's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary healthcare service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the state's plan to the rest of the medical assistance population. The EPSDT program consists of two mutually supportive, operational components:

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

These components enable medical assistance agencies to:

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

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

Periodicity Schedules

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

Since each child is unique, the recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will

need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The AAPD emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references. Refer to the text in the Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents for supporting information and references.

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

Detailed Clinical Criteria

Diagnostic Care—Radiographs

Avēsis typically follows the standards of care and periodicity schedules for the use of radiographs as set by the American Dental Association. Radiographs should be kept to a minimum to be consistent with good diagnostic procedures. Radiographs must be of sufficient quality to be readable. If the radiograph quality is too poor to read, reimbursement will not be made to the dentist for the radiographs. All radiographs must be labeled with the beneficiary's name and date taken.

Mississippi Guidelines for Radiographs

Full mouth radiograph or panoramic radiograph is allowed once every two years per member except under unusual circumstances. Two years must have elapsed from the date the previous panoramic was given before the same provider can be paid for the next panoramic. A full mouth series should include 10-14 intraoral films and bitewings. Payment will not be made for both full mouth intraoral and panoramic. If an emergency extraction is done on the day a full mouth series is taken, payment will not be made for any additional radiographs.

Tests and Examinations Mississippi Guidelines

Laboratory Services

Providers must have a Clinical Laboratory Improvement Amendment (CLIA) certificate number on file with the fiscal agent for laboratory and pathology charges to be paid. Providers may bill for lab and pathology services if the provider performs the service. The provider may only bill for tests that CLIA has approved to be performed in his/her office.

Diagnostic Casts

Diagnostic casts made and billed by the dental provider are reimbursable only for orthodontic workups.

Preventive Care

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

Mississippi Guidelines for Preventive Care

Periodic oral evaluation D0120 is payable two (2) per benefit year either D0120, D0145, or D0150. Five months between billing either D0120, D0145 or D0150.

Beneficiaries receiving D0140 or limited oral evaluations are limited to four (4) times per fiscal year (July 1-June 30th). Typically, this type of evaluation is a referral for a specific problem and/or present with dental emergencies, trauma, acute infection, etc.

Comprehensive oral evaluation D0150 is used by a general dentist and/or specialist when performing a comprehensive evaluation of an EPSDT eligible beneficiary. This service is allowed twice per fiscal year (July 1-June 30th) for EPSDT eligible beneficiaries and must be at least five (5) months apart. In cases where the beneficiary received services from more than one (1) dentist within this time period, payment of these services is made to the provider whose claim is received first.

Oral evaluation of children under the age of 3 D0145 is payable for children ages 0-3. This evaluation is payable twice per fiscal year (July 1-June 30th) and must be at least five (5) months apart.

Sealants

Sealants are covered for EPSDT eligible beneficiaries when applied to newly erupt first and second permanent molars or to first and second pre-molars. Sealant may be placed on primary molar only for children at highest risk for caries i.e. special needs children and will require prior authorization. Sealants are allowed once every five years and prior authorization does not override the five-year limitation. Providers may bill for sealants only when the sealants are applied to all pits and fissures on the occlusal surface and in some instances the lingual groove surface of upper molars. Documentation must include the tooth number and tooth surface being treated.

Mississippi Restorative Care Guidelines

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

Restorative services are covered for EPSDT eligible beneficiaries as described in the EPSDT criteria detailed in this manual section. These services are covered for the purposes of repairing the effects of dental caries; protection of teeth from further damage; reestablishing tooth

function; and restoring or preserving an esthetic appearance. Restorative treatment must be the result of an appropriate and thorough examination by a dentist and should be part of a treatment plan that includes:

1. Assessment and intervention related to the child's dentition status;
2. Caries risk assessment;
3. Oral hygiene;
4. The child's compliance with the dental treatment plan (in the office and at home); and
5. The child's behavioral and developmental status, including any special needs.

Mississippi Medicaid policy for coverage of dental restorative services is based on recommendations from the American Academy of Pediatric Dentistry, the CMS Guide to Children's Dental Care in Medicaid, and the American Dental Association Current Dental Terminology (CDT) reference manual. Restorative services should be provided as part of a comprehensive dental screening, diagnostic, and treatment plan that emphasizes prevention and early treatment of dental conditions in children.

Amalgam Restorations

1. Amalgam restorations (including polishing) are covered for EPSDT eligible beneficiaries for the restoration of carious lesions and/or developmental defects in primary and permanent posterior teeth.
2. Tooth preparation, all adhesives (including amalgam bonding agents), liners, and bases are included as part of the restoration.
3. Prior authorization is not required.
4. Documentation in the beneficiary's record must clearly describe the restoration provided, the reason for the restoration, and the appropriate ADA CDT Procedure code, tooth number, and tooth surface.
5. All restored surfaces on a single tooth are considered connected if performed on the same date. Payment will be made for a particular surface on a single tooth only once in each episode of treatment, irrespective of the number or combinations of restorations placed.
6. Topical or local anesthesia is not reimbursed separately.

Composite Restorations

1. Resin-based composite restorations (direct) are covered for EPSDT eligible beneficiaries for the restoration of carious lesions and/or developmental defects in primary and permanent anterior and posterior teeth.
2. Gold foil and inlay/onlay restorations are not covered.
3. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration.
4. Prior authorization is not required.

5. Documentation in the beneficiary's record must clearly describe the restoration provided, the reason for the restoration, and the appropriate ADA CDT Procedure code,

6. Tooth number, and tooth surface.

7. All restored surfaces on a single tooth are considered connected if performed on the same date. Payment will be made for a particular surface on a single tooth only once in each episode of treatment, irrespective of the number or combinations of restorations placed.

8. Topical or local anesthesia is not reimbursed separately.

Crowns

In general, criteria for crowns will be met only for permanent teeth or primary teeth where no permanent successor is present needing multi-surface restorations where other restorative materials have a poor prognosis.

Mississippi Medicaid covers prefabricated stainless-steel crowns and porcelain-fused-to-metal crowns for EPSDT eligible beneficiaries according to the policy criteria described below. Other types of crowns (e.g., resin, porcelain/ceramic, noble metal, etc.) are not covered.
Stainless steel crowns (SSCs), including prefabricated SSC primary tooth and prefabricated SSC permanent tooth, are covered for beneficiaries when an amalgam or composite restoration is not sufficient to meet the dental needs of the beneficiary. Prefabricated stainless steel crowns with resin window or prefabricated esthetic coated stainless steel crowns (primary tooth) are covered for anterior teeth only. Prior authorization is not required for stainless steel crowns.

Stainless steel crowns are covered when at least one of the following criteria is met:
Restoration of primary teeth with caries on more than one surface;
Primary or permanent teeth with extensive caries;

- Restoration of primary teeth caries on more than one surface;
- Primary or permanent teeth with extensive caries;
- Primary or permanent teeth with cervical demineralization, decalcification, and/or developmental defects (such as hypoplasia and hypocalcification); When failure of other available restorative materials is likely (e.g., interproximal cavities extending beyond line angles, patients with bruxism);
- Following pulpotomy or pulpectomy;
- Restoration of a primary tooth that is to be used as an abutment for a space maintainer;
- Intermediate restoration of fractured teeth;

- Children at high risk for development of dental caries based on a risk assessment of factors including, but not limited to, previous caries; early clinical signs of potential caries development; lack of fluoride; frequent exposure to cavity-producing foods and drinks; behavioral, developmental, or medical conditions that affect the child's ability to practice preventive dental care; family history of extensive caries; and other risk factors identified in dental professional literature. Risk factors must be thoroughly documented by the dentist in the beneficiary's dental record. Medicaid eligibility

- alone is not sufficient reason for application of crowns.

- Children who require caries treatment under general anesthesia because of behavioral, medical, or developmental conditions where behavior management and in-office sedation are not safe or effective.

Porcelain-Fused-to-Metal crowns, including porcelain fused to high noble, predominantly base, or noble metal, are covered only for permanent anterior teeth.

Coverage criteria for porcelain-fused-to-metal crowns are the same as the criteria for stainless steel crowns.

Prior authorization is required for porcelain-fused-to-metal crowns.

Both stainless steel crowns and porcelain-fused-to-metal crowns are not indicated and will not be covered in the following circumstances:

- Absence of documentation that clearly demonstrates coverage policy is met;
- Primary tooth with exfoliation expected within six (6) months;
- Tooth has advanced periodontal disease, bone resorption, or insufficient tooth or root structure to sustain retention of the tooth;
- Crowns to alter vertical dimension

Documentation requirements for Crowns

Documentation to support the use of stainless-steel crowns and porcelain-fused-to-metal crowns must be maintained by the dentist in the beneficiary record. In addition to the Documentation Requirements listed, dentists must provide:

1. Written documentation that supports the use of crown(s) for at least one of the covered indicators listed in this section.
2. Radiographs are required prior to placement of crown(s). Exception: If the child requires general anesthesia for dental treatment, and must receive dental treatment in the hospital rather than a dentist office, and the hospital is unable to perform dental radiographs, the requirement for radiographs prior to placement of crown(s) is waived.

The dentist must document, very clearly and thoroughly in the beneficiary record, why radiographs were not done.

3. Appropriate ADA CDT procedure code, tooth number, and tooth surface for each tooth receiving a crown.
4. When applicable, reason for referral to the hospital (inpatient or outpatient) or an ambulatory surgical center (ASC) for placement of crowns and why the treatment could not be done in the dentist office (e.g., required general anesthesia due to severe behavioral management issues).
5. If applicable, reason for early replacement of crown(s). A provider is responsible for any replacements necessary within the first twelve (12) months for restoration of primary teeth and the first twenty-four (24) months for restoration of permanent teeth, except when failure or breakage results from circumstances beyond the control
6. Photographs – are not required but may be used in addition to radiographs and written documentation.

Placement of crowns that do not meet coverage criteria in this policy or failure to provide required documentation may result in repayment of Medicaid funds upon post-payment review or audit.
Protective restorations require prior authorizations. Radiographs must be submitted with the prior authorization request.

Post and Core

Cast and core coverage is limited to ages 21 and younger. Coverage is further limited to anterior endodontically treated teeth. Prior authorization is required. Radiographs must be submitted with the prior authorization request. Authorization still be approved on a case by case basis when determined to be medically necessary. Providers must retain proper and complete documentation to verify medical necessity.

Endodontics Guidelines for Mississippi

Endodontic therapy for permanent teeth does not requires prior authorization. A post-operative radiograph is required to verify service was provided and the fee is inclusive of endodontic therapy. The fee for endodontic therapy does not include restoration to close a root canal access.

Criteria for approval of endodontic treatment include evidence of one or more of the following:

- Tooth is damaged because of trauma or carious exposure
- Fill is properly condensed/obturated; filling material does not extend excessively beyond the apex

A request for prior authorization for endodontic therapy will not meet criteria if:

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

Periodontics Mississippi Guidelines

Avēsis typically follows the standards of care of periodontics treatment as set by the American Dental Association and the American Academy of Periodontology. This includes:

- Gingivectomy or Gingivoplasty
- Periodontal Scaling and Root Planing
- More than one periodontal procedure in the same quadrant per fiscal year requires prior authorization.
- A pre-treatment radiographic image demonstrating significant calculus must be submitted with prior authorization.

Gingivectomy or Gingivoplasty

Criteria for approval of gingivectomy or gingivoplasty include evidence of one or more of the following:

- Covered service is payable for ages 0-20.
- This covered service is payable for ages 21 and older only if the member is on Dilantin therapy. Documentation relating to the member being on Dilantin therapy must be retained in the dental record and available upon review.

- Osseous surgery is an integral part of the gingivectomy or gingivoplasty and will not be reimbursed separately.
- Comprehensive periodontal evaluation (i.e., description of periodontal tissues, pocket depth chart, tooth mobility, mucogingival relationships)
- Other separate procedures including, but not limited to D3450, D3920, D4268, D4264, D4266, D4267, D6010 and D7140 may be required concurrent to D4260.
- Gingivectomy or Gingivoplasty are not payable with alveoloplasty (in conjunction with extractions) on the same date of service.

Gingival Flap Procedure

- Scaling, D4341 or D4342 cannot be billed on the same date of service.
- Payable for ages 10-20; members ages 10 and younger require prior authorization
- Osseous contouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, Widman surgery and modified Widman surgery.
- This procedure is performed in the presence of moderate to deep probing depths, loss of probing attachment, need to maintain esthetics and need for increased access to the tooth surface and alveolar bone.

Periodontal Scaling and Root Planing

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

- Periodontal procedures are limited to once per quadrant per fiscal year. Prior authorization is required with a pre-treatment radiographic image.
- Scaling cannot be billed together on the same date of service.
- Service is payable for members ages 10-21; members aged 10 and younger require prior authorization

Curettage is not covered by Mississippi Medicaid.

Prosthodontics—Removable and Fixed

Criteria for approval of prosthodontic services includes evidence the prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

Requests for partial dentures will only be considered for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

Abutments should be adequately restored and not have advanced periodontal disease.

Pre-existing removable prosthesis (includes partial and full dentures) must be at least 5 years old and unserviceable to qualify for replacement.

A request for prior authorization for a removable prosthesis will not meet criteria if:

- There is a pre-existing prosthesis that is not at least five years old and unserviceable
- Good oral health and hygiene, good periodontal health, and a favorable prognosis are not present
- There are untreated caries on or active periodontal disease around the abutment teeth
- Less than 50 percent of bone support is visible radiographically in abutment teeth
- The recipient cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped)
- The recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons

Mississippi Guidelines for Prosthodontics (removable)

- Dentures are non-covered except when medically necessary and prior authorization is submitted for ages 21 and younger.
- Dentures/partials (with cast framework) will only be covered in cases where teeth are congenitally missing, i.e. Ectodermal Dysplasia. Denial reasons include lost teeth due to cavities, periodontal disease or trauma.
- Flipper type partials are covered.

- Partials are covered for ages 21 and younger with prior authorization including a pre-treatment radiographic image.

Mississippi Oral Surgery Guidelines

Consistent with the policy of the Medicaid dental program, it is desirable to retain the teeth for beneficiaries whenever possible.

- The removal of primary teeth whose exfoliation is imminent does not meets criteria.
- Fee for simple extractions includes local anesthesia and routine post-operative care.
- Simple extractions do not require prior authorization.
- Alveoloplasties are allowed with the simple extraction of 3 or more adjacent teeth in the same quadrant.
- Alveoloplasty is payable when not in conjunction with extractions.
- In order to bill for alveoloplasty, a minimum of 5 teeth must have been treated.
- Prior authorization is required for the extraction of supernumerary teeth.
- Payment of third molar extractions is only payable if there is evidence of severe impaction or chronic infection.
- Surgical removal of root tips is not billable with an extraction.
- Fees for complicated suturing are only paid in instances of trauma where simple sutures cannot be placed, or simple suturing is not possible. It is not payable for extractions of unerupted teeth or when the dentist creates the flap or incision. Detailed documentation of trauma must be clearly stated in the dental record.

Mississippi Anesthesia Guidelines

All forms of sedation and anesthesia administered in a dental office-based setting must comply pursuant to Miss. Code Ann. § 73-9-13 to ensure that beneficiaries are provided with the benefits of anxiety and pain control in a safe and efficacious manner.

The use of topical anesthetics and local anesthesia are inclusive of the procedure being performed and cannot be billed separately.

Conscious sedation is a covered service. However, related administration fees and uses or oral medications or gases to achieve conscious sedation are not covered.

The use of general anesthesia or IV sedation is considered acceptable for procedures covered by the health plan, provided appropriate criteria are met. These include, but may not be limited to, extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth
- Surgical root recovery from maxillary antrum
- Surgical exposure or impacted or unerupted cuspids
- Radical excision of lesions in excess of 1.25 cm

General anesthesia or IV sedation may also be allowed for any of the following medical situations:

- Medical conditions that require monitoring such as cardiac problems or severe hypertension
- Underlying hazardous medical condition (such as cerebral palsy, epilepsy, mental retardation including Down Syndrome), which might render the member non-compliant
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective

Mississippi Orthodontic Guidelines

Members aged 20 and under may qualify for orthodontic care under the program.

In order to obtain approved prior authorization for orthodontia, a member must meet at least one of the following pre-qualifying criteria:

- Cleft lip, cleft palate and other craniofacial anomalies
- Overjet of 9 mm or more
- Extensive hypodontia with restorative implications (more than one tooth per quadrant)
- Requiring pre-prosthetic orthodontics
- Anterior open bites greater than 4mm
- Upper anterior contact point displacement greater than 4mm
- Individual anterior tooth crossbites with greater than a 2mm discrepancy between retruded contact position and intercuspal position

- Impinging overbite with evidence of gingival or palatal trauma
- Impeded eruption of teeth (except third molars) due to crowding, displacement, presence of supernumerary teeth, retained primary teeth, and any pathologic cause; unless extraction of the displaced teeth or adjacent teeth, requiring no orthodontic treatment would be more expedient.

First phase (mixed dentition) treatment is allowed in cases where early intervention could result in no further need, or reduced need for later comprehensive appliance therapy. The fee for this treatment will be based up on the complexity of the condition, as determined by the orthodontic consultant. Fee awarded for first phase treatment will not be more than one-half of the maximum allowable amounts as determined by the orthodontic consultant. It should be noted that the fees awarded for the first phase treatment are subtracted from the patient's lifetime maximum allowable amount for orthodontic treatment.

A member with a pre-qualifying condition may not display sufficient need to have orthodontic services covered by Medicaid. Detailed records and adequate models must be available for review as well as a detailed course of treatment.

All orthodontic services require prior authorization. The prior authorization request should document that the member has 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. Documentation required for prior authorization of orthodontia includes diagnostic models, full-mouth radiographs or panoramic radiograph, cephalogram, and photographs. Please note a letter of medical necessity is also required. If surgery is required with the orthodontic treatment, the surgeon's plan of treatment should also be attached.

Treatment should not begin prior to receiving notification from Avēsis indicating coverage or non-coverage for the proposed treatment plan. If you begin treatment before receiving an approved or denied prior authorization, you are financially obligated to complete treatment at no charge to the member or face possible termination of your Provider Agreement. You cannot bill prior to services being performed.

Replacement retainers who have received prior orthodontic procedures are eligible for replacement of lost, stolen, or broken retainer once per lifetime, including both arches if necessary. Documentation including, but not limited to how the original appliance was lost, stolen or broken must be submitted to obtain approval for prior authorization.

Billing for Orthodontic Treatment

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

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

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

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

Initial payments for orthodontics (code D8080) include pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, 1 set of retainers, and 12 months of retainer adjustments (if retainer fees are not separate).

Orthodontia related services are limited to $4,200 per member per lifetime. Eligible members are ages 21 and younger. The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and 7 quarterly payments thereafter, covering 21 periodic orthodontic treatment visits (D8670). Additional periodic orthodontic treatment visits beyond 21 will be your financial responsibility and not the member’s.

Reimbursement for orthodontic consultation, cephalogram, diagnostic casts, photographs and radiographs and other charges pertaining to the orthodontic evaluation are included in the comprehensive orthodontic treatment rate. Providers are not allowed to bill separately for these services unless the request for orthodontia is denied. If the orthodontia treatment plan is denied, reimbursement for pre-treatment orthodontic records such as a consultation, panoramic, cephalometric film, intraoral and extraoral photographs, and diagnostic casts will be paid separately to an orthodontist, once (1) per three (3) years per member per orthodontist. If an orthodontist bills for records more than once within a three-year period, a narrative describing medical necessity.

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

If a member becomes ineligible for Medicaid during the course of treatment, the orthodontic provider should complete the treatment. Eligibility status can change from month to month, and there is a possibility that eligibility will be reinstated. The member or his/her guardian will be responsible for any bills accrued during the interim.

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

Continuation of Orthodontic Treatment

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

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

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

Adjunctive Services

Examinations billed on the same date of service as the initial consultation by the consulting dentist or specialist will not be reimbursed.

Consulting dentist or dental specialist may bill for the initial consultation along with diagnostic and therapeutic procedures which may or may not be performed on the same date as the consultation.

An occlusal guard is a covered service if medical necessary for ages 21 and younger. Prior authorization is required with a pre-treatment radiograph.

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

MCO—Managed Care Organization

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

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

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

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

Molina Mississippi Hospital Worksheet

Member's Name:

Member's DOB:

Member's ID Number:

Provider's Name:

Facility Name:

Dental Services Anticipated:

Type of Failed Attempt:

Special Healthcare Needs:

(**Special healthcare needs** include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, **healthcare** intervention, and/or use of specialized services or programs.)

Anticipated DOS:

Contact Name:

Contact Email:

Contact Fax:

ORTHODONTIC CONTINUATION OF CARE FORM

Member ID Number: _____

Member Name (Last/First):_____

Date of Birth: _____

Name of Original Approved Vendor: _____

Banding Date: _____

Approved Case Rate(s): _____

Amounts Paid Prior to Avesis: _____

Amount Owed Prior to Avesis: _____

Estimated Balance: _____

Number of Remaining Adjustments: _____

Additional Required Information:

- Completed ADA claim form listing services to be rendered.
- If the member is transferring from an existing Medical Assistance program: A copy of the original orthodontic approval.
- If the member is a private payer transferring from a commercial insurance program, please enclose pictures of the original diagnostic models or OrthoCad equivalent. Radiographs are optional.

Mail to: Avesis
P. O. Box 38300
Phoenix, AZ 85069-8300

Molina Mississippi Medicaid Non-Covered Services Disclosure Form

Section to be completed by the DENTIST rendering care

I recommend that _____ receive services
Member Name and Identification Number
that are not covered by his/her health plan. I will accept my usual and customary fee as payment in full. The following procedure code(s) are recommended:

CODE	DESCRIPTION	FEES
		$
		$
		$
		$
		$

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

_____
Doctor's Signature Date

Section to be completed by the MEMBER or Member's Parent/Guardian

I, _____, have been told that I require
Member Name (please print)
services that are not covered by my health plan. I understand that my plan includes a $2,500 annual plan maximum and, if applicable, that after reaching this maximum all other services are my financial responsibility.

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

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