The dental Provider Manual and covered benefits schedules for the Avesis Health Partners Health Plan programs have been updated and are available on the Avesis website at www.avesis.com. You will need to log in to the web portal in order to view these documents. Your office can download an electronic copy to reference on your computer or you may print the documents from the website should you wish to have a paper copy. If your office does not have internet access, you may request a paper copy of the Provider Manual or covered benefits documents by calling our Customer Service team at 855-536-7764. We urge your office to download or print both the Provider Manual and covered benefits schedules, as they provide you with Avesis’ administrative guidelines for the Health Partners Health Plan programs.

A Letter From Our Chief Dental Officer

Dear Avesis Doctor:

We would like to thank you for your continued participation in the Health Partners Health Plan dental programs administered by Avesis. We are hopeful that you have been treated fairly and promptly by Avesis.

Avesis is committed to providing responsive service to Health Partners Health Plan and our dental providers. If you have any questions about the changes outlined within this newsletter, please contact our Customer Service team at 855-536-7764.

Sincerely,

Fred L Sharpe, DDS
Chief Dental Officer
Filing Claims And Pre-Treatment Estimates With Avesis

Avesis is interested in making your claim submission and payment process as simple as possible. If your office is currently able to file claims electronically, we encourage you to send your Health Partners claims and pre-treatment estimates to us electronically. If you have questions, please contact your Provider Services representative and ask how you can get set up for electronic claims submission. You may also submit claims directly to Avesis on the Avesis web portal at www.avesis.com.

Providers may submit claims and pre-treatment estimates on an ADA claim form to the following address: Avesis, PO Box 7777, Phoenix, AZ 85011 – 7777. Avesis has no special restrictions or requirements regarding which version of the ADA claim form providers may submit, as long as your office uses at least the CDT 2007 – 2008 codes when submitting claims and include the rendering provider’s NPI number on the claim form. Failure to submit your NPI number on the claim form will result in your claim being returned to you unprocessed. Please be sure that the information is entered clearly in the appropriate field on the ADA claim form. Avesis scans all claim forms and they are entered into the system using OCR (Optical character recognition).

If your information is not clearly entered in the appropriate field, it is possible that characters may be misread or not recognized as being present on the claim form at all. You will receive written notification of the status of both claims and pre-treatment estimates in the mail. Should you have claims or pre-treatment estimates for which you do not believe you have received a response, you may check the status of those claims and/or pre-treatment estimates on the Avesis web portal at www.avesis.com, or by calling our Customer Service team at 855-536-7764.

Benefit Limit Exception Benefits (BLE)

Avesis would like to reiterate the changes to benefits for Health Partners Health Plan members ages 21 and over that became effective April 1, 2012. Effective April 1, 2012, Health Partners Health Plan adult members (age 21 and older) experienced a change to their dental benefit that limits the following dental services:

- Periodic oral evaluations (D0120) are limited to one (1) per 180 days per adult Member. Additional oral evaluations and prophylaxis require a benefit limit exception (BLE). NOTE: Providers will not be paid for a periodic oral evaluation (D0120) and a comprehensive oral evaluation (D0150) within the same 180 day time period.
- Prophylaxis, adult (D1110) is limited to one (1) per 180 days per adult Member. Additional prophylaxis will require a BLE.
- Dentures are limited to one per upper arch, full or partial, regardless of procedure code (D5110, D5130, D5211, D5213) and one per lower arch, full or partial, regardless of procedure code (D5120, D5140, D5212, D5214), per lifetime. Avesis will review claim payment history for Health Partners Health Plan Members for dates of service on and after March 1, 2004 to determine if the Member previously received a denture for the arch. Additional dentures will require a BLE.

Effective April 1, 2012, Health Partners Health Plan adult members (age 21 and older) are eligible for the following services only if Avesis approves a BLE request:

- Crowns and adjunctive services (D2710, D2721, D2740, D2751, D2791, D2910, D2915, D2920, D2952, D2954, D2980)
Avesis will grant benefit limit exceptions to the dental benefits when one of the following criteria is met:

1. Avesis determines the Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member.
2. Avesis determines the Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the recipient.
3. Avesis determines that granting a specific exception is a cost effective alternative.
4. Avesis determines that granting an exception is necessary in order to comply with Federal law.

In order to request a dental BLE, dentists must submit the following information to Avesis:

1. An American Dental Association (ADA) claim form completed in its entirety. Providers must include their NPI number on the claim form. Failure to do so will result in your request being sent back to the requesting office as not being able to be processed.
2. A completed Avesis Dental BLE request form which has been included herein for your reference.

Providers must submit the completed forms and supporting documentation to Avesis at:

Avesis
PO Box 7777
Phoenix, AZ 85011 – 7777
ATTN: Benefit Limit Exceptions

Please remember that providers may not bill the Member for payment for services rendered in excess of the dental limits unless:

1. The provider informs the Member prior to the service being rendered that the service requires a BLE and the Member is liable for the payment if the request for an exception is denied; and,
2. The provider requests an exception to the limit and Avesis denies the request.

**BLE Questions And Answers**

**Q:** Does every office have to have a declined BLE in order to charge an Avesis Medicaid adult patient an out of pocket fee for treatment?

**A:** Yes – the new guidelines for adults require a denied BLE before charging the Medicaid Member for any treatment.

**Q:** What are the reasons that would allow a BLE to be approved?

**A:** The requirement is that the Member has a medical condition that would be negatively impacted if the dental services were not rendered.

**Q:** Are we allowed to charge the patient for the service without having a denied BLE if they do not fit into any of the medical criteria?

**A:** Unfortunately – No – the Dept of Public Welfare requires that you to have a BLE denied first.

(continued on next page)
**BLE Questions And Answers (cont’d)**

**Q:** Is the patient allowed to decline having the BLE filed on their behalf and pay for the treatment out of pocket?
**A:** No. See above.

**Q:** Can an office charge the patient up front and file a BLE after they have had the treatment and paid for it?
**A:** Again, the Department of Public Health guidelines do not allow this.

**Q:** If a BLE is not approved, what fees do we charge the Member?
**A:** Please refer to the Provider Manual. A non-covered services disclosure form should be completed and the member should be billed at a discounted rate of 20% off of your offices usual and customary fee.

**Q:** If the Member is in a great deal of pain and needs immediate treatment and are unable to wait 4 weeks for a response to the BLE, what should we do?
**A:** You can start a RCT to relieve the pain under the expectation that the pain will subside and then wait for the BLE denial to complete the root canal and charge the Member.

**Q:** What should we do about Members who will be turning 21 in the near future? If we submit a preauthorization for treatment before the patient turns 21, how long will we have to render that treatment?
**A:** Until the end of the month they turn 21.

**Q:** Will any authorization expire like a regular preauthorization after 6 months or does it expire the day they turn 21?
**A:** At the end of the month in which they turn 21.
Health Partners Program Changes

Kidz Partners

There are some changes that have been required from the Department of Insurance for calendar year 2013. Those are as follows:

A) Members enrolled in KidzPartners will no longer have access to an expanded dental benefit. This expanded dental benefit (EDB) was only available for calendar year 2012. The annual maximum for all services will be $1500.00.

B) The orthodontic benefits will no longer be reimbursed at a case rate. Beginning with new cases banded 1/1/2013 and after, Avesis will be paying based upon the previous process of an initial banding fee followed by quarterly payments. All newly approved and billed orthodontic cases for 2013 will be reimbursed with a banding fee, up to seven quarterly fees and retention. This reimbursement will mirror how you are currently being reimbursed through the Health Partners Medicaid benefits.

Special Needs Program

Avesis has been working diligently with the Pennsylvania Department of Public Welfare on a Special Needs initiative. Your offices will receive a special needs survey from Avesis. Please complete your survey and return it to the Avesis Provider Services department.

Program Initiatives

Both Avesis and Health Partners are committed to putting forth every effort to ensure that the Health Partners population is following AAPD (American Academy of Pediatric Dentists) standards encouraging a dental visit by age one. As time progresses, Avesis will continue to update the network on these initiatives and steps we are taking for its implementation.

Claims and Provider Billing

Avesis would like to take this opportunity to advise all of our dental providers regarding issues that have been found on our office reviews. We want your office to follow our claim guidelines to ensure that your billings are paid promptly and accurately. Situations have been discovered where dental offices are billing for services on one date and then resubmitting using a different date if the claim is not paid.

Some of the reasons we have heard for this are because of Medicaid time limitations or computer mistakes. We have also been aware of billing for services not rendered. These are clear violations of the Pennsylvania Medicaid
rules and, if determined to be accurate, will result in termination from the network.

Another frequent issue is offices billing for services rendered by one dentist under another dentist’s name. If your office has been doing this, you need to immediately cease this practice unless you are in a Locum Tenens situation. If you are using a dentist as a Locum Tenens, then you must notify Avesis that your office is employing such a dentist, prior to the Locum Tenens provider beginning to see patients, except in the case of an emergency. Remember that use of a Locum Tenens dentist is limited to 60 days.

If Avesis discovers offices billing under a provider other than the one rendering services we will perform a complete review of all billings from your office for accuracy and we will be required to report the situation to Health Partners Health Plan and the appropriate state agency for their investigation. As a dentist in the practice, you are responsible for all acts of your staff members regarding claim submission. You should be aware if there are any inappropriate claim practices occurring within your office and should stop them immediately.

Please understand that these issues are some of the key issues that we will be concerned about when reviewing your office’s claims. Any office in violation of these guidelines will be required to refund all payments made from Avesis and may risk being terminated from the dental network.
Cultural Competency

As a Company dedicated to providing clients with superior service, Avesis 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 health care differently than the dominant culture.

To be culturally competent, Providers shall:

• Work with Members so that once Members are identified that may have cultural or linguistic barriers alternative communication methods can be made available.

• Utilize culturally sensitive and appropriate educational materials based on the Member’s race, ethnicity and primary language spoken.

• Ensure that resources are available to overcome the language barriers and communication barriers that exist in the Member population.

• Make certain that you recognize the culturally diverse needs of the population.

• Teach staff to value the diversity of both their co-workers inside the organization and the population served, and to behave accordingly.
Contact Us

If you have any questions about any information provided in this newsletter, please contact our Customer Care Department at 1-855-536-7764. Inquiries may also be submitted through the Avesis website at www.avesis.com. Please click on Health Partners Health Plan, log in and then click on “Contact Us” to submit your inquiry.