Table of Contents

1.0 Introduction........................................................................................................................................5
1.1 Provider Welcome .................................................................................................................................5
1.2 Kentucky Medicaid Program ..................................................................................................................6
1.2.1 Department for Medicaid Services ....................................................................................................6
1.3 Overview of Passport Health Plan .........................................................................................................7
1.4 Passport Health Plan’s Mission and Values ..............................................................................................7
1.5 Important Telephone Numbers (Quick Reference listing in Attachment B) ........................................8
1.5.1 Compliance Department (502) 585-8239 ...........................................................................................8
1.5.2 Member Services (800) 578-0603 .......................................................................................................8
1.5.3 Provider Services Call Center (866) 909-1083 ................................................................................8
1.5.4 Utilization Management (866) 909-1083 ........................................................................................8
1.6 Claim Submission ..................................................................................................................................9
2.0 Administrative Procedures ....................................................................................................................9
2.1 Eligibility ............................................................................................................................................9
2.2 Identification Cards ...............................................................................................................................10
2.2.1 Member Identification and Eligibility Verification ...........................................................................11
2.2.2 Release for Ethical Reasons ............................................................................................................12
2.3 Health Education and Special Programs ...............................................................................................12
2.3.1 Language Assistance for Members ..................................................................................................12
2.3.2 Help for Those with Impaired Vision or Hearing ..............................................................................13
2.3.3 24-Hour Nurse Advice Line and Audio Library ...........................................................................13
2.4 Marketing Rules ..................................................................................................................................13
2.4.1 Approval Process .............................................................................................................................15
2.5 Credentialing/Re-Credentialing ............................................................................................................15
2.5.1 Initial Application Process ...............................................................................................................15
2.5.2 Credentialing Process .......................................................................................................................16
2.5.3 Reimbursement and the Credentialing Process ..............................................................................17
2.5.4 Providing Services Prior to Becoming a Credentialed PHP Provider .............................................17
2.5.5 Re-credentialing Process ...............................................................................................................17
2.6 Provider Terminations/Changes in Provider Information ......................................................................18
2.6.1 Provider Terminations ......................................................................................................................18
2.6.2 Changes in Provider and Demographic Information ......................................................................18
2.6.3 Change in Location ..........................................................................................................................19
2.6.4 Panel Closings ................................................................................................................................19
2.6.5 Locum Tenens ..................................................................................................................................19
2.6.6 Member Dismissal from Provider Practices .....................................................................................20
2.7 Members’ Rights ..................................................................................................................................20
2.8 Member Appeals ..................................................................................................................................21
2.8.1 Member Pre-service Medical-Necessity Appeals ............................................................................22
2.8.2 Fair Hearing Appeal .........................................................................................................................23
2.8.3 Expedited Fair Hearing ...................................................................................................................24
2.8.4 Title VI Requirements: Translator and Interpreter Services .........................................................24
2.8.5 Title VI Training/Resources ..........................................................................................................25
3.0 Statement of Providers’ Rights and Responsibilities ............................................................................26
4.0 CDT Codes for Dental Programs ........................................................................................................28
5.0 Non - Covered Items or Services ..........................................................................................................29
6.0 Services Performed by the General/Pediatric Dentist ........................................................................29
7.0 Prior Approval for Non-Emergency Situations ....................................................................................30
1.0 Introduction

1.1 Provider Welcome

We are pleased you are part of the Passport Health Plan (also referred to as the Plan throughout this document) provider network. As a participant in the Plan’s network, you have the opportunity to make the Plan beneficial for both you and the members you serve. Passport Health Plan knows providers are essential in making this Plan a success. Passport Health Plan is committed to earning your ongoing support and looks forward to working with you to provide the best service possible to the Plan’s members.

This Provider Manual explains the policies and administrative procedures of Passport Health Plan. You may use it as a guide to answer questions about member benefits, claim submission, and many other issues. This Provider Manual also outlines day-to-day operational details for you and your staff. It will describe and clarify the requirements identified in the executed Provider Agreement. Updates to this Provider Manual will be provided on a periodic basis and available on the below-stated websites. As your office receives communications from the Plan, it is important that you and/or your office staff read the Dental Network Alerts, Medical Office Notes, and other special mailings and retain them with this Provider Manual so you can integrate the changes into your practice. All Passport Health Plan provider materials, including the Provider Manual and Provider Directory, are available online at www.passporthealthplan.com and www.avesis.com. Please note, the term “Provider” as used throughout this Provider Manual is inclusive of all practitioners, individual and group affiliated, as well as facilities and ancillary service suppliers, as appropriate.

Please take the time to familiarize yourself with this Manual as it contains a great deal of information. If you have any questions please do not hesitate to call for assistance or clarification:

Provider Services:  866-909-1083
Monday - Friday 7:00 AM to 8:00 PM (EST)

All offices will be notified thirty (30) days prior to the effective date of any changes or revisions to this Provider Manual, unless the change is required by law or regulation. An update/revision will be sent to the office and will be accompanied by a cover sheet to indicate the subject matter being addressed as well as the page(s) to be replaced or added and the effective date of the change. To assist you with the administration of benefits to members, information in this Provider Manual will be updated on the Avesis website at www.avesis.com. It is your responsibility to stay abreast of changes to this Manual. If you print the Manual from the Avesis website, when changes occur, you should:

- Remove the older page(s)
- Replace with the revised page(s)
If you require assistance or information that is not included within this Provider Manual, please contact our dental benefit administrator’s Provider Services Department, Avesis by phone (866) 909-1083. The hours for the Provider Services Department are: Monday – Friday 7:00 AM to 8:00 PM (EST).

1.2 Kentucky Medicaid Program

The Kentucky Department for Medicaid Services (DMS), under the Cabinet for Health and Family Services, is responsible for administering the Kentucky Medicaid Program as explained in Section 1.3 below. DMS has contracted with Passport Health Plan to administer the Medicaid benefits in Region 31 covering Jefferson and 15 other Kentucky counties including Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965 and operates according to a state plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint federal and state assistance program that provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of their care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining needed medical care.

As a provider of medical services, please be aware DMS is bound by both federal and state statutes and regulations governing the administration of the state plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Passport Health Plan may request a return of any monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program should not be confused with Medicare. Medicare is a federal program, identified as Title XVIII, primarily serving persons 65 years of age and older and some disabled persons under 65. The Kentucky Medicaid Program and Passport Health Plan services eligible recipients of all ages.

1.2.1 Department for Medicaid Services

The Kentucky Department for Medicaid Services (DMS), within the Cabinet for Health and Family Services (CHFS), bears the responsibility for developing, maintaining, and administering the policies and procedures, scope of benefits, and basis for reimbursement for the medical care aspects of the program. As the fiscal agent for DMS, Passport Health Plan makes the actual reimbursement to providers for covered services provided to Passport Health Plan members. It is important to note Passport Health Plan does not determine member eligibility. Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Community Based Services (DCBS) offices located in each county of the Commonwealth (see Section 20.2, “Other Important Contact Information” for local offices).
1.3 Overview of Passport Health Plan

Passport Health Plan is the operating name for University Health Care, Inc. (UHC), a managed care plan that serves Medicaid, and the Kentucky Children’s Health Insurance Program (KCHIP) populations in 16 counties in the Commonwealth of Kentucky. UHC is a nonprofit health maintenance organization licensed in the Commonwealth of Kentucky. The sponsors of Passport Health Plan are:

- The University of Louisville Medical School Practice Association;
- University Hospital;
- Jewish Hospital & St. Mary’s HealthCare;
- Norton Healthcare; and,
- Louisville/Jefferson County Primary Care Association.

The Partnership Council is a broad coalition of consumers and providers, including physicians, nurses, hospitals, health departments, and ancillary providers who help govern the operations of Passport Health Plan. Passport Health Plan covers Medicaid-eligible members in the following 16 counties: Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington.

1.4 Passport Health Plan’s Mission and Values

Our mission is to improve the health and quality of life of our Members.

Our NCQA ranking announced September 21, 2012: The National Committee for Quality Assurance (NCQA) ranks Passport Health Plan #26 among Medicaid health insurance plans in “NCQA’s Medicaid Health Insurance Plan Rankings 2012-2013.”

The Organizational Values are:

- Integrity
- Community
- Collaboration
- Stewardship

1.5 Important Telephone Numbers
(Quick Reference listing in Attachment B)

1.5.1 Compliance Department (502) 585-8239

Providers are also required to cooperate with the investigation of suspected Fraud and Abuse. If you suspect Fraud and Abuse by a Passport Health Plan member or provider, it is your responsibility to report this immediately by calling one of the telephone numbers listed below:

- Passport Health Plan Compliance Hotline: (855) 512-8500
- KYHealth Choices Fraud Hotline: (800) 372-2970
- Passport Health Plan Compliance Department: (855) 512-8500

1.5.2 Member Services (800) 578-0603

Member services representatives are available 7:00 a.m. to 7:00 p.m. EST, Monday through Friday. Member Services representatives assist members by answering questions regarding changes, benefits, and grievance issues, or by directing members to other Plan departments as needed, and by sending communication materials to members as needed.

1.5.3 Provider Services Call Center (866) 909-1083

Avesis Provider Services Call Center is available Monday through Friday, 7:00 a.m. to 8:00 p.m. EST to assist providers with questions about policies, procedures, member eligibility, and benefits. Representatives are also available if providers need to request forms or literature, report member noncompliance, or assist members in obtaining ancillary direct access services or other specialty care.

A Passport Provider Field Representative can offer orientations and in-service meetings for providers and their staff. This representative can also provide service calls and process any changes in your provider status, such as addresses and telephone numbers.

1.5.4 Utilization Management (866) 909-1083

The Utilization Management department is available 8:00 a.m. to 5:00 p.m., EST Monday through Friday. The Utilization Management department assists providers with medical necessity determinations and requests for Prior Authorizations.

Authorization requests for certain services may be submitted online. We highly recommend that providers utilize this functionally as available. Additional detail is available in Section 8 of this Manual. Utilization Management (866) 909-1083.

The Utilization Management department is available 8:00 a.m. to 5:00 p.m., EST Monday through Friday. The Utilization Management department assists providers with medical necessity determinations and requests for Prior Authorizations.
Authorization requests for certain services may be submitted online. We highly recommend that providers utilize this functionality as available. Additional detail is available in Section 8 of this Manual.

1.6 Claim Submission

Paper claims and correspondence for reconsideration or recovery are to be submitted to the following address:

Avesis Third Party Administrators, Inc.
Attention: Dental Claims
P.O. Box 7777
Phoenix, AZ 85011-7777

To submit electronically, register on the Avesis website @ www.avesis.com.

An active valid Kentucky Medicaid identification number, assigned by DMS, is required to receive any payment for services rendered.

2.0 Administrative Procedures

2.1 Eligibility

Most individuals who meet the Department for Medicaid Services (DMS) eligibility criteria for Medicaid and reside in Passport Health Plan’s service area are assigned to one of the following categories:

- Temporary Assistance to Needy Families (TANF).
- Child and family related medical cases (KTAP).
- Aged, blind, and disabled (Medicaid only).
- Pass through.
- Pregnant women and children, SOBRA (Sixth Omnibus Budget Reconciliation Act), including presumptive eligibility.
- State supplementation for aged, blind, and disabled.
- Supplemental Security Income (SSI).
- Younger than 21 years and in a psychiatric residential treatment facility (PRTF).
- Younger than 18 years, placed in foster care and under supervision of a Kentucky public or private child welfare agency.
- Children younger than 18 who are adopted and have special needs.
- Kentucky Children’s Health Insurance Program (KCHIP).
- Receiving non-institutional hospice services.

DMS does not allow certain categories of Medicaid members to participate in managed care. Individuals in the following categories are not eligible for Passport Health Plan:

- Individuals who must spend down to meet eligibility income criteria.
• Individuals currently Medicaid-eligible who have been in a nursing facility for more than 31 days (Passport Health Plan is responsible for professional services until member is dis-enrolled by DMS).
• Individuals determined eligible for Medicaid because of a nursing facility admission.
• Individuals served under the alternative intermediate services, mental retardation, or developmental disabilities (AIS-MR-DD), home and community-based or other Medicaid waivers.
• Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), or Qualified Disabled Working Individuals (QDWIs).
• Individuals in an intermediate care facility for the mentally retarded (ICF-MR).
• Individuals in a psychiatric facility, excluding a PRTF.

If you have any questions regarding eligibility criteria, contact Avesis’ Provider Services at (866) 909-1083.

*See Attachment A for Eligibility and Verification Form.

2.3 Identification Cards

Passport Health Plan issues a plastic identification card for each family member enrolled. Members are advised to keep the ID card with them at all times.

ID cards contain the following information:

• Member’s name and date of birth.
• PCP group name and telephone number.
• Passport Health Plan identification number.

Besides the Passport Health Plan ID card, each member is issued a Medicaid ID card by the Department for Medicaid Services (DMS). The Medicaid ID card is NOT the same as the Passport Health Plan ID card. The Kentucky Medicaid ID card represents eligibility for the Medicaid Program and is also used to obtain Medicaid covered services that are not covered through Passport Health Plan, such as services from behavioral health providers. Members are requested to keep and present their Kentucky Medicaid ID card along with their Passport Health Plan ID card.
2.3.1 Member Identification and Eligibility Verification

Passport Health Plan member eligibility varies by month. Therefore, each participating provider is responsible for verifying member eligibility with Avesis before providing services.

Providers may verify eligibility using any of the following methods:

**IVR (Interactive Voice Response System)**

1. Call the IVR at: (866) 234-4806
2. Enter your Avesis Provider PIN number
3. Enter the member’s KY Medicaid identification number
4. You will receive a real time response
5. Please be mindful that the Interactive Voice Response system provides verification of coverage only and does not provide utilization of benefit information

**Internet**

1. Go to www.avesis.com
2. Enter your User Name and Password
3. Click “Check Eligibility”
4. Enter the member information

You will receive a real time response

**FAX**

1. Fill out the Avesis Verification Fax Form (attached herein)
2. Fax toll free to: (866) 332-1632

You will receive a reply to the fax within one (1) business day

**Provider Services**

- Call Avesis Provider Services toll free at the number provided on the State/Program Exhibit page
- Provide your Avesis Provider PIN number
- Provide the member’s identification number

Remember: Eligibility verification is not a guarantee of payment. Benefits are determined at the time the claim is received for processing.

*NOTE: These options will only provide eligibility information for Passport.*
As a way to help prevent Medicaid “card sharing”, always ask to see the member’s Passport Health Plan ID card or the member’s Kentucky Medicaid ID card and confirm member using a picture ID.

**Please note that Passport Health Plan cards are not returned to Passport Health Plan when a member becomes ineligible.** Therefore, the presentation of a Passport Health Plan ID card is not sole proof that a person is currently enrolled in Passport Health Plan. Providers should request a picture ID to verify that the person presenting is indeed the person named on the ID card. Services may be refused if the provider suspects the presenting person is not the card owner and no other ID can be provided. If you suspect a non-eligible person is using a member’s ID card, please report the occurrence to Passport Health Plan’s Fraud and Abuse Hotline at (855)-512-8500 or the Medicaid Fraud Hotline at (800) 372-2970.

### 2.4 Release for Ethical Reasons

A participating provider is not required to perform any treatment or procedure that may be contrary to the provider’s conscience, religious beliefs, or ethical principles. If such a situation arises, the provider should contact Provider Services at (866) 909-1083. A Provider Services representative will work with the provider to review the member’s needs and transfer or refer the member to another appropriately qualified provider for care.

### 2.5 Health Education and Special Programs

Members also have access to over 1,200 health topics through an audio library. A Member may call the 24-Hour Nurse Advice Line to access the audio library (800-606-9880).

#### 2.5.1 Language Assistance for Members

Federal law requires providers to ensure that communications are effective.

Providers who render dental or medical services to Passport Health Plan members benefit from a program that receives federal financial assistance and are, therefore, subject to the requirements of Title VI of the Civil Rights Act of 1964. This act prohibits recipients of benefits from a program receiving federal financial assistance, such as Medicaid, from being prohibited from or refused service on the grounds of race, color, or national origin. The term “on the grounds of national origin” has been interpreted to include persons with limited-English proficiency (LEP). Title VI requires every Medicaid provider, including Passport Health Plan providers, to offer

Members equal access to benefits and services by ensuring that each LEP person can communicate effectively in his or her language of choice. This law also requires providers to take necessary steps to provide language assistance at no cost to Passport Health Plan members with LEP.

Providers may contact Passport Health Plan’s Cultural & Linguistics Services Program at (502) 585-7303 for additional information and/or questions.
2.5.2 Help for Those with Impaired Vision or Hearing

The member Handbook is available in alternative formats for members with visual impairments. Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, Passport Health Plan’s TDD/TTY number for Member Services is (800) 691-5566.

2.5.3 24-Hour Nurse Advice Line and Audio Library

Members may talk with a nurse 24 hours a day, 7 days a week by calling the 24-Hour Nurse Advice Line at (800) 606-9880. Spanish speaking members may access this service and other languages are available via the use of translation services. For members that use a telecommunications device, please call the Kentucky Relay TDD/TTY number at (800) 648-6057. Through the same number, members may access an audio library of over 35 categories of health care topics, including (but not limited to):

- Cancer
- Women’s Health
- First Aid
- Allergies and Asthma
- Disease and Injury Prevention

Spanish speaking members may also access the 24-Hour Nurse Advice Line. Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, the TDD/TTY number for the Nurse Advice Line is (800) 648-6056.

NOTE: The 24-Hour Nurse Advice Line is not meant to take the place of the provider and may not be used for after-hour coverage.

2.6 Marketing Rules

Passport Health Plan’s contract with DMS defines how Passport Health Plan and its providers market and advertise Passport Health Plan. Accordingly, providers must adhere to the following graphic standards:

*Plan Name:*

- The name of the Plan may only be referenced, in print and audio, as Passport Health Plan. Other deviations of this name are not permitted (PHP, Passport, etc.).
- The name, Passport Health Plan, may only appear in black and only in Adobe Garamond or Arial fonts.
- The name, Passport Health Plan, may not be animated or graphically altered in any way for television, print, or web-based advertising.

*Logos:*
• The Passport Health Plan logo may not be copied, scanned, downloaded, animated, replicated, or modified for print or used as a graphic element as part of a television or web-based advertisement.

Tag Lines:

• No past, present, or future tag lines of Passport Health Plan may be utilized in any provider advertising.

Copy:

• The following copy may be used to indicate a provider’s affiliation or participation in Passport Health Plan:
  o We accept Passport Health Plan and The Kentucky Children’s Health Insurance Program (KCHIP) members.
  o We accept Passport Health Plan and The Kentucky Children’s Health Insurance Program (KCHIP) cards.
  o We welcome Passport Health Plan and The Kentucky Children’s Health Insurance Program (KCHIP) members.

Unacceptable references include:

• References to Passport Health Plan benefits and co-pays
• Statements that indicate services are guaranteed by Passport Health Plan
• Statements that indicate that eligibility is determined by Passport Health Plan

Images:

• Images or duplications of the Passport Health Plan member ID card may not be used in any advertisements
• Images of actual Passport Health Plan members or associates

KyHealth Choices/Kentucky Department for Medicaid Services*

KyHealth Choices/Kentucky Department for Medicaid Services

• The use of the name KyHealth Choices or the words, Medicaid, DMS, or the Kentucky Department for Medicaid Services will be approved or disapproved at the discretion of the Kentucky Department for Medicaid Services.

* In addition to these graphic standards, The Kentucky Department for Medicaid Services, along with Passport Health Plan, will review and approve or disapprove all proposed and/or existing advertising related to providers promoting their participation and/or affiliation with Passport Health Plan.
2.6.1 Approval Process

Mockups must be submitted to Passport Health Plan’s Director of Public Affairs before publication. The Director will review and correct the mock up as necessary. After artwork is approved by Passport Health Plan, it will be forwarded by compliance to DMS for review and approval. Providers may not advertise or promote their affiliation with Passport Health Plan until artwork has been reviewed and approved by both entities.

Questions or comments about the Passport Health Plan Provider Advertising Graphic Standards should be directed to:

Director, Marketing & Community Outreach Department
Passport Health Plan
Phone: (502) 585-7331, or 1-800-578-0603, ext. 7331

2.7 Credentialing/Re-Credentialing

2.7.1 Initial Application Process

To begin the application process and join the Passport Health Plan (PHP), first call Avesis’ Provider Services department at (866) 909-1083. Avesis will send you a provider application packet and work with you to become credentialed and if approved, contracted as a PHP dental provider.

Avesis participates with the Council for Affordable Quality Healthcare (CAQH). Providers who are participating with this common credentialing application database should contact Avesis’ Provider Services department at (866) 909-1083 and include their CAQH Provider ID number with documents submitted to Avesis.

Practitioners

New practitioner applicants are required to complete all residency and/or training programs prior to joining the network. Practitioners still completing a residency program are required to bill under the attending practitioner.

Applicants must submit a completed application, which includes the following as applicable:

- Two Participating Provider Agreements signed by the provider indicating their intent to join the network if approved after being credentialed.
- Completed Provider Application either a CAQH (Council for Affordable Quality Healthcare universal credentialing application) or the most current version of KAPER1 (Kentucky Department for Medicaid Services application), including:
  - Additional copies of pages from the application (as needed);
  - Disclosure questions, as applicable, including but not limited to:
    - Documentation of any malpractice suits or complaints.
- Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
- Documentation of any conviction of a criminal offense within the last 10 years (excluding traffic violations); and,
  - The attestation page (including the practitioner signature and current date).
- Original, complete, and signed MAP Forms, if a Medicaid ID number is needed per the Kentucky Department for Medicaid Services Provider enrollment web page. If the Provider has a current Kentucky Medicaid ID number, the Provider must include a completed MAP-347 form.
- Copy of current State License Registration Certificate.
- Copy of current Federal Drug Enforcement Agency Registration - if applicable.
- Curriculum vitae or a summary specifying month and year for work history, explaining any lapse in time exceeding six months.
- Copy of a completed, dated and signed W-9 in the name of the provider or facility/group, including the Tax Identification Number and mailing address for all tax information.
- Copy of claim history form for each malpractice activity within the past five years.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.
- A letter adding practitioner to each existing group contract, including group ID number(s), if applicable.
- Copy of social security card (If applicant has as social security card stating “valid for work only with DHS/INS Authorization”, please refer to additional requirements at http://www.chfs.ky.gov/dms/provenr/), if submitted MAP forms for Medicaid ID numbers
- ECFMG (Education Council for Medical Graduates), if applicable.

Failure to submit a complete application may result in a delay of the credentialing process. Practitioners may contact the Avesis Provider Services department at (866) 909-1083 to check the status of their applications.

### 2.7.2 Credentialing Process

Avesis, acting on behalf of Passport Health Plan (PHP), assesses practitioner applicants through Passport Health Plan’s credentialing process. With the receipt of all of the application materials, primary source verification is conducted by Avesis’ Credentialing department. Following the verification of credentials, Avesis’ Chief Dental Officer/designated Dental Director or Credentialing Committee reviews each application for participation. Avesis will not initiate the credentialing review until a completed and signed application with attachments has been received. The normal processing time is between thirty (30) and sixty (60) days from date of submission of a completed application.
2.7.3 Reimbursement and the Credentialing Process

Providers will be considered participating Passport Health Plan providers once they have met Passport Health Plan’s credentialing requirements and have an executed agreement and a Medicaid number. Providers will be notified by Avesis when they have been credentialed by Avesis. Providers applying for participation are excluded from the Provider Directory until the credentialing process has been completed in its entirety.

Providers will be reimbursed at the participating provider rate, retroactive to the first of the month in which the application is received provided the provider has an active Medicaid ID number and has submitted the MAP 347 form to be linked to Passport Health Plan. Providers may begin submitting claims for services provided to PHP members once they have been notified of the receipt of their completed application and have been assigned a Provider ID number. Providers are required to submit all claims within 180 days of service, but no payment is made until Passport Health Plan receives confirmation that the provider has been issued a Kentucky MAID number. Please note, claims submitted without a Kentucky Medicaid Identification (MAID) number will be denied. Providers will receive notification from DMS when a MAID number is assigned. Providers are encouraged to notify Avesis and the Passport Health Plan of receipt of a MAID number assignment.

2.7.4 Providing Services Prior to Becoming a Credentialed PHP Provider

If a Provider feels a PHP member must be seen prior to the assignment of a Provider ID number, the Provider should see the member and submit for reimbursement under the plan after receiving his/her Provider ID number. As stated previously the Provider will not be eligible for payment until they have an executed contract and a Medicaid number. If payment is denied because the Provider is not participating or they do not have a Medicaid ID, the member cannot be held liable.

2.7.5 Re-credentialing and Ongoing Monitoring Process

Passport Health Plan, through Avesis, re-credentials its providers, at a minimum, every 36 months. In addition, Passport Health Plan conducts ongoing monitoring of Medicare and Medicaid sanctions and sanctions or limitations on licensure. Practitioners who become participating and subsequently have restrictions placed upon their license will be reviewed by the committee and evaluated on a case-by-case basis, based upon their ability to continue serving Passport Health Plan’s members.

Member complaints and adverse member outcomes are also monitored and Passport Health Plan will implement actions as necessary to improve trends or address individual incidents. If efforts to improve practitioner performance are not successful, the practitioner may be referred to the Credentialing Committee for review prior to his/her normally scheduled review date.
Practitioners

Avesis, on behalf of Passport Health Plan, will generate a re-credentialing application on all practitioners with current CAQH applications on file. Practitioners without a CAQH on file will be notified by letter to submit a re-credentialing application (most current version of the KAPER 1 or CAQH) with the following list of attachments:

- Disclosure questions, as applicable, including but not limited to:
- Documentation of any malpractice suits or complaints.
- Documentation of any restrictions placed on practitioner by licensing board, or governing agency.
- The attestation page (including the practitioner signature and current date).
- Copy of current State License Registration Certificate.
- Copy of current Federal Drug Enforcement Agency Registration - if applicable.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.

Failure to return documents in a timely fashion may result in a period of non-participation. The initial credentialing process will need to be completed in order to re-enroll as a participating provider. Practitioners may contact the Avesis Provider Services at (866) 909-1083 to check the status of their re-credentialing application.

Should Avesis decide to deny or terminate a provider from participation with Passport Health Plan, the provider will receive notification of the decision. The notification will include the reasons for the denial or termination, the provider’s rights to appeal and request a hearing within thirty (30) days of the date of the denial notice, and a summary of the provider’s hearing rights.

2.8 Provider Terminations/Changes in Provider Information

2.8.1 Provider Terminations

Termination of an existing PHP contract requires ninety (90) days written notice. A provider desiring to terminate his/her participation must submit a written termination notice, including the final termination date, to the Provider Services via fax (866) 542-3599 within the applicable notice period as outlined in the provider agreement.

2.8.2 Changes in Provider and Demographic Information

Providers are required to provide a written notice to both Avesis’ Provider Network Management department and the Department for Medicaid Services of any changes in information regarding their practice. Such changes include:

- Address changes, including changes for satellite offices.
- Additions to a group.
- Changes in billing locations, telephone numbers, tax ID numbers.
Reimbursement may be affected if changes are not reported in accordance with Passport Health Plan policy. Please note that providers are required by DMS to annually submit a copy of current license and annual disclosure of ownership. If these documents are not provided, the Provider’s Kentucky Medicaid (MAID) number may be terminated. Your office will receive notice from the DMS when these documents are due for submission. Please respond timely to these requests.

2.8.3 Change in Location

If a provider working in multiple offices discontinues working in one or more locations, written notification must be provided to Avesis, on behalf of Passport Health Plan, as to where employment is terminating, as well as the specific offices where employment is continuing.

2.8.4 Panel Closings

Passport Health Plan requests a ninety (90) day advance written notice from the practice if closing the practice from accepting new patients.

2.8.5 Locum Tenens

According to PHP policy, participating providers may utilize the services of a locum tenens provider, under temporary circumstances, for a maximum period of sixty (60) consecutive days or less. When locum tenen services are needed, participating providers must register the substitute provider. This process must be completed prior to the provision of any services by a locum tenens provider.

To register a locum tenen provider, the participating PHP provider must complete the Registration of Locum Tenens Physician form (you may request this form from your local Provider Service Rep). Both the participating PHP provider and the locum tenens provider must sign the form. To complete the registration process, the signed form must be returned to Avesis, on behalf of Passport Health Plan by mail, or by fax at:

Fax: (866) 542-3599
Attn: Provider Enrollment
Phone (866) 909-1083

Services rendered by a locum tenens provider must be billed utilizing the absent provider’s Passport Health Plan ID number and the Q6 modifier with the applicable procedure code(s). The Q6 modifier signifies that the service was provided by a locum tenen provider. According to the PHP Provider Agreement, the absent provider remains liable and all contractual terms remain effective throughout the employ of a locum tenens provider.

If services by a locum tenens provider remain necessary beyond the period of sixty (60) consecutive days, the locum tenens or substitute provider must apply for participation with PHP and complete the credentialing process and have or apply for a Kentucky Medicaid number. Upon becoming credentialed with Passport Health Plan, the provider will be assigned a Provider ID number for billing purposes.
2.8.6 Member Dismissal from Provider Practices

If, in accordance with practice standards, the Provider determines that a member will no longer be seen at the practice, notification must be provided to the member, a copy of which should be placed in the member’s record.

2.9 Members’ Rights

Members are informed of their rights and responsibilities through the member Handbook. Passport Health Plan providers are also expected to respect and honor members’ rights.

Passport Health Plan members have the following rights:

- To receive information about Passport Health Plan, its benefits, services and providers, and their rights and responsibilities.
- To be treated with respect and have recognized their dignity and the right to privacy and non-discrimination as required by law.
- To participate with their providers in making decisions regarding their health care.
- To discuss treatment options, regardless of cost or benefit coverage.
- To voice grievances or file appeals about Passport Health Plan decisions that affect their privacy, benefits, or the care provided.
- To expect their medical records and care to be kept confidential, as required by law.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To privacy of their health care needs and information, as required by law.
- To allow or refuse their personal information be sent to another party for uses such as data used in research studies, workers compensation claims, and outside marketing purposes, except when the release of information is required by law.
- To choose a Primary Care Provider (PCD) and to change to another PCD.
- To receive timely access to care, including referrals to specialists when medically necessary, without barriers.
- To look at and get a copy of their medical records, as required by law.
- To file for a State Hearing with the Department for Medicaid Services at any time.
- To receive materials in alternative formats and other languages if necessary at no cost to the member.
- To be given an interpreter during all contact and during normal business hours at no cost to the member.
- To make an advance directive, such as a living will.
- To choose a person to represent them for the use of their information by Passport Health Plan if they are unable to.
- To make suggestions about their rights and responsibilities.
Passport Health Plan members have the following responsibilities:

- To take all their ID cards (Passport Health Plan ID card, Kentucky Medicaid ID card, and any other insurance card) to all medical appointments.
- To follow the policies and procedures of the Department for Medicaid Services and Passport Health Plan.
- To provide, to the best of their ability, information that Passport Health Plan and Providers need in order to care for them.
- To follow the instructions and plans of care they have agreed to with their provider.
- To learn about their rights.
- To be honest with providers and treat them with respect and kindness.
- To get regular medical care from their Primary Care Provider (PCD).
- To obtain a referral from their Primary Care Provider (PCD) before seeing a specialist.
- To ask their provider questions about the care they receive.
- To ask their provider questions about his or her instructions.
- To understand their health problems and work with their provider as much as possible to decide treatment goals that both agree on.
- To follow the steps of the appeal process.
- To make good decisions about their health and things that affect their health.
- To notify Passport Health Plan if they suspect fraud or misuse of Passport Health Plan ID cards or benefits by a member or provider.
- To notify the Department for Community Based Services (DCBS), Passport Health Plan, and their providers of any changes that may affect their membership, health care needs, or access to benefits. Some examples may include:
  - If they have a baby.
  - If their address changes.
  - If their telephone number changes.
  - If they or one of their children are covered by another health plan.
  - If they have a special medical concern.
  - If their family size changes.
- To keep appointments with providers and call to cancel appointments when they cannot be there.

### 2.10 Member Appeals

All members have the right to appeal an action by Avesis, on behalf of Passport Health Plan. An appeal is a request for review of an action or a decision by Passport Health Plan related to covered services or services provided. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure to act within specified timeframes; or a denial of a request to obtain services outside the network for specific reasons.
Member appeals must be submitted in writing. At no time will a member be discriminated against because he or she has filed an appeal. We always respect our members’ privacy. Anything they say or write is kept confidential.

There are two types of member appeals that may be directed to the Avesis appeals coordinator:

1. A pre-service medical-necessity denial appeal
2. A benefit denial appeal

An expedited review process is available for a member pre-service medical-necessity appeal when Avesis determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member’s life; health; or ability to attain, maintain, or regain maximum function.

Please address all pre-service medical-necessity and benefit appeals to:

Avesis
Attn: Appeals Dept
PO Box 7777
Phoenix, AZ 85011-7777

LEP persons will be given interpretation/translation assistance when necessary to navigate the appeals process.

2.10.1 Member Pre-service Medical-Necessity Appeals

A pre-service appeal is a request for review of an action by Avesis, on behalf of Passport Health Plan, related to requested services not yet received by the member. The member, an authorized representative of the member, or a provider acting on behalf of the member may file a pre-service appeal.

Appeals filed by the provider on the member’s behalf require the member’s written consent. **If the member’s written consent is not received within thirty (30) calendar days of the action then no appeal will be initiated.**

The appeal must be filed in writing, and Passport Health Plan must receive it within 30 calendar days from the date of a notice of an action by Avesis. A 14 calendar-day extension will be granted at the member’s request. Avesis can also request a fourteen (14) calendar-day extension if there is a need for additional information and the delay is in the member’s best interest. Within three (3) business days of receipt of the written appeal, Avesis will send the member a letter acknowledging receipt of the appeal and advising of the date the appeal will be heard. The member may present supporting documentation or evidence in person or in writing on or before that date. A board-certified practitioner with clinical expertise in treating the member’s condition or disease who was not involved in the initial denial reviews all member pre-service medical appeals. Avesis will communicate to the member and the provider an appeal decision within thirty (30) calendar days from Avesis’ receipt of the appeal. The appeal decision is final, and at this point, the member has exhausted all appeal options with
Passport Health Plan. The member may also contact Kentucky’s Ombudsman for assistance at any time during the appeal process. Members may call Passport Health Plan Member Services at (800) 578-0603 for help filing a medical appeal.

Please address all pre-service medical-necessity and benefit appeals to:

Avesis
Attn: Appeals Dept
PO Box 7777
Phoenix, AZ 85011-7777

LEP persons will be given interpretation/translation assistance when necessary to navigate the appeals process.

Members may contact the Kentucky Ombudsman at any time at the following address:

Cabinet for Health Services
Office of Ombudsman
275 East Main St., 1E-B
Frankfort, KY 40601
(800) 372-2973
TDD/TTY (800) 627-4702

Passport Health Plan will cooperate with any State decision. A member may send a request for a State Hearing to the following address:

Kentucky Department for Medicaid Services
Division of Administration and Financial Management
275 East Main St., 6W-C
Frankfort, KY 40601
(800) 635-2570
TDD/TTY (800) 775-0296

Fair Hearing Appeal

A Member may ask for a Fair Hearing Appeal. A Member requests this appeal by sending a letter to Department for Medicaid Services within 45 days from the date of the notice by regarding the denial, decrease in services, or approval of a different service.

If services the Member is currently receiving are being denied, reduced, or approved for a different service, the Member may want to continue the services during the appeal. To do so, the Member must file the appeal to Department for Medicaid Services within 10 days from the date of the notice. The Fair Hearing Appeal should be sent to:

Kentucky Dept. of Medicaid Service
275 East Main Street
Frankfort, KY 40621
Expedited Fair Hearing

If a Provider believes the usual timeframes for deciding a complaint or grievance will harm his or her health, the Provider or the Member can call the Kentucky Department for Medicaid Services at (800) 635-2570 and ask for an expedited fair hearing.

2.11 Title VI Requirements: Translator and Interpreter Services

Title VI of the Civil Rights Act (1964) is a Federal law that requires any organization receiving direct or indirect Federal financial assistance to provide services to all beneficiaries without exclusion based on race, color, or national origin.

All Passport Health Plan (PHP) providers indirectly benefit from Federal financial assistance (via Medicaid). Therefore, under Title VI and the Culturally and Linguistically Appropriate Services (CLAS) Standards 4 - 7, as outlined by the Office of Minority Health, U.S. Department of Health and Human Services (DHHS), all Passport Health Plan providers are required by law to:

- Provide written and oral language assistance at no cost to any patient, including, but not limited to Passport Health Plan members with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters.

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation in their preferred language and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

- Provide patients, including Passport Health Plan member’s verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read member signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in the preferred language or format of patients, including Passport Health Plan members.

Additionally, under the CLAS Standards, Passport Health Plan providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all patients, including Passport Health Plan members in a manner compatible with his/her cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
• Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
• Establish written policies to provide interpretive services for patients, including Passport Health Plan members.
• Routinely document each patient’s preferred language or format, such as Braille, audio, or large type, in all medical records.

Potential penalties of non-compliance with Title VI may include:

• Loss of federal and state funding, including future funding (i.e. providers may be prohibited from participating in Medicaid, Medicare, and/or incentive programs such as the Electronic Health Records incentive).
• Legal action against providers from the DHHS, legal service organizations, and private individuals.
• "Informed consent" issues which may also lead to medical malpractice charges.
• Change in participation status with Passport Health Plan.

Providers may contact Passport Health Plan’s Cultural and Linguistics Services Program Coordinator at (502) 585-7303 or e-mail cals@passporthealthplan.com for additional information or to schedule an on-site training.

2.11.1 Title VI Training/Resources

Passport Health Plan’s Cultural and Linguistics Services (CLSP) Program offers the following training materials and resources. Contact the CLSP Coordinator at (502) 585-7303, e-mail cals@passporthealthplan.com, or visit our web site, www.passporthealthplan.com/Provider/services/cals, for more details.

• Onsite Trainings/Resources

Our CLSP staff is a resource for Title VI/CLAS Standards and assists providers in reaching and maintaining compliance. We offer free on-site trainings for office staff, an informative Provider Toolkit, and web-based information and resources.

• Provider Office Materials - These materials are available online or by calling Provider Services at (866) 909-1083.
• In addition to the Provider Toolkit and other educational resources, Passport Health Plan also offers provider office signage to assist office staff in complying with Title VI.
• Translated Member Materials and TDD/TYY Lines.

Many member materials, including the Passport Health Plan Member Handbook, are available in other languages and alternative formats such as Braille, audio, and large type.

Members may download these on Passport Health Plan website or call Member Services for copies.
Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf (TDD), Passport Health Plan’s TDD/TYY numbers for Member Services are: Passport Health Plan (800) 691-5566.

- Discounts for Telephonic and Video Interpretation

Passport Health Plan also contracts with a telephonic and video interpretation vendor, InterpreTalk by Language Services Associates (LSA), to offer our providers a discounted rate. To set up an account and receive InterpreTalk services, please call (800) 305-9673, ext.55314. It may take 48 to 72 hours to set up InterpreTalk account to begin receiving interpretive services.

3.0 Statement of Providers’ Rights and Responsibilities

Providers shall have the right and responsibility to:

- Communicate openly and freely with Avesis including, but not limited to support of Provider Services and Customer Services representatives and information on participating providers for the purpose of referrals
- Communicate openly and freely with member(s)
- Suggest dental treatment option(s) to member(s)
- Manage the dental health care needs of members to assure that all necessary services are made available in a timely manner including, but not limited to informing members of all treatment options both covered and non-covered
- Ensure disclosure form is signed for non-covered service(s) by all parties prior to rendering service(s)
- Maintain the confidentiality of members’ personal health information, including medical records and histories in accordance with all state and federal laws and regulations regarding privacy, security and confidentiality as may be amended from time to time
- Obtain written parental or guardian consent for treatment to be rendered to members who have not yet reached the age of maturity in accordance with State Dental Board rules or ADA guidelines
- Obtain information regarding claim status and pre-treatment estimates for services to be rendered and re-submit claims with additional information by following the guidelines set forth herein
- Receive prompt payments from Avesis for clean claims
- Make a complaint or file an appeal with Avesis on behalf of a member with the member’s consent and inform the member of the status of the appeal
- Inform a member of appeal status
- Question policies and/or procedures that Avesis has implemented on behalf of Passport
- Request Pre-Treatment Estimate for services identified herein as requiring pre-treatment estimates
- Refer members to participating specialists for treatment that is outside your normal scope of practice
• Update credentialing materials including State licensure, DEA and professional liability insurance
• Inform Avesis in writing within twenty-four (24) hours of any revocation, suspension and/or limitation of your license to practice, certification(s), and/or DEA number by any licensing or certification authority
• Consistent with Avesis’ credentialing and re-credentialing policies, inform Avesis in writing prior to changes in licensure status, tax identification numbers, telephone numbers, addresses, loss or modification of insurance or any other change that would affect status with Avesis. Failure to notify Avesis prior to these changes may result in delays in claims processing and payment
• Consistent with the terms of your Provider Agreement, notice of termination of participation must be submitted at least ninety (90) days prior to the termination effective date
• Maintain an environmentally safe office with equipment in proper working order to comply with city, county, state and federal regulations concerning safety and public hygiene
• Respond promptly to requests from Avesis for dental records as needed to review appeals and/or quality of care issues
• Abide by the rules and regulations set forth under applicable provisions of State or Federal law

Provider further understands that provider is prohibited from:

• Discriminating against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency. Provider agrees to comply with the Americans with Disabilities Act, and the Rehabilitation Act of 1973 and all other applicable laws related to the same. See Title VI Civil Rights Act of 1964, [www.usdoj.gov/crt/cor/coord/titlevi.htm](http://www.usdoj.gov/crt/cor/coord/titlevi.htm)
• 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 solicit from other providers for financial consideration
• Referring members to an independent laboratory, pharmacy, radiology or other ancillary service in which the provider or professional corporation has an ownership interest
• Billing, charging, or seeking compensation, remuneration, or reimbursement from any member other than for supplemental charges, copayments (as applicable; example: in 2013 there are no copayments for any member type) or fees for non-covered services. Non-covered services are services not listed on the Benefits and Fee Schedule included herein.
• Provider Responsibilities
• Suspected Child or Adult Abuse or Neglect
• Cases of suspected child or adult abuse or neglect might be uncovered during examinations.
• Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission.
• If suspected cases are discovered, an oral report should be made immediately, by telephone or otherwise, to a representative of the local Department for Social Services office at (502) 595-4550. To facilitate reporting of suspected child abuse and neglect cases, legislation affecting the reporting of child abuse (KRS 620.030) is printed on the reverse of the Child Abuse Reporting Form (DSS--115). These forms may be obtained from the local Department for Social Services office.
• Adult abuse is defined by KRS. 209.020 as “the infliction of physical pain, mental injury, or injury of an adult.” The statute describes an adult as “(a) a person 18 years of age who because of mental or physical dysfunction is unable to manage his [her] own resources or carry out the activity of daily living or protect himself [herself] from neglect or a hazardous or abusive situation without assistance from others and who may be in need of protective services; or (b) a person without regard to age who is the victim of abuse and neglect inflicted by a spouse.”

4.0 CDT Codes for Dental Programs

Detailed descriptions for CDT Codes including benefit limitations and attachments required for claims processing may be found on the Covered Benefits Schedule located behind the Agreement in this Manual.

Medically necessary dental services must be appropriate and consistent with the standard of care for local dental practices. You understand that the omission of appropriate services could 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. However, 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 should be dentally or 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.
5.0 Non-Covered Items or Services

Passport, through Avesis’ dental benefit management, will not pay Providers for non-covered services. Providers will hold harmless Passport, Avesis and DMS for payment of non-covered dental services.

Non-covered services include investigational items and experimental drugs or procedures not recognized by the United States Food and Drug Administration, the United States Public Health Service, CMS, and the Avesis Chief Dental Officer and State Dental Director as universally accepted treatment, including but not limited to, positron emission tomography, dual photon absorptiometry, etc.

The Member may purchase additional services as non-covered procedure(s) or treatment(s) for an additional charge. Passport requires that you and the Member complete the Non-Covered Services Disclosure Form or a similar form that contains all of the elements of the Passport Non-Covered Services Disclosure Form included herein prior to rendering these services. If the Member elects to receive the non-covered procedure(s) or treatment(s), the Member would pay your usual and customary rate as payment in full for the agreed upon procedure(s) or treatment(s). The Member is financially responsible for such services. If the Member will be subject to collection action upon failure to make the required payment, the terms of the action must be kept in the Member’s treatment record. Failure to comply with this procedure will subject the Provider to sanctions up to and including termination.

Members may not be billed for any service, with the exception of services in which a Passport Non-Covered Services Disclosure Form has been signed prior to the service being rendered.

*See Attachment B for Non-Covered Services Disclosure form.

6.0 Services Performed by the General/Pediatric Dentist

The Passport Dental Programs are intended to be General/Pediatric Dentistry programs. Passport considers the General/Pediatric Dentist to be the Provider responsible for rendering all primary care to our Members. That dentist is responsible for the initial examination and basic radiographs necessary for any professional review by Avesis.

General/Pediatric Dentists should render the following services whenever possible:

1. Preliminary diagnostic and all preventive care
2. Simple forceps extractions (D7140)
3. All anterior (D3310) and bicuspid (D3320) root canal therapies
4. Initial root planing, scaling (requires Prior Authorization) and follow-up evaluation for all periodontal cases
5. Endodontic may require a request for Prior Authorization along with radiographs and is not considered for cases with rampant cavities or
multiple missing teeth. Refer to the applicable Passport Covered Benefits Schedule for more information.

6. Routine restorative dentistry.

The aforementioned procedures should not be referred to a specialist unless they present with unusual complications or fall outside the scope of your practice.

Note: It is the responsibility of the General/Pediatric Dentist to provide a copy of diagnostic quality radiographs to any Successor Dental Provider, whenever possible. If radiographs cannot be obtained from the General/Pediatric Dentist, the Successor Dental Provider shall contact Avesis. Avesis shall notify the General/Pediatric Dentist, in writing, within thirty (30) calendar days or less, that the Successor Dental Provider did not receive diagnostic quality radiographs. If necessary, Avesis will charge back the General/Pediatric Dentist for radiographs that the Successor Dental Provider must retake for appropriate care if:

1. The General/Pediatric Dentist has taken radiographs that were not of diagnostic quality as determined by Avesis clinical staff; and/or,
2. Radiographs were not submitted to the Successor Dental Provider within ten (10) business days following a request for said radiographs.

For those Providers requesting radiographs less than ten (10) days prior to a Member being treated by the Successor Dental Provider, Avesis will not charge back the General/Pediatric Dentist.

If the specialist deems that radiographs do not need to be repeated, the specialist must include a narrative to clearly explain the dental conditions found upon examination.

7.0 Prior Approval for Non-Emergency Situations

Non-emergency treatment for services requiring prior approval started prior to the granting of prior authorization will be performed at the financial risk of the dental office. If authorization is denied, the dental office or treating Provider may not bill the Member, the sponsor, or Avesis.

Receipt of authorization or denial of the request for prior approval will be provided within the time frames dictated by the State or Program for which services are being rendered.

Services that require Prior Approval for non-emergency care can be found in the Covered Benefits Schedule “Passport Approved Benefit Grid 01.29.2013” on the Avesis secure website at www.avesis.com.

Form to use:

ADA Claim Form for Pre-Treatment Estimates

You may submit a Pre-Treatment Estimate in one of two ways:
1. Electronic submission, please go to the Avesis website at www.avesis.com
2. Or Mail on an ADA claim form to:

Avesis Third Party Administrators, Inc.
P. O. Box 7777
Phoenix, Arizona 85011-7777
Attn: Dental Pre-Treatment Estimate

Avesis does not accept ADA claim forms via fax. Because all prior authorization requests must be submitted electronically on our website or on an ADA claim form, you must either submit them on the Avesis website or mail in an ADA claim form with the appropriate box checked indicating that you are submitting a request for pre-treatment estimate.

**NOTE**: Prior authorization of dental services must be performed as a part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

- pertinent dental history;
- pertinent medical history, if applicable;
- the strategic importance of the tooth;
- the condition of the remaining teeth;
- the existence of all pathological conditions;
- preparatory services performed and completion date(s);
- documentation of all missing teeth in the mouth;
- the general oral hygiene condition of the Member;
- 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, if known;
- the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis;
- identification of abutment teeth by number;
- for periodontal services, include a comprehensive periodontal evaluation.

**Note**: For those Service Programs or situations where dental services are limited to services provided in an inpatient hospital, hospital short procedure unit or ambulatory surgical center, please include a statement identifying where the service will be provided.

**8.0 Specialty Referral Process**

A Member requiring a referral to a dental specialist can be referred directly to any specialist contracted with Passport without authorization from Avesis. The dental specialist is responsible for obtaining prior authorization for services according to the covered benefits schedule found in this Manual. If you are unfamiliar with the Avesis
contracted specialty network or need assistance locating a certain specialty, please contact Avesis’ Member Services Department. In addition, Members may self-refer to any network Provider without authorization from Avesis.

8.1 Use of Specialists

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

8.2 Second Opinion

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

8.3 Preventive Treatment

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

A. Update medical history
B. Review of oral hygiene practices and necessary instruction provided
C. Complete prophylaxis and periodontal maintenance procedures
D. Topical application of fluoride if indicated
E. Sealant application if indicated

Hospital Referral

Hospital referrals will be handled by Passport. If hospitalization of a Member for dental services is necessary, the hospital must be authorized using the regular process for PHP.

8.4 Emergency Care

In the event that a dental emergency occurs after Avesis business hours and you cannot treat the Member within twenty-four (24) hours, please refer the Member back to their health plan for further assistance. Passport requires that you provide sufficient access so that you attempt to keep the Member from having services rendered in a hospital emergency room.
8.5 Emergency Access and Authorizations

All Passport Provider offices shall be responsible for the effective response to and treatment of dental emergencies. In relation to dental emergencies, there are two types of Members:

1. Members of record; or
2. Members who have not been part of the practice

and two situations:

1. during regular office hours; or
2. after hours

To confirm whether the situation is a true emergency, the dentist should speak with the Member to determine the Member’s problem and take the necessary actions. If it is determined by you and the Member that it is a true dental emergency (that is: a situation that cannot be treated simply by medication and, that left untreated, could affect the Member’s health of the stability of their dentition), then you 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 dental Provider or a hospital emergency room, if the condition warrants emergency room treatment.

8.6 Patient of Record

If the Member telephones with an emergency before 12 Noon, you must respond to the Member that business day, if possible. If the Member telephones after 12 Noon, the Member must be responded to that day if possible, but no later than the following business day. If you are not treating patients the following business day, then weekend requirements will apply.

For a weekend, holiday, or other "off hour" dental emergency, you must have make available an answering service or telephone number available for the Member of record to contact. The responding dentist should assess the emergency request from the patient and make arrangements to provide appropriate follow up care. If the situation is determined to be a true dental emergency (a situation that cannot be treated simply by medication and, that left untreated, could affect the Member’s health or the stability of their dentition), the responding dentist must either:

- arrange for the Member to come into the office to treat the emergency, or
- assist the Member in obtaining proper dental care from another network dental Provider

Avesis is committed to providing effective emergency care for patients without the use of hospital emergency rooms, unless absolutely necessary. Members of record shall be required to see their dentist of choice prior to any hospital admission.

In accordance with the Provider Agreement, Section D. Urgent/Emergency Dental Condition, in the case of a Dental Emergency or Urgent dental condition, Participating
Provider shall make every effort to see the Member immediately and shall see the Member within twenty-four (24) hours. For weekend Dental Emergencies, Participating Provider and/or Dentist Participating Provider(s) shall have an answering service or cell phone number available for contact. Avesis shall permit treatment of all dental services necessary to address the Dental Emergency for Member without prior authorization. However, elective dental services, not necessary for the relief of pain and/or prevention of immediate damage to dentition shall fall under standard Pre-Treatment/Prior Authorization estimate procedures.

9.0 Waiver of Pre-Treatment Estimate/Prior Approval for Emergencies

Avesis recognizes that in the case of emergency care, you may not be able to obtain Pre-Treatment Estimate / Prior Authorization. In this situation, Avesis requires that documentation be submitted after treatment to Avesis along with your ADA claim form including radiographs, narrative, and CDT codes within thirty (30) business days of the date of service. Claims sent without documentation will be denied and the Member is not liable for payment. The minimum materials must include:

1. Narrative explaining the emergency and treatment rendered
2. Claim form complete with all applicable ADA-CDT codes or medical CPT codes
3. Radiograph(s) of tooth / teeth and any area of treatment, if appropriate
4. Hospital records, if admitted to hospital
5. Anesthesia records, if general anesthesia was administered

The Avesis clinical reviewer and/or the State Dental Director or Dental Advisory Board Member will review the claim along with the accompanying documentation submitted. If the claim is found to not be a qualified emergency, the payment may be reduced or denied.

In the event that the emergency occurs after Avesis business hours and you cannot treat the Member within twenty-four (24) hours, you must contact Avesis at the number provided on the State/Program Exhibit page to allow for the arranging of timely emergency care. Although Avesis requires that you provide sufficient access so that you attempt to limit having services rendered in a hospital emergency room, do refer Members to a hospital emergency room when you cannot provide or arrange immediate care.

Emergency services shall not include the following:

1. Prophylaxis, fluoride and routine examinations
2. Routine restorations, including stainless steel and composite crowns
3. Dentures, partial dentures and denture relines and repair
4. Extraction of any asymptomatic teeth, including 3rd molars
10.0 Post Treatment Review

10.1 Routine Services

While Avesis will review some dental services after the treatment is completed, Avesis will not delay payment for this review. You are however responsible for submitting all necessary attachments. If Avesis does not receive these attachments, Avesis will deny and request additional information requirements.

If the Avesis State Dental Director or Member of the Dental Advisory Board determines that the treatment was inappropriate or excessive based upon the status of the tooth on the radiograph, Avesis may reduce future claim payments. If there are extenuating circumstances that are relevant, it is imperative that the dental Provider include a written explanation with the claim.

• Any dental service codes requiring post treatment review are indicated in detail in the Passport Covered Benefits Schedules. These services are indicated as requiring attachments to accompany the claim. Avesis clinical staff will review these services after the treatment has been performed.

All of these services will require copies of pre-treatment radiographs of the tooth or teeth to be included at the same time that the claim form is submitted. The claim form and pre-treatment radiographs may be submitted either electronically or on the current ADA claim form. Please note that no additional radiographs will be requested other than those necessary for proper diagnosis and treatment.

11.0 Claims Process

All claims submitted will be processed and paid according to the Passport Covered Benefits Schedule. PHP follows American Dental Association (ADA) Current Dental Terminology (CDT) guidelines. Each claim must include the appropriate line item with your usual charge, current CDT Code, and tooth number when applicable.

Claims must be received within one hundred eighty (180) days from the date of service to meet timely filing. Claims received after the 180 days will be denied.

Claims may be submitted in one of the following three formats:

• Through EDI (arrangements must be made with the Avesis IT Department prior to submission)
• On our website at: www.avesis.com
• On paper submit ADA claim form to:

Avesis Third Party Administrators, Inc.
Attn: Dental Claims
P.O. Box 7777
Phoenix, Arizona  85011-7777
11.1 Electronic Claims Submission via Clearinghouses

You may submit claims using Emdeon or EHG clearinghouses that can convert paper claims into a HIPAA Compliant Electronic Data Interchange (EDI) format. The Avesis payor identification number is 86098. If you have any questions regarding Emdeon, please contact EHG directly at (877) 469-3263. If you have any questions regarding EHG, please contact EHG directly at (800) 576-6412.

11.2 Electronic Attachments

You may submit images, charting, and notes directly to Avesis at no charge on our website at www.avesis.com. Avesis also accepts electronic attachments via FastAttach™, a National Electronic Attachment, LLC (NEA) company, for Prior Authorizations requests requiring these documents. This program allows transmissions via secure internet lines. For more information contact FastAttach™ at: www.fast.nea.com or NEA at: (800) 782-5150.

12.0 Claim Follow - Up

The Provider has a right to correct information submitted by another party or to correct his/her own information submitted incorrectly. Changes must be made in writing and directed to the Avesis Claims Manager within the appropriate time frame.

When calling or writing to Avesis to follow up on a claim(s) please have the following information available:

1. Patient’s Name
2. Date of Service
3. Patient’s Date of Birth
4. Member’s Name
5. Member’s ID Number
6. Member’s Group Number
7. CDT Codes
8. Claim Number, if the claim has been paid

Providers are encouraged to follow up on any and all claims not paid within thirty (30) days of the date the claim was filed. We are required to strictly adhere to the timely filing guideline of one hundred eighty (180) days. There will be no exceptions. Claims received after the filing guideline will be denied. Do not wait more than thirty (30) days after claim submission before notifying Avesis of a claim that has not been adjudicated.

Note: Avesis Members cannot be balanced billed for any charges or penalties incurred as a result of late or incorrect submissions.
12.1 To Resubmit Claims

Resubmitted claims must be submitted within ninety (90) days of the initial submission and include the original claim number. If submitting them on an ADA claim form, please write CORRECTED at the top of the form to ensure proper handling of the claim in the Processing Department.

12.2 Summary of Claim

A summarization of the claim payment will be included with your claim check. A summarization of previously submitted claims for underpayments and/or overpayments may also be included. Summarizations of claim payments are available after submission of a claim on Avesis' website. In addition, Providers may view remittance advices within one business day of payment on the website at www.avesis.com.

13.0 Payment

Avesis complies with all applicable prompt payment laws regarding the processing and payment of clean claims. Check runs are routinely done on a weekly basis.

A "CLEAN" claim contains the following correct and true information:

1. Member’s Name
2. Member’s Date of Birth
3. Member’s Identification Number
4. Acceptable CDT Code
5. Approval Number, if applicable
6. Provider information including NPI number and State Medicaid number, if applicable
7. Provider’s signature

Missing or incorrect information will cause delays in your payment or the claim may be returned to you unpaid.

If payment is not received in a timely manner, it may be due to:

1. Avesis not having received the claim
2. Eligibility verification
3. Claim was returned to you for missing information

Do not wait more than thirty (30) calendar days after claim submission before notifying Avesis of a claim that has not been adjudicated.

Note: Members cannot be balance billed for any charges or penalties incurred as a result of late or incorrect submissions
Claims being investigated for fraud or abuse or pending medical necessity review are not Clean Claims.

**14.0 Coordination of Benefits**

**14.1 Primary vs. Secondary Insurance**

Avesis, on behalf of Passport, is the payor of last resort for Members. All claims must be filed with commercial insurance companies or third party administrators prior to filing claims with Avesis for reimbursement for services rendered to Members. If it is later determined that the Member had other insurance coverage you will be notified and will be required to either reimburse Avesis for the amounts paid to you or Avesis will recoup the money from future payments.

If Avesis is not the primary payer you must bill the primary payer first. If the claim is initially filed with Avesis, the claim will be denied. If the primary payor pays less than the agreed upon fee, you may bill PHP for the balance. You must enclose the Remittance Advice from the primary payor. Avesis must receive the claim within the time frame specified on the PHP Exhibit page. Remaining charges will be reimbursed up to the maximum allowed amount had Avesis paid as the primary payer. However, PHP agrees to pay all Clean Claims for EPSDT services to children. PHP recognizes that cost avoidance of these Claims is prohibited.

**14.2 Member Inquiries, Complaints, Grievances and Appeals**

Upon enrollment, Passport informs the Members of their right to file complaints, grievances, or appeals. With written consent from the Member or the Member’s legal representative if the Member is a minor, the Provider may file a grievance or complaint on behalf of the Member and/or serve as the Member’s advocate. Therefore, the Provider must be aware of the Member complaint, grievance, and appeal processes, including the timeframes for filing. Complaint and Grievance procedures must comply with applicable State and/or CMS statutes.

**14.3 Grievances and Appeals**

Member appeals must be in writing. At no time will a member be discriminated against because he or she has filed an appeal. We always respect our members’ privacy. Anything they say or write is kept confidential.

**15.0 Provider Appeal Process for Denial of Claim(s)**

Avesis confirms that you have the right to appeal a claim that has been denied in whole or in part.

Please refer to Section 27.0 for the detailed appeal process.
16.0 Provider Complaints

Avesis has designated personnel for the program who shall be available to receive phone call or email questions from Providers regarding their complaints. Providers are permitted to consolidate their complaints or appeals of multiple claims involving the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.

In the event of a complaint by a Provider, all of the specifics surrounding the complaint are to be thoroughly investigated and documented. Investigation and resolution of the complaint shall be made using applicable statutory, regulatory and contractual provisions.

Information regarding the ways that Providers can appeal adverse determinations shall be included with the RA sent to the Provider.

17.0 Standards of Care for Dental Offices

The Passport Dental Program has established standards that our Provider offices are expected to fulfill. The following are the summaries of those standards:

17.1 Dental Professional Standard of Care

Each dentist and dental specialist within our network is expected to practice within the standard of care for dentists within Passport. You are required to practice within the scope of dental practice as established by the State board of dentistry. You are expected to be aware of any applicable State and Federal laws that impact your position as an employer, a business owner and a healthcare professional.

17.2 Parameters of Care

You should be aware of the ADA parameters of care that can be found on the Internet at: http://www.ada.org/Members/prac/tools/parameters/index.asp. While only guidelines, Passport will look to these parameters as indicative of the appropriate care for the situations described. For the actual treatment that occurs, you are expected to use all relevant training, knowledge and expertise to provide the best care for the Member.

17.3 Standards for Member Records

Each Member shall have an individual record and an individual file kept at the dental office. The record shall include a current health history and listing of any prescription or non-prescription drugs taken; the Member’s primary care physician’s name and phone number; a summary of all services provided by the dental office; all radiographs taken during the Member’s previous dental visits; a copy of all authorizations or referrals for the Member; and copies or notations regarding any drugs prescribed for the Member. See page (insert page number) for a complete listing of requirements for a Member Record. The records shall be carefully maintained at the dental office and available for review by Avesis staff during any facility review. If computerized, the records shall be
non-changeable and properly backed-up for protection in accordance with any applicable Health Insurance Portability and Accountability Act (HIPAA) requirements. The Provider shall confirm that all records conform to the applicable State Board of Dental Examiners.

17.4 Standards for Infection Control

The dental office shall follow all appropriate State and Federal 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. Furthermore, appropriate disinfection procedures for all surfaces in the treatment areas shall be performed following each patient visit. Masks and gloves shall be worn for all Member treatment. Protective eyewear shall be available for all dental staff. Members shall be protected from all chemical and biological hazards at all times.

OSHA requirements:

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

17.5 Medical Emergencies

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

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

All staff required to use radiograph technology must be trained on the proper use of this technology prior to its use. The dental office shall have only radiograph machines that have been checked by the appropriate State authorities and were confirmed to be within the standards set down 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 as described in the ADA parameters of care. Radiation badges to monitor the levels of radiation in the dental office shall also be worn by all personnel on a voluntary basis.

17.7 Standard for Member Contacts

Your 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 of time dictated by the State administration. Emergency coverage shall be in keeping with the requirements established in your Avesis Provider Agreement, by the State administration and as described within this Provider Manual. No charges shall be permitted for late or broken appointments as required by the Avesis and Passport Dental program.

17.8 Standard 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 their age and dentition. Each Member must have a written treatment plan in the Member record that clearly explains all necessary treatment(s).

17.9 Standard for Treatment Planning

All treatment plans must be recorded and presented to the Member and parent, if the Member is a minor. 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.

17.10 Standard for Services not covered under Passport Dental Programs

Your office should be aware of those dental services that are not covered under the Passport Dental programs. If the Member is willing to have you provide any non-covered services and is willing and able to pay directly for those services, you must complete the enclosed Passport Non-Covered Services Disclosure Form or use a
similar disclosure form that contains all of the elements on the PHP Non-Covered Services Disclosure Form included herein and maintain such form in the Member’s record.

17.11 Standards for Submitting Claims

Whenever possible, claims should be submitted to Avesis for all dental services within ten (10) business days of the Member’s appointment. Claims shall be submitted promptly following the Member’s appointment and with all of the necessary materials included for Avesis’ review.

18.0 EPSDT Program, if applicable

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service 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 health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the Commonwealth’s Medical Assistance plan to the rest of the Medical Assistance population. The EPSDT program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) 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, to seek out eligibles 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. It also enables them to assess the child’s health needs through initial and periodic examinations and evaluations, and also to assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

18.1 EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program developed to ensure that the Medicaid population younger than the age of 21 is monitored for preventable and treatable conditions. KCHIP III members do not have the EPSDT benefits. (Note this pertains to KCHIP III members only - not KCHIP I and II)

All EPSDT Special Services require pre-authorization by Avesis. Indicate “EPSDT” on the pre-authorization form and submit with X-rays and/or charting to Avesis. Requests for pre-authorization must be made on an ADA form with supporting documentation explaining the rationale for treatment. Requests for EPSDT pre-authorization may be submitted electronically at Avesis’s website or mailed to our office at:
18.2 Reminder, Follow-up and Outreach Call Policy and Procedures

Each Passport Provider office is required to maintain and document the following Member recall policy and procedures for all eligible Members:

- For Members of record (under age 18) Providers must attempt to make contact at least two (2) times per year
- For Adult Members of record (over age 18) Providers must attempt to make contact at least one (1) time per year

CMS comprehensive and preventive child health program for individuals under the age of eighteen (18) is called Early and Periodic Screening, Diagnostic, and Treatment Service (EPSDT). The explanation of this program can be found at www.cms.hhs.gov/Medicaid/epsdt. Based upon the requirements of the EPSDT program, each Passport Provider office is required to maintain and document the following Member recall policy and procedures for all eligible Members:

- For Members of record (under age 21) Providers must attempt to make contact at least two (2) times per year

The recall policy must be written and implemented upon the commencement of the PHP Dental program. The office procedures may be determined by each dental office, but must include a written process of notification for Dental Members including:

- Recall month for routine preventive care
- Date of a missed appointment(s)
- Date for follow up appointments

Note: Follow up appointments must be scheduled within thirty (30) calendar days following the initial appointment and incrementally thereafter. Avesis may audit this system during any office audit.

A log must be kept notating when a “Reminder Notice” was sent to the Member or a telephone attempt was made to the Member prior to the appointment.

Documentation of contact attempts and results must be submitted to Avesis on a quarterly basis, if requested.

18.3 FOLLOW-UP PROCEDURE

The dentist or specialist shall conduct an affirmative outreach whenever a Member misses an appointment. This outreach should be documented in the medical/dental record. Such an effort shall be deemed to be reasonable if it includes the prescribed
number of attempts to contact the Member. Such attempts may include but are not limited to written attempts and telephone calls. At least one attempt must be a follow-up telephone call, whenever possible.

19.0 Office Standards

Each Dentist’s office must:

A. Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.
B. Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
C. Be accessible to all patients, including but not limited to its entrance, parking and bathroom facilities.
D. Have offices that are clean, presentable and have a professional appearance.
E. Have clean and properly equipped patient toilet and hand-washing facilities.
F. Have a waiting room that will accommodate at least (4) four patients.
G. Have treatment rooms that are clean, properly equipped and contain functional, adequately supplied hand-washing facilities.
H. Have at least one (1) staff person (in addition to the Dentist) on duty during normal office hours.
I. Provide a copy of current licenses and certificates for all dentists, dental hygienists and other non-dentist dental professionals practicing in the office, including state professional licenses and certificates, Federal Drug Enforcement and State Controlled Drug Substance licenses and certification (where applicable).
J. Keep a file and make available to Avesis any state required practices and protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in the office.
K. Have appropriate, safe X-ray equipment. Radiation protection devices, including, without limitation, lead aprons shall be available and used according to professionally recognized guidelines (e.g. Food and Drug Administration).
L. Maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state and local laws and regulations including, but not limited to, those mandated by OSHA, and as advocated by the American Dental Association (ADA) and state and local societies.
M. Comply with all applicable federal, state and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.
N. Make appointments in an appointment book (or an electronic equivalent acceptable to Avesis). Appointments should be made in a manner that will prevent undue patient waiting time and in compliance with the access criteria listed in this manual.
O. Have documented emergency procedures, including procedures addressing treatment, evacuation and transportation plans to provide for the safety of members.
P. Upon request provide patients with a copy of their rights and responsibilities as listed in the manual.

Q. Have a functional recall system in place for notifying members of the need to schedule dental appointments. The recall system must include the following requirements for all enrolled members:

- The system must include either written or verbal notification.
- The system must have procedures for scheduling and notifying members of routine check-ups, follow up appointments and cleaning appointments.
- The system must have procedures for the follow up and rescheduling of missed appointments.

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

**RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE**

(Adapted from the American Academy of Pediatric Dentistry)

### Periodicity Recommendations

<table>
<thead>
<tr>
<th>Age</th>
<th>Infancy 6-12 Months</th>
<th>Late infancy 12-24 Months</th>
<th>Preschool 2-6 Years</th>
<th>School Aged 6-12 Years</th>
<th>Adolescence 12-21 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Oral Examination:</strong> <strong>First examination at the eruption of the first tooth and no later than 12 months and every 6 months thereafter.</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Prophylaxis/Topical Fluoride Treatment:</strong> Especially for children at high risk for caries and periodontal disease.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Radiographic Assessment:</strong> As per Food and Drug Administration/American Dental Association Guidelines on Prescribing Dental Radiographs.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Assessment for Pit and Fissure Sealants</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>First permanent molars as soon as possible after eruption</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Premolars, first and second permanent molars as soon as possible after eruption</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Second permanent molars and premolars as soon as possible after eruption</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Treatment of Dental Disease/Caries Risk Assessment</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
**Anticipatory Guidance**

Appropriate discussion and counseling should be an integral part of each visit for care. Topics for counseling when appropriate should cover Oral Hygiene counseling

1. Injury, Prevention Counseling
2. Dietary counseling
3. Counseling for non-nutritive habits
4. Fluoride Supplementation
5. Assessment of oral growth and development
6. Assessment of oral growth and development
7. Counseling for speech/language development, Assessment and treatment of developing malocclusion, Counseling for intraoral/perioral piercing, Substance abuse counseling, Assessment and/or removal of third molars and Referral for regular periodic dental care/transition to adult dental care.
8. Initially, responsibility of parent; as child develops jointly with parents, and then by age 12 responsibility of the child only.
9. Initially play objects, pacifiers, car seats; then when learning to walk; sports, routine playing and intraoral/perioral piercing
10. At every appointment discuss role of refined carbohydrates; frequency of snacking.
11. At first discuss need for additional sucking; digits vs. pacifiers; then the need to wean from habit before eruption of a permanent incisor.
12. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
13. Up to at least 16 years.

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

**Periodicity and Anticipatory Guidance Recommendations**

Dental Health Guidelines – Ages 0-18 Years
Recommendations for Preventive Pediatric Dental Care

<table>
<thead>
<tr>
<th>Periodicity Recommendations</th>
<th>Age (1)</th>
<th>Infancy 6-12 Months</th>
<th>Late infancy 12-24 Months</th>
<th>Preschool 2-6 Years</th>
<th>School Aged 6-12 years</th>
<th>Adolescence 12-18 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Hygiene counseling (2)</td>
<td>Parents/guardians/caregivers</td>
<td>Parents/guardians/caregivers</td>
<td>Parents/guardians/caregivers</td>
<td>Parents/guardians/caregivers</td>
<td>Patient</td>
<td></td>
</tr>
<tr>
<td>Injury, Prevention Counseling (3)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Dietary counseling (4)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Service Description</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Counseling for non-nutritive habits (5)</td>
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<tr>
<td>Fluoride Supplementation (6,7)</td>
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<tr>
<td>Assess oral growth and development (8)</td>
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<tr>
<td>Clinical oral exam</td>
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<td>Prophylaxis and topical fluoride treatment (9)</td>
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<tr>
<td>Radiographic assessment (10)</td>
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<td>Pit and Fissure Sealants</td>
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<tr>
<td>Treatment of dental disease</td>
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<tr>
<td>Assessment and treatment of developing malocclusion</td>
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<tr>
<td>Substance abuse counseling</td>
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<tr>
<td>Assessment and/or removal of third molars</td>
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<tr>
<td>Referral for regular periodic dental care</td>
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<tr>
<td>Anticipatory guidance (11)</td>
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</tbody>
</table>
21.0 Member Records

- You must maintain and may be required to disclose Member records as required by State law. The records:
  - Are to be maintained in a current, comprehensive and organized manner
  - Are to be legible
  - Must include the patient’s identification number on all pages
  - Must include complete medical history
  - Must include current medications
  - Must include hematological disorders
  - Must include cardiovascular disorders
  - Must include respiratory disorders
  - Must include endocrine disorders
  - Must include communicable diseases
  - Must include neurological disorders
  - Must include initial examination data
  - Must include radiographs
  - Must include oral hygiene status
  - Must have all entries dated and signed or initialed by the Provider
  - Must include a tobacco, alcohol and substance abuse history for ages fourteen (14) and older
  - Must include medication allergies and sensitivities, or reference “No Known Allergies” (NKA) to medications prominently on the record
  - Must include a physical assessment, including Member’s current complaint, if any (problem directed) that has been documented and reviewed
  - Must include a diagnosis that is reasonably based on the history and/or examination
  - Must include a treatment plan that is consistent with the diagnosis
  - Must include documentation of any prescriptions including quantities and dosages
  - Must include progress notes
  - Must include a date for return or follow up visit
  - Must include documentation that problems from previous visits were addressed
  - Signed HIPAA Confidentiality Statement
• Original handwritten personal signature, initials, or electronic signature of practitioner performing the service as well as the provider’s professional designation
• Must be written in Standard English

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
• Current medications being taken that may contraindicate dental treatment
• Infectious diseases that may endanger others

21.1 Review:

An Avesis representative may visit your office to review the patient records of Avesis/MCO Members. The Member’s record must:

1. Contain a signed consent to permit Avesis to access patient records upon request.
2. Be retained by you for all covered services rendered for the greater of ten (10) years for adults and thirteen (13) years for minors or longer as required by your State law.

21.2 Access:

You are required to comply with Avesis’ rules for reasonable access to patient records during the Agreement term and upon termination allowing:

1. The following parties may have access to the Members’ records:

   Avesis representatives or their delegates, the Member’s subsequent physician(s), or any authorized third party including employees or agents of the appropriate State Department for Medicaid Services, CMS, the Department of Insurance or MCO.

2. For a maintenance period of ten (10) years from the last Date of Service for adult patients and at least thirteen (13) years from date of last service for minors.

21.3 Copies:

Avesis has the right to request copies of the Member’s complete record.
When medical records are required by Avesis due to a claims appeal initiated by you, then you may not charge a fee for the medical records.

When medical records are required by Avesis due to a claims appeal initiated by a Member, then you may not charge a fee for the medical records.

It is the responsibility of the General/Pediatric Dentist to provide a copy of diagnostic quality radiographs to any Successor Dental Provider without charge. If radiographs cannot be obtained from the General/Pediatric Dentist, the Successor Dental Provider shall contact Avesis to advise.

**On-Site Office Survey**

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

A. **General Information** – the name of the practice, address, name of principal owner and associates, license numbers, staffing information, office hours, list of foreign languages spoken in the office, availability of appointments and method of providing 24 hour coverage (e.g., answering machine answering services, etc.) the name of the covering dentist when the office is closed, such as on vacation.

B. **Practice History** – the office provides information regarding malpractice suits, settlements and disciplinary actions, if applicable.

C. **Office Profile** - indicates services they routinely perform.

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

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

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

G. **Verification** that all Avesis participating dental providers in a group practice are credentialed by Avesis on behalf of Passport.
22.0 Quarterly Statistical Provider Review

At the end of each quarter, Avesis will compile and review total services rendered by all dental Providers in the PHP Dental Program. The objective of the utilization review process is intended to provide Avesis and/or PHP feedback regarding the demand for dental services and appropriateness of care. Each code will be analyzed against the number of total PHP Dental Members being treated. The result will be an average frequency of services per 100 recipients treated in the PHP Dental Program. Providers’ per Member cost will be calculated for the quarter. An average Region 31 per Member cost income will be the result. The following items formulate the basis of the utilization review:

1. Average Service Comparison – Avesis will prepare a summary of the statistical results by ADA code for each Provider compared with the state average. Avesis will perform this analysis only if the Provider has treated a sufficient number of PHP Dental 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 undertreatment patterns.

2. Relative Service Comparison – Certain dental services are typically performed with or after other services. Avesis will review a series of related dental services for appropriate care. Examples of such services would be:
   - 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 their prophylaxis. These related services would be compared to the averages and to other similarly utilized Providers to detect any over or underutilization.

3. Total Quarterly Per Member Cost – Avesis shall calculate the per Member cost for all PHP Providers using the services rendered during each quarter. The results shall be compared to all other Providers and to previous quarters. Providers may request a summary of their per Member cost compared to the state average.

4. Accurate Claim Submission – This will be accomplished
   - During the quarterly statistical review Avesis 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).
   - Compliance with Avesis process.
Avesis’ goal in the utilization review process is to ensure Provider satisfaction along with quality care for recipients.

### 23.0 Quarterly Wait Time Review

In lieu of requiring Providers to submit a report of average wait times on a quarterly basis, Avesis will perform random and anonymous surveys of Provider practices to inquire whether scheduling wait times as well as office wait times are excessive. Providers found to have excessive wait times will be required to implement a corrective action plan.

1. If a Member complains to Passport, CMS or appropriate State agency that wait times in your office were excessive, Avesis is required to contact your office to advise you that there was a complaint filed against your office. Once you are notified, Avesis will work with you to formulate a written corrective action plan and follow up to ensure that the action has been implemented.

2. If a Member complains to Passport, CMS, or the appropriate State agency that it was difficult to make an appointment for routine care, Avesis is required to contact your office to advise you that there was a complaint filed against your office. Once you are notified, Avesis will work with you to formulate a written and follow up to ensure that the action has been implemented.

It is important to note that Providers who do not implement a corrective action plan upon request may be subject to termination from the network.

### 24.0 Avesis Dental Committees

Avesis welcomes involvement from the dentists who participate in the Passport Dental program. To provide opportunities for feedback from the local dental communities, Avesis has established a series of committees with specific functions in our processes.

There are currently three active committees that are staffed with dentists who participate in the Avesis programs.

#### 24.1 Committee Structure for Avesis Dental Programs

##### 24.1.1 CREDENTIALING COMMITTEE

**Members:** Chief Dental Officer, Director of Quality Assurance, Director of Provider Services, Members of the Dental Advisory Board and others.

**Responsibilities:** Credentialing of new network Providers; review of credentials upon re-credentialing every thirty-six (36) months and review of any appeals from dentists who have been sanctioned. Meetings held: every other week. The Credentialing Committee also reviews disciplinary information received during the continuous credentialing process done on a monthly basis.
Critical focus: Confirming the acceptability of new dentists before entry into the network and continuing the process upon re-credentialing.

24.1.2 QUALITY ASSURANCE COMMITTEE

Members: Director of Quality Assurance, Chief Operating Officer, Director of Operations, Chief Information Officer, Chief Eye Care Officer, State Dental Director(s), Customer Service Manager, Claims Department Manager, QA Coordinator, Senior Operations Specialist, Director Client Relations and Project Manager.

Responsibilities: Review of efforts by Avesis toward continuous quality improvement, establishing standard for quality review of the program and input toward Avesis’ planning for future planned improvements.

Meetings held: Quarterly

Critical focus: Reviewing the statistical summary of the dental program and determining the primary areas within the administration of the Passports’ program to focus on for improvement.

24.1.3 COMPLAINT RESOLUTION / PEER REVIEW COMMITTEE

Members: Chief Dental Officer, Advisory Board and up to (3) dentists from the Avesis Provider network.

Responsibilities: Review of complaints from network Providers; review of clinical complaints regarding network Providers; and decisions concerning the appropriate settlement of clinical disputes between Providers and patients.

Meetings held: Quarterly

Critical focus: Reviewing the complaints received from network Members and dental network Providers. Determine the validity of the complaints and the appropriate response to the party bringing the complaint.

24.1.4 DENTAL DIRECTOR ROLE

The State Dental Director is an employee or contractor with Avesis who is your local contact as a dental professional. We intend to have the State Dental Director represent you, as an Avesis dental Provider, in Avesis’ role as administrator of Passport Dental program in your area.
The State Dental Director will represent Avesis at meetings of the local Dental Association and its component societies and at meetings with PHP. The State Dental Director will be available for discussion and consultation concerning issues of importance to Passport’s dental network Providers. If you wish to speak the State Dental Director, please call Provider Services at (866) 909-1083.

All of Passports’ dental program committees include the Chief Dental Officer as either an active Member or as an attendee.

25.0 Fraud, Waste and Abuse

The Centers for Medicare & Medicaid Services (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 himself or some other person.”

Committed to preventing, detecting and reporting possible fraud, waste and abuse, Avesis, its staff and Providers adhere to the Avesis Anti-Fraud Program. All Avesis personnel receive annual training with regard to the detecting of fraud, waste and abuse and staff involved with claims processing and payment and utilization review receive more in-depth training.

All of our Providers are also expected to be alert to possible fraud, waste and abuse and report any suspicious activity to Passport. Avesis will then work with Passport, their fraud unit and the applicable State / Federal Fraud, Waste and Abuse authorities.

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.

As a Provider treating Medicaid and/or Medicare Advantage Members, you must also be aware of the Office of the Inspector General (OIG) website. The OIG’s List of Excluded Individuals and Entities provides information on individuals and entities excluded from participating in the Medicare Advantage, Medical Assistance or other Federal health care programs.

Prior to your being approved for participation in the PHP network for these programs, a check of the OIG List was conducted to be certain that your name does not appear. Avesis also checks the OIG List annually and at time of hire for all of its personnel. As a Participating Provider, you are also required to ensure that no staff providing services to Medical Assistance or Medicare Advantage Members appears on the list. The website for the OIG list is: http://exclusions.oig.hhs.gov/.
25.1 Reporting Fraud and Abuse to the Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services has established a hotline to report suspected fraud and abuse committed by any person or entity providing services to Medicare Advantage beneficiaries.

The hotline number is 1-800-HHS-TIPS (800-447-8477), and it is available Monday through Friday from 8:30 AM to 3:30 PM EST. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

25.2 False Claims Act

The Federal False Claims Act and the Federal Administrative Remedies for False Claims and Statements Act are specifically incorporated into § 6032 of the Deficit Reduction Act. These Acts outline the civil penalties and damages against anyone who knowingly submits, causes the submission, or presents a false claim to any U.S. employee or agency for payment or approval. U. S. agency in this regard means any reimbursement made under Medicare or Medicaid and includes Passport Health Plan. The False Claims Acts prohibits anyone from knowingly making or using a false record or statement to obtain approval of a claim.

Knowingly is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but situations in which the person acts with his eyes shut, in deliberate ignorance of the truth or falsity of the claim, or in reckless disregard of the truth or falsity.

The following are some examples of billing and coding issues that can constitute false claims and high-risk areas under this Act.

- Billing for services not rendered;
- Billing for services that are not medically necessary;
- Billing for services that are not documented;
- Upcoding; and,
- Participation in kickbacks

Penalties (in addition to amount of damages) may range from $5,000 to $10,000 per false claim, plus three (3) times the amount of money the government is defrauded. In addition to monetary penalties, the provider may be excluded from participation in the Medicaid or Medicare program.
Providers are also required to cooperate with the investigation of suspected Fraud and Abuse. If you suspect Fraud and Abuse by a Passport Health Plan member or provider, it is your responsibility to report this immediately by calling one of the telephone numbers listed below:

<table>
<thead>
<tr>
<th>Provider Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>KyHealth Choices Fraud Hotline</td>
<td>(800) 372-2970</td>
</tr>
<tr>
<td>Passport Health Plan Compliance Department</td>
<td>(855) 512-8500</td>
</tr>
</tbody>
</table>

### 26.0 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.

Avesis is committed to ensuring that network Providers, as well as its policies and infrastructure, are attuned to meeting the diverse needs of all Members, especially those who face these challenges. Cultural competency is a key component of Avesis’ continuous quality improvement efforts.

To be culturally competent, you 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.
27.0 Provider Appeal Process for Denial of Claim(s)

27.1 Procedure Levels

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

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

27.1.2 Medically Necessary Appeals – Appeals involving adverse determinations finding that there was no medically necessary reason to pay the claim.

27.1.3 Level One:

1. Provider sends a written notice of appeal to Avesis within thirty (30) days of receipt of the adverse determination. The appeal should include documentation in support of the appeal not previously provided.
2. The 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 Avesis Dental Advisory Board.
3. Within thirty (30) days of receipt of the appeal a decision will be made to either support or reversal the initial determination. If the adverse determination decision is upheld, the Provider will be notified in writing within ten (10) business days of the decision being made. If the decision is to reverse the initial determination, the claim will be processed and paid within fifteen (15) business days.

28.0 Covered Benefits and Fees

Covered benefits and fee schedules for Passport Health Plan can be found on the Avesis website: www.avesis.com.
29.0 Payment

Avesis honors the Federal or applicable State prompt pay law requiring that all eligible clean claims be processed within a specified time period. Avesis will pay eligible clean dental claims on a weekly basis. Submit a clean claim form or file electronically after services and materials have been provided. Should your clean claim not be processed within thirty (30) business days, Avesis will pay interest at the rate of 12% per annum as of the 31st to 60 days late; 18% as of the 61st to 90 days late; and 21% per annum interest due as to any claims over 91 days late.

Avesis providers are eligible to receive payments from Avesis via Electronic Funds Transfer thereby enabling your practice to maintain a positive cash flow. Providers may access their remittance advice electronically within twenty-four (24) hours of the payments being deposited. The remittance advice will still be mailed to the address of record in the provider file once weekly as well.

All claims should be submitted to Avesis on an ADA compliant claim form. The claim form must include the following information:

A. Member name  
B. Member identification number  
C. Member and/or Guardian Signature (or Signature on File)  
D. Member date of birth  
E. Description of services rendered  
F. Dentist NPI and MAID number (included with electronic or online submissions)  
G. Dentist name, state license number and signature (included with electronic or online submissions)  
H. Dentist address, office ID# and phone number (included with electronic or online submissions)  
I. Proper CDT coding with tooth numbers, surfaces, quadrants and arch when applicable  
J. Full mouth x-ray series, bitewings and/or periapical x-rays when needed

Explanation of Benefits (EOBs) will be available online for all offices.

- For offices receiving Electronic Funds Transfer (EFT) payments, the EOB will only be available online.  
- For offices receiving a paper check, the EOB will be included in the envelope.  
- Offices that receive EFT payments have the option to request a paper.  
- EOB be sent at the time of payment.
30.0 Co-payments

Passport Health Plan members do not pay a co-payment for their dental office visit in 2013.

31.0 Clinical Criteria

Requests for approvals for treatment are evaluated using criteria as defined in the American Dental Association's most current CDT volume. Determinations are reached using generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature or other State or Federal agency will define the requirements for dental procedures and medical necessity.

These criteria and policies are designed as guidelines for dental service authorization and payment decisions and are not intended to be all-inclusive or absolute. Additional narrative information is appreciated when there may be a special situation. We recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards.

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

31.1 Criteria for Dental Extractions

- The prophylactic removal of asymptomatic teeth (i.e. third molars) or other teeth exhibiting no overt clinical pathology (for orthodontics) may be covered, based on the clinical history provided.
- Symptoms should be present for approval of all third molar extractions. Those symptoms may include, cysts, resorption of adjacent teeth, angulation causing inability for tooth to erupt and other clinical symptoms. Normal eruption pain is not considered a pathological symptom that would require an extraction, unless accompanied by another symptom.
- The removal of primary teeth whose exfoliation is imminent does not meet criteria, unless the tooth presented with any unusual complication(s).
- Alveoloplasty (code 07310) in conjunction with three or more extractions in the same quadrant will be covered subject to consultant post-review.
31.2 Criteria for Cast 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.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and that destruction should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and that destruction should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and that destruction must involve four or more surfaces and at least 50% of the incisal edge.

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

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

Authorizations for Crowns will not meet criteria if:

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

31.3 Criteria for Endodontics

- Tooth must be damaged as a result of trauma or carious exposure.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Endodontic therapy will not meet criteria if:

- The endodontic treatment is for aesthetic reasons
• Gross periapical or periodontal pathosis is demonstrated radiographically.
• Caries is demonstrated radiographically to be present belong 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 being requested for third molars, unless they are an abutment for a partial denture.
• The tooth has advanced periodontal disease and/or pocket depths greater than 5mm.
• Endodontic therapy is in anticipation of placement of an overdenture.
• An endodontic filling material not accepted by the Federal Food and Drug Administration is used.

31.4 Criteria for Removable Prosthodontics (Full and Partial Dentures)

• Prosthetic services must be 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.

Authorizations for a removable prosthesis will not meet criteria if:

• There is a pre-existing prosthesis which is not at least 5 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% 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.
31.5 Criteria for General Anesthesia and Intravenous (IV) Sedation

The use of general anesthesia or IV sedation is considered acceptable for procedures Covered by Passport, if appropriate criteria are met, including but not limited to any of the following:

- Extensive or complex oral surgical procedures such as:
  - Impacted wisdom teeth.
  - Surgical root recovery from maxillary antrum.
  - Surgical exposure of impacted or unerupted cuspids.
  - Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down syndrome) which would render patient noncompliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 5 years old and younger with extensive procedures to be accomplished.

NOTE: The reference in the Provider Manual to IV Sedation Clinics and Hospital Referrals do not apply to the Kentucky Medicaid program. Hospital authorizations must be obtained from Passport.

31.6 Criteria for Periodontal Treatment

31.6.1 Gingivectomy or gingivoplasty:

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

- Comprehensive periodontal evaluation (i.e. description of periodontal tissues, pocket depth chart, tooth mobility, mucogingival relationships).
- Documentation of severe gingival hyperplasia restricting the ability to perform effective daily oral hygiene procedures (i.e. photos).

31.6.2 Periodontal scaling and root planning:

Criteria for approval of periodontal scaling and root planning includes evidence of one or more of the following:
• Radiographically demonstrated evidence of bone loss
• 3-5mm pocket depths on at least 4 or more teeth in each quadrant with perio charting no more than a year old
• Medication related gingival hyperplasia
• Persistent inflammation characterized by generalized bleeding points on at least ½ of the remaining dentition per quadrant.

32.0 Orthodontic Coverage Criteria – Medicaid Members

Members age 20 and under may qualify for orthodontic care under the program. Members must have a severe, dysfunctional, handicapping malocclusion.

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

Minor tooth guidance, if a covered benefit, will be authorized on a selective basis to help prevent the future necessity for full-banded treatment. All appliance adjustments are incidental and included in the allowance for the tooth guidance appliance. With the exception of situations involving gingival stripping or other nonreversible damage, appliances for minor tooth guidance (codes D8010 through D8030) will be approved when they are the only treatment necessary. If treatment is not definitive, the movement will only be covered as part of a comprehensive orthodontic treatment plan.

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

Diagnostic study models (trimmed) with wax bites or OrthoCad electronic equivalent, and treatment plan must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from Avesis indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member or face possible termination of their Provider agreement. Providers cannot bill prior to services being performed to Passport or the member.

If the case is denied, the prior authorization will be returned to the Provider indicating that Avesis will not cover the orthodontic treatment. However, an authorization will be issued for the payment of the pre-orthodontic visit (code D8660), which includes treatment plan, radiographs, and/or photos, records and diagnostic models, for full treatment cases only (D8080), at the Provider’s contracted rate. This payment will be automatically generated for any case denied for full treatment.
Cleft Palate Services:

Orthodontic care under the program will be evaluated based on medical necessity. All orthodontic services require prior authorization by one of Avesis’ Dental Consultants.

32.1 General Billing Information for Orthodontics:

The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Member's mouth. The Member must be eligible on the first date of service. Should the Member lose eligibility during treatment, the full treatment will be covered/paid.

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

Electronically file, fax or mail a copy of the completed ADA form with the date of service (banding date) filled in. Our fax number is (866) 653-5544.

32.1.1 Orthodontic Payment Information

- Initial payments for orthodontics (code D8080) includes 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).
- Once Avesis receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit a claim for a periodic treatment visits (Code D8670) after six months of treatment to receive the final payment for orthodontics. At the end of treatment, Providers may bill for D8680 for retention.
- The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and one (1) periodic orthodontic treatment visits (D8670) six months after banding. Members may not be billed for broken, repaired, or replacement of brackets or wires.
- Payment of records for cases that are denied will be made automatically. There is no need to submit for the records payment (Code D8660).
- Payment of records/exams (Code D8660) will NOT be paid prior to the case being reviewed by the consultant. Please do not submit separate claims for these procedures.

***Please notify Avesis should the Member discontinue treatment for any reason***
32.1.2 Continuation of Orthodontic Treatment:

Avesis 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.

If the Member started treatment under commercial insurance or fee for service, we must receive the ORIGINAL diagnostic models (or OrthoCad), or radiographs (optional), banding date, and a detailed payment history.

It is the Provider's and Member's responsibility to get the required information. Cases cannot be set-up for possible payment without complete information.

Payments for orthodontics (code D8080) includes pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, 1 set of retainers, and 12 months of retainer adjustments.

The maximum case payment for orthodontic treatment will be 1 initial payment (D8080), initial and final records (D8660), 1 payment for the 6 periodic orthodontic treatment visits (D8670), and retention (D8680). Members may not be billed for broken, repaired, or replacement of brackets or wires.

33.0 Orthodontic Coverage Criteria – KCHIP Members

Eligible Members ages 18 and under may qualify for orthodontic care under the program. Members must have a severe, dysfunctional, handicapping malocclusion. Since a case must be dysfunctional to be accepted for treatment, Members whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is not usually dysfunctional in spite of the aesthetic considerations.

Minor tooth guidance, if a covered benefit, will be authorized on a selective basis to help prevent the future necessity for full-banded treatment. All appliance adjustments are incidental and included in the allowance for the tooth guidance appliance. With the exception of situations involving gingival stripping or other nonreversible damage, appliances for minor tooth guidance (codes D8010 through D8030) will be approved when they are the only treatment necessary. If treatment is not definitive, the movement will only be covered as part of a comprehensive orthodontic treatment plan.
All orthodontic services require prior authorization by one of Avesis' Dental Consultants. The Member should present with a fully erupted set of permanent teeth. At least 1/2 to 3/4 of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

Diagnostic study models (trimmed) with wax bites or OrthoCad electronic equivalent, and treatment plan must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from Avesis indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member or face possible termination of their Provider agreement. Providers cannot bill prior to services being performed.

If the case is denied, the prior authorization will be returned to the Provider indicating that Avesis will not cover the orthodontic treatment. However, an authorization will be issued for the payment of the pre-orthodontic visit (code D8660), which includes treatment plan, radiographs, and/or photos, records and diagnostic models, for full treatment cases only (D8080), at the Provider's contracted rate. This payment will be automatically generated for any case denied for full treatment.

Cleft Palate Services:

Orthodontic care under the program will be evaluated based on medical necessity. All orthodontic services require prior authorization by one of Avesis' Dental Consultants.

34.0 General Billing Information for Orthodontics:

The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Member's mouth. The Member must be eligible on the first date of service. Should the Member lose eligibility during treatment, the full treatment will be covered/paid.

To guarantee proper and prompt payment of orthodontic cases, please electronically file, fax or mail a copy of the completed ADA form with the date of service (banding date) filled in. Our fax number is (866) 653-5544.

34.1 Orthodontic Payment Information

- Initial payments for orthodontics (code D8080) includes 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).
- Once Avesis receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit a claim for a periodic treatment visits
(Code D8670) after six months of treatment to receive the final payment for orthodontics. At the end of treatment, Providers may bill for D8680 for retention.

- The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and one (1) periodic orthodontic treatment visits (D8670) six months after banding. Members may not be billed for broken, repaired, or replacement of brackets or wires.
- Payment of records for cases that are denied will be made automatically. There is no need to submit for the records payment (Code D8660).
- Payment of records/exams (Code D8660) will NOT be paid prior to the case being reviewed by the consultant. Please do not submit separate claims for these procedures.

***Please notify Avesis should the Member discontinue treatment for any reason***

35.0 Continuation of Orthodontic Treatment:

Avesis 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.

If the Member started treatment under commercial insurance or fee for service, we must receive the ORIGINAL diagnostic models (or OrthoCad), or radiographs (optional), banding date, and a detailed payment history.

It is the Provider’s and Member’s responsibility to get the required information. Cases cannot be set-up for possible payment without complete information.

*See Attachment D for Orthodontic Criteria Index Form.
*See Attachment F for Orthodontic Continuation of Care Form.

36.0 Passport Health Plan Participating Ambulatory Surgical Centers (ASC)

With Pre-Treatment Estimate/Prior Approval from Avesis, providers may render services at approved Ambulatory Surgical Centers (ASC) or IV Sedation Clinic when services are unable to be performed in the dental clinic setting. Please see the following link for a list of Passport Health Plan approved ASC:
37.0 Passport Participating Hospitals

With Pre-Treatment Estimate/Prior Approval from Avesis, providers may render services at Passport approved hospitals when services are unable to be performed in the dental clinic setting. Please see the following link for a list of those hospitals:

Guidelines Regarding Advance Directives

An advance directive is generally a written statement that an individual composes in advance of serious illness regarding medical decisions affecting him or her. The two most common forms of advance directives are a living will and a health care durable power of attorney.

All adults have the right to create advance directives. In the event that an individual is unable to communicate the kind of treatment he or she wants or does not want, this directive informs the Provider, in advance, about that treatment.

A Living Will

A living will takes effect while the individual is still living. It is 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.

A Health Care Durable Power of Attorney

A health care durable power of attorney is 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.

Neither document becomes effective until the individual is unable to make decisions for himself or herself. The individual can change or revoke either document at any time. Otherwise, the documents remain effective throughout the person’s life.

Closer Look at Advance Directives

If a Provider is unable to honor an advance directive, the individual may transfer to the care of a Provider willing to carry out his or her wishes, as appropriate to the Member’s benefit plan.

What Is the Legislative Basis for Advance Directives?

The requirements for advance directives are outlined in the Omnibus Budget Reconciliation Act of 1990, which went into effect on December 1, 1991. If a Member decides to execute a living will or a health care durable power of attorney, the Member is encouraged to notify his or her PCD of its existence, provide a copy of the document to be included in personal medical records, and discuss this decision with the PCD.
Closer Look at the Legislation

Hospitals and other health care Providers that participate in the Medicare Advantage and Medical Assistance programs must provide Members with written information about their right to make their own health care decisions, including the right to accept or refuse medical treatment and the right to execute advance directives.

For more information about advance directives, contact:

Member Services at: (800) 578-0603

Health Plan Case Management Services

Case management is available to all Health Plan Members who require a multidisciplinary approach to their care. Registered nurses and social workers assist Members with needs spanning various aspects of social services and the medical community.

Certain diseases and situations prompt a case manager to telephone a Member seeking permission to be involved in the Member’s care. Once permission is granted by the Member, the case manager contacts the Member’s Provider.

Some of these diseases and/or situations are:

- Asthma
- Cerebrovascular accident
- Complex trauma/spinal cord injury/brain injury/end-stage disease
- Chronic heart disease
- Cystic fibrosis
- Diabetes
- Frequent visits to the emergency room
- Hemophilia
- HIV/AIDS
- Neonatal pediatric cases with complex needs
- Sickle cell disease
- Three or more admissions in six months
- Transplant

Closer Look at List of Diseases and Situations Diseases and/or situation that may prompt Case Management services may not be limited to those documented above. If a Provider believes a Member would benefit from case management, the Provider should call Medical Management at (800) 425-7800.
Special Needs Coordination

The Health Plan’s Special Needs Department can assist Providers in locating language interpreters, and those who can provide American Sign Language. Providers may contact the Health Plan’s Special Needs Department at the number provided herein. Avesis will work in coordination with the Special Needs Unit at the Health Plan to ensure that the dental needs of every Member are met. Avesis has an open network of dental Providers and Members have access to services with any contracted dental Provider without the need for referral. If you have a Member that requires help in securing dental treatment please direct them to call Special Needs Member Services at the number provided herein. Additionally, if you have a Member that requires foreign language interpretation services, you can contact the appropriate Member Service number as set forth on page 5 of this Manual. The Avesis representative will conference in a Voiance interpreter for any language that the Member speaks and understands.
Exhibit 1 - CONTACT INFORMATION

Avesis Contact Information

Avesis Executive Offices

10324 South Dolfield Road
Owings Mills, Maryland 21117
(410) 581-8700
(800) 643-1132

Avesis Corporate Offices

3030 North Central Avenue, Suite 300
Phoenix, Arizona 85012
(602) 241-3400
(800) 522-0258

Avesis Provider Services

Provider Services
(855) 214-6776

Avesis Utilization Management

Utilization Management
(866) 653-5544 (secure fax)

Avesis Chief Dental Officer

Fred L. Sharpe, DDS
fsharpe@avesis.com

Avesis EFT Contact

Avesis Third Party Administrators, Inc.
Attn: Finance
P.O. Box 782
Owings Mills, Maryland 21117

Avesis State Dental Director

Please see State/Program Exhibit
Avesis Pre-Treatment Estimate
Avesis Third Party Administrators, Inc.
Attn: Pre-Treatment Estimate
P.O. Box 7777
Phoenix, Arizona 85011-7777

Avesis Post Review
Avesis Third Party Administrators, Inc.
Attn: Post Review
P.O. Box 7777
Phoenix, Arizona 85011-7777

Avesis Dental Claims
Avesis Third Party Administrators, Inc.
Attn: Dental Claims
P.O. Box 7777
Phoenix, Arizona 85011-7777

For Claims Correction
Avesis Third Party Administrators, Inc.
Attn: Corrected Dental Claims
P.O. Box 7777
Phoenix, Arizona 85011-7777

Passport Health Plan Compliance Hotline: (855) 512-8500
KYHealth Choices Fraud Hotline: (800) 372-2970
Passport Health Plan Compliance Department: (855) 512-8500
Passport Health Plan

Provider Services:  (866) 909-1083

Avesis Kentucky Dental Director
Dr. Terrence Poole
(866) 909-1083

Passport Member Services
(800) 578-0603
TTY/TDD (800) 691-5566

For Claims/Billing Information on Fee-for-Service Members, please contact:
HP Enterprise Solutions (800) 807-1232

Kentucky Department for Medicaid Services
General Information:  (800) 807-1232

Ky_Provider_inquiry@eds.com
Definitions:

Appeal – any of the procedures that deal with the review of adverse organization determinations on health care services a Member believes he/she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service. These procedures include appeal by the MCO and if necessary, an independent review organization, hearings before Administrative Law Judges (ALJs) or judicial review.

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.

Complaint – an issue that a Provider or Member presents to the MCO or Avesis, either verbally or in writing, that is subject to informal resolution within the time frame specified on the State/Program Exhibit page. A complaint involves dissatisfaction regarding a Provider, benefits, exclusions, operations or management. Complaints include issues of contract exclusions and non-covered benefit disputes.

Dental Emergency – a situation where the Member has or believes there is a current, acute dental crisis that could be detrimental to their health if not treated promptly.

Grievance – a Member’s request for reconsideration of a decision regarding the medical necessity and appropriateness of services. A grievance must be resolved within the time frames specified on the State/Program Exhibit page.

Inquiry – a request for administrative service or information, or an expression of an opinion regarding services received or benefits available.

Medically Necessary – Except as otherwise defined for Medical Assistance and CHIP Product Regulatory Requirements or by the applicable State or Federal 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 Dentist (PCD) – 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 the Avesis network General/Pediatric dentist.
Frequently Asked Questions

General Information

What is the relationship between Avesis and the Passport?

Passport has contracted with Avesis to arrange for the provision of dental services to our eligible Members through our network of contracted dentists as well as to credential, re-credential and adjudicate, process and pay claims to Providers.

Do I contract with Passport or Avesis?

You are contracted directly with Passport.

Will third party liability still be the same?

For Centers of Medicaid and Medicare Services programs and CHIP programs, Avesis, on behalf of Passport is always the payer of last resort. If the Member has other health/dental insurance, claims must be filed with the other payer(s) first. Upon receipt of the primary Remittance Advice (RA), you will submit a claim to Avesis with the primary payer’s RA within ninety (90) days of the date on the primary payer’s RA.

Will we get new Medicaid Provider numbers?

You will keep your current Medicaid Provider number. If you do not have a Medicaid Provider number, you will need to apply for one. You should apply for your Medicaid number through the Commonwealth’s website. The application can also be found on the Avesis website at www.avesis.com. Please note that you may need a unique number for each location where you render services.

Will we get an Avesis Provider number?

After you are credentialed, you will receive an Avesis PIN number which will be your Avesis identification number.

Will we need to obtain a separate Kentucky Medicaid EPSDT provider number?

You will keep your current Medicaid Provider number. If you do not have a Medicaid Provider number, you will need to apply for one. You should apply for your Medicaid number through the Commonwealth’s website. The application can also be found on the Avesis website at www.avesis.com. Please note that you may need a unique number for each location where you render services.
What is a NPI number?

The NPI (National Provider Identifier) number was mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It is a unique identification number used by health care Providers when submitting claims for reimbursement. Health care Providers and all health plans and health care clearinghouses are required to use the NPI numbers in the administrative and financial transactions specified by HIPAA. The NPI contains no embedded intelligence; that is, it contains no information about the health care Provider such as the type of health care Provider or State where the health care Provider is located. The NPI must be used in connection with the electronic transactions identified in HIPAA. **The NPI does not:**

- Replace the DEA number when required for prescribing controlled substances or other DEA-regulated activities.
- Replace state-issued licenses and certifications verifying a Provider’s licensing or qualifications.
- Replace Social Security Number, Individual Tax ID, or Employer ID for tax purposes.

http://www.ada.org/prof/resources/topics/npi.asp

Does Passport pay on a Fee for Service Schedule?

Yes.

Will Members have to choose a primary care dentist?

No, the Member may go to any Provider in the Passport Dental Provider Network.

Can our office refuse to see a Member who comes to the office and does not present a Health Plan identification card?

It is not necessary to refuse treatment to a Member who does not present with his/her Health Plan identification card. Eligibility can be verified 24 hours a day 7 days a week with Avesis for any Member by calling our IVR or checking on the secure Avesis website at: [www.avesis.com](http://www.avesis.com). Medical Assistance Members may also produce their Medical Assistance issued card to Providers to verify eligibility.

Benefits

Will we be able to view the Member’s benefits online?

Full benefit information is available on the Avesis website at [www.avesis.com](http://www.avesis.com).
Are dentures ever a covered benefit?

Dentures may be covered for medical necessity. A Prior Authorization Request must be requested and approved by Avesis prior to this service being rendered.

Billing and Claims

How will dentists be assured that Avesis is financially solvent and will pay claims timely?

Avesis is contracted as the dental program administrator for Passport as an Administrative Services Only (ASO) agreement. Passport adheres to all applicable federal and state insurance laws and regulations as well as adheres to the requirements in our Department for Medicaid Services contract. Avesis is appropriately licensed as a third party administrator and will work closely with Passport to ensure that claims are paid correctly and in a timely manner.

What if a Member requests Non-Covered Services?

If, in the course of the exam, you determine that the Member requires services not covered by the Program you will be expected to discuss possible options with the Member. Should the Member choose to receive Non-Covered Services, it is required that the Non-Covered Services Form included herein or a similar form available from your office that contains the same elements be completed and signed by you and the Member.

The Benefit Exception Process further described in this Manual can be utilized when a Provider requests review of a service that is not a covered benefit under the Program to determine if an exception should be made based on medical necessity.

* See Attachment B for Non-Covered Services form

Should I send a copy of the Non-Covered Services Form to Avesis?

No, this form should be included in and become part of the Member’s permanent record.

Can the non-covered services form be completed online?

No, that is not possible since the form requires signatures.
Electronic Funds Transfer

Will I need to send a check with the EFT agreement?

Yes, if you are interested in electronic remittance, you will need to provide Avesis a voided check with the completed EFT form, available in this Manual.

Where do I send my EFT Agreement?

Please mail the EFT Agreement and voided check to:

Avesis Third Party Administrators, Inc.
Attn: Finance
PO Box 782
Owings Mills, Maryland 21117

How are claims submitted to Avesis?

In one of three ways:

• Electronic Data Interchange (EDI)
• Manually entered on the Avesis website at www.avesis.com
• By mail, using the current ADA Form

Will you accept faxed claims?

No.

Will Avesis accept HIPAA compliant electronic claims 837?

Yes, Avesis will accept HIPAA compliant 837 claims.

How often are claims paid?

Avesis and Passport adhere to applicable State and/or Federal prompt payment laws regarding the processing and payment of clean claims. Avesis processes weekly check runs.

*See Attachment C for Electronic Funds Transfer Agreement form.*
Attachment A

Avesis Eligibility Verification Fax Form

Provider Name: __________________________________________

Provider PIN#:    _________________________________________

Provider Tax ID #: ________________________________________

Fax Number:          ________________________________________

<table>
<thead>
<tr>
<th>Member ID #</th>
<th>Member Name</th>
<th>Member DOB</th>
<th>Date of Service</th>
<th>Active Coverage:</th>
<th>Member eligible for:</th>
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</thead>
<tbody>
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<td></td>
<td>Yes</td>
<td>No</td>
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</table>
Instructions:

- Complete the appropriate fields indicated above (one line per Member) and fax to Avesis’ secure fax line at: (866) 332-1632.
- You will receive a reply by fax within one (1) business day.
Attachment B

Non - Covered Services Disclosure Form

To be completed by Dentist Rendering Care

I am recommending that _______________________________ receive services that are **not** covered by the Passport Health Plan Covered Benefits Schedule. I am willing to accept my Usual and Customary Fee as payment in full. The following procedure codes are recommended:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEES</th>
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</table>

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

Provider's Signature         Date

To be completed by Member

I ________________________________, have been told that I require services or have requested services that are not covered by the Passport Health Plan Covered Benefits Schedule.

Read the question and check either YES or NO

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor has assured me that there are no other covered benefits.</td>
<td></td>
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<tr>
<td>I am willing to receive services not covered by the dental program.</td>
<td></td>
</tr>
<tr>
<td>I am aware that I am financially responsible for paying for these services.</td>
<td></td>
</tr>
<tr>
<td>I am aware that Passport Health Plan is not paying for these services.</td>
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</tbody>
</table>

As agreed to with the dentist, I agree to pay $__________. **If I fail to make the agreed upon payment(s) I may be subject to collection action.**

Member’s Signature if over eighteen (18) or Parent / Guardian         Date
## Attachment C

### Electronic Funds Transfer Agreement

**ACCOUNT REGISTRATION INFORMATION**

<table>
<thead>
<tr>
<th>Name</th>
<th>Tax ID Number</th>
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<th>Address</th>
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<tr>
<th>City, State, Zip Code</th>
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**BANK INFORMATION**

<table>
<thead>
<tr>
<th>Bank Name</th>
<th>☐ Checking</th>
<th>☐ Savings</th>
<th>☐ Other</th>
</tr>
</thead>
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<th>Address</th>
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<table>
<thead>
<tr>
<th>City, State, Zip Code</th>
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<table>
<thead>
<tr>
<th>Routing #</th>
<th>Account #</th>
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</tbody>
</table>

I, ____________________________________, as the authorized party, allow Avesis to deposit funds into my Bank Account using Electronic Funds Transfer. A voided check is included with this agreement to facilitate this process. This transfer is for my convenience. All claims filed are in accordance with the terms of the executed Passport Agreement and the PHP Provider Manual. All funds shall be deposited into my bank account at the banking institution shown above. The bank shall provide to Avesis your most current address upon request.

I understand that:

1. The origination of electronic credits to my account must comply with the provisions of United States law.
2. Avesis and the Bank will share with each other limited account and contract information as necessary to affect these credits.
3. By signing this document, I agree to accept the terms of the Electronic Funds Transfer.
4. This form must processed by Avesis before funds will be transferred into my Bank Account.

Printed Name of Account Holder

_________________________________________  ________________________
Signature of Account Holder

Date

Printed Name of Joint Account Holder

Signature of Joint Account Holder

Date

Telephone Number: __________________

Please mail to:

Avesis Third Party Administrators, Inc.
Attention: Finance
PO Box 782 Owings Mills, Maryland 21117
ORTHODONTIC CRITERIA INDEX FORM - COMPREHENSIVE D8080

Patient Name: ________________________________ DOB: __________

<table>
<thead>
<tr>
<th>ABBREVIATIONS</th>
<th>CRITERIA</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO</td>
<td>Deep impinging overbite that shows palatal impingement of the majority of lower incisors.</td>
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</tr>
<tr>
<td>AO</td>
<td>True anterior open bite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).</td>
<td></td>
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</tr>
<tr>
<td>AP</td>
<td>Demonstrates a large anterior-posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III)</td>
<td></td>
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</tr>
<tr>
<td>AX</td>
<td>Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).</td>
<td></td>
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</tr>
<tr>
<td>PX</td>
<td>Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, one of which must be a molar).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PO</td>
<td>Significant posterior open bites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion).</td>
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</tr>
<tr>
<td>IMP</td>
<td>Impacted Incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).</td>
<td></td>
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</tr>
<tr>
<td>CR</td>
<td>Crowding of 7 - 8 mm in either the maxillary or mandibular arch.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OJ</td>
<td>Overjet in excess of 9 mm.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CDD  | Dentition exhibits a profound impact from a congenital or developmental disorder.
---|---
FAS  | Significant facial asymmetry requiring a combination orthodontic and orthognathic surgery for correction.

Approved ☐

When all are answered "NO", please refer to the Salzmann
Attachment E

ORTHODONTIC CONTINUATION OF CARE FORM

Member ID Number:____________________________________________________

Member Name (Last/First):_______________________________________________

Date of Birth:_________________________________________________________

Name of Previous Vendor that issued original approval:
_____________________________________________________________________

Banding Date:________________________________________________________

Case Rate Approved By Previous Vendor:_________________________________

Amount Paid for Dates of Service That Occurred Prior to Avesis:_______________

Amount Owed for Dates of Service That Occurred Prior to Avesis:_______________

Balance Expected for Future Dates of Service:_______________________________

Number of Adjustments Remaining:_______________________________________

Additional information required:___________________________________________

- 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 private payer transferring from a commercial insurance program, please enclose the original diagnostic models (or OrthoCad equivalent). Radiographs are optional.

Mail to:

Avesis
2300 Lake Park Drive, Suite 400
Smyrna, Georgia 30080
Attn: Utilization Management
Attachment F

907 KAR 1:026. Dental services.

RELATES TO: KRS 205.520, 205.8451, 42 U.S.C. 1396a-d


NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to dental services.

Section 1. Definitions. (1) "Comprehensive orthodontic" means a medically necessary dental service for treatment of a dentofacial malocclusion which requires the application of braces for correction.

(2) "Current Dental Terminology" or "CDT" means a publication by the American Dental Association of codes used to report dental procedures or services.

(3) "Debridement" means a procedure that is performed:

(a) For removing thick or dense deposits on the teeth which is required if tooth structures are so deeply covered with plaque and calculus that a dentist or staff cannot check for decay, infections, or gum disease; and

(b) Separately from a regular cleaning and is usually a preliminary or first treatment when an individual has developed very heavy plaque or calculus.

(4) "Department" means the Department for Medicaid Services or its designee.

(5) "Direct practitioner contact" means the billing dentist or oral surgeon is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(6) "Disabling malocclusion" means that a patient has a condition that meets the criteria established in Section 13(7) of this administrative regulation.

(7) "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:
(a) Requires little additional practitioner resources; or
(b) Is clinically integral to the performance of the primary procedure.

(8) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(10) "Mutually exclusive" means that two (2) procedures:
(a) Are not reasonably performed in conjunction with one another during the same patient encounter on the same date of service;
(b) Represent two (2) methods of performing the same procedure;
(c) Represent medically impossible or improbable use of CDT codes; or
(d) Are described in CDT as inappropriate coding of procedure combinations.

(11) "Other licensed medical professional" means a health care provider other than a dentist who has been approved to practice a medical specialty by the appropriate licensure board.

(12) "Prepayment review" or "PPR" means a departmental review of a claim to determine if the requirements of this administrative regulation have been met prior to authorizing payment.

(13) "Prior authorization" or "PA" means approval which a provider shall obtain from the department before being reimbursed for a covered service.

(14) "Provider" is defined in KRS 205.8451(7).

(15) "Recipient" is defined in KRS 205.8451(9).

(16) "Resident" is defined in 42 C.F.R. 415.152.

(17) "Timely filing" means receipt of a claim by Medicaid:
(a) Within twelve (12) months of the date the service was provided;
(b) Within twelve (12) months of the date retroactive eligibility was established; or
(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.
Section 2. Conditions of Participation. (1) A participating provider shall be licensed as a provider in the state in which the practice is located.

(2) A participating provider shall comply with the terms and conditions established in the following administrative regulations:

(a) 907 KAR 1:005;

(b) 907 KAR 1:671; and

(c) 907 KAR 1:672.

(3) A participating provider shall comply with the requirements to maintain the confidentiality of personal medical records pursuant to 42 U.S.C. 1320d and 45 C.F.R. Parts 160 and 164.

(4) A participating provider shall have the freedom to choose whether to accept an eligible Medicaid recipient and shall notify the recipient of the decision prior to the delivery of service. If the provider accepts the recipient, the provider:

(a) Shall bill Medicaid rather than the recipient for a covered service;

(b) May bill the recipient for a service not covered by Kentucky Medicaid, if the provider informed the recipient of noncoverage prior to providing the service; and

(c) Shall not bill the recipient for a service that is denied by the department for:

1. Being:
   a. Incidental;
   b. Integral; or
   c. Mutually exclusive;

2. Incorrect billing procedures, including incorrect bundling of procedures;

3. Failure to obtain prior authorization for the service; or

4. Failure to meet timely filing requirements.

Section 3. Record Maintenance. (1) A provider shall maintain comprehensive legible medical records which substantiate the services billed.

(2) A medical record shall be signed by the provider and dated to reflect the date of service.
(3) An X-ray shall be of diagnostic quality and shall include the:

(a) Recipient's name;

(b) Service date; and

(c) Provider's name.

(4) A treatment regimen shall be documented to include:

(a) Diagnosis;

(b) Treatment plan;

(c) Treatment and follow-up; and

(d) Medical necessity.

(5) Medical records, including x-rays, shall be maintained in accordance with 907 KAR 1:672, Section 4(3) and (4).

Section 4. General Coverage Requirements. (1) A covered service shall be:

(a) Medically necessary;

(b) Except as provided in subsection (2) of this section, furnished to a recipient through direct practitioner contact; and

(c) Unless a recipient's provider demonstrates that dental services in excess of the following service limitations are medically necessary, limited to:

1. Two (2) prophylaxis per twelve (12) month period for a recipient under age twenty-one (21);

2. One (1) dental visit per month per provider for a recipient age twenty-one (21) years and over; and

3. One (1) prophylaxis per twelve (12) month period for a recipient age twenty-one (21) years and over.

(2) A covered service provided by an individual who meets the definition of other licensed medical professional shall be covered if the:

(a) Individual is employed by the supervising oral surgeon, dentist, or dental group;
(b) Individual is licensed in the state of practice; and

(c) Supervising provider has direct practitioner contact with the recipient, except for a service provided by a dental hygienist if the dental hygienist provides the service under general supervision of a practitioner in accordance with KRS 313.310.

(3)(a) A medical resident may provide services if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.170, 415.172, and 415.174.

(b) A dental resident, student, or dental hygiene student may provide services under the direction of a program participating provider in or affiliated with an American Dental Association accredited institution.

(4) Coverage shall be limited to services identified in 907 KAR 1:626, Section 3, in the following CDT categories:

(a) Diagnostic;

(b) Preventive;

(c) Restorative;

(d) Endodontics;

(e) Periodontics;

(f) Removable prosthetics;

(g) Maxillofacial prosthetics;

(h) Oral and maxillofacial surgery;

(i) Orthodontics; or

(j) Adjunctive general services.

Section 5. Diagnostic Service Coverage Limitations. (1)(a) Except as provided in paragraph (b) of this subsection, coverage for a comprehensive oral evaluation shall be limited to one (1) per twelve (12) month period, per recipient, per provider.

(b) The department shall cover a second comprehensive oral evaluation if the evaluation is provided in conjunction with a prophylaxis to an individual under twenty-one (21) years of age.
(c) A comprehensive oral evaluation shall not be covered in conjunction with the following:

1. A limited oral evaluation for trauma related injuries;
2. Space maintainers;
3. Root canal therapy;
4. Denture relining;
5. Transitional appliances;
6. A prosthodontic service;
7. Temporomandibular joint therapy;
8. An orthodontic service;
9. Palliative treatment; or
10. A hospital call.

(2)(a) Coverage for a limited oral evaluation shall:

1. Be limited to a trauma related injury or acute infection;
2. Be limited to one (1) per date of service, per recipient, per provider; and
3. Require a prepayment review.

(b) A limited oral evaluation shall not be covered in conjunction with another service except for:

1. A periapical x-ray;
2. Bitewing x-rays;
3. A panoramic x-ray;
4. Resin, anterior;
5. A simple or surgical extraction;
6. Surgical removal of a residual tooth root;
7. Removal of a foreign body;

8. Suture of a recent small wound;

9. Intravenous sedation; or

10. Incision and drainage of infection.

(3)(a) Except as provided in paragraph (b) of this subsection, the following limitations shall apply to coverage of a radiograph service:

1. Bitewing x-rays shall be limited to four (4) per twelve (12) month period, per recipient, per provider;

2. Periapical x-rays shall be limited to fourteen (14) per twelve (12) month period, per recipient, per provider;

3. An intraoral complete x-ray series shall be limited to one (1) per twelve (12) month period, per recipient, per provider;

4. Periapical and bitewing x-rays shall not be covered in the same twelve (12) month period as an intraoral complete x-ray series per recipient, per provider;

5. A panoramic film shall:

   a. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider; and

   b. Require prior authorization in accordance with Section 15(2) and (3) of this administrative regulation for a recipient under age six (6);

6. A cephalometric film shall be limited to one (1) per twenty-four (24) month period, per recipient, per provider; or

7. Cephalometric and panoramic x-rays shall not be covered in conjunction with a comprehensive orthodontic consultation.

(b) The limits established in paragraph (a) of this subsection shall not apply to:

1. An x-ray necessary for a root canal or oral surgical procedure; or

2. An x-ray that exceeds the established service limitations and is determined by the department to be medically necessary.

Section 6. Preventive Service Coverage Limitations. (1)(a) Coverage of a prophylaxis shall be limited to:
1. For an individual twenty-one (21) years of age and over, one (1) per twelve (12) month period, per recipient; and

2. For an individual under twenty-one (21) years of age, two (2) per twelve (12) month period, per recipient.

(b) A prophylaxis shall not be covered in conjunction with periodontal scaling or root planing.

(2)(a) Coverage of a sealant shall be limited to:

1. A recipient age five (5) through twenty (20) years;

2. Each six (6) and twelve (12) year molar once every four (4) years with a lifetime limit of three (3) sealants per tooth, per recipient; and

3. An occlusal surface that is noncarious.

(b) A sealant shall not be covered in conjunction with a restorative procedure for the same tooth on the same date of service.

(3)(a) Coverage of a space maintainer shall:

1. Be limited to a recipient under age twenty-one (21); and

2. Require the following:

a. Fabrication;

b. Insertion;

c. Follow-up visits;

d. Adjustments; and

e. Documentation in the recipient's medical record to:

   (i) Substantiate the use for maintenance of existing intertooth space; and

   (ii) Support the diagnosis and a plan of treatment that includes follow-up visits.

(b) The date of service for a space maintainer shall be considered to be the date the appliance is placed on the recipient.
(c) Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination thereof shall not exceed two (2) per twelve (12) month period, per recipient.

Section 7. Restorative Service Coverage Limitations. (1) A four (4) or more surface resin-based anterior composite procedure shall not be covered if performed for the purpose of cosmetic bonding or veneering.

(2) Coverage of a prefabricated crown shall be:

(a) Limited to a recipient under age twenty-one (21); and

(b) Inclusive of any procedure performed for restoration of the same tooth.

(3) Coverage of a pin retention procedure shall be limited to:

(a) A permanent molar;

(b) One (1) per tooth, per date of service, per recipient; and

(c) Two (2) per permanent molar, per recipient.

(4) Coverage of a restorative procedure performed in conjunction with a pin retention procedure shall be limited to one (1) of the following:

(a) An amalgam, three (3) or more surfaces;

(b) A permanent prefabricated resin crown; or

(c) A prefabricated stainless steel crown.

Section 8. Endodontic Service Coverage Limitations. (1) Coverage of the following endodontic procedures shall be limited to a recipient under age twenty-one (21):

(a) A pulp cap direct;

(b) Therapeutic pulpotomy; or

(c) Root canal therapy.

(2) A therapeutic pulpotomy shall not be covered if performed in conjunction with root canal therapy.

(3)(a) Coverage of root canal therapy shall require:
1. Treatment of the entire tooth;
2. Completion of the therapy; and
3. An x-ray taken before and after completion of the therapy.

(b) The following root canal therapy shall not be covered:
1. The Sargenti method of root canal treatment; or
2. A root canal on one (1) root of a molar.

Section 9. Periodontic Service Coverage Limitations. (1) Coverage of a gingivectomy or gingivoplasty procedure shall require prepayment review and shall be limited to:

(a) A recipient with gigival overgrowth due to a:
   1. Congenital condition;
   2. Hereditary condition; or
   3. Drug-induced condition; and

(b) One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period.

1. Coverage of a quadrant procedure shall require a minimum of a three (3) tooth area within the same quadrant.
2. Coverage of a per-tooth procedure shall be limited to no more than two (2) teeth within the same quadrant.

(2) Coverage of a gingivectomy or gingivoplasty procedure shall require documentation in the recipient's medical record that includes:

(a) Pocket-depth measurements;

(b) A history of nonsurgical services; and

(c) Prognosis.

(3) Coverage for a periodontal scaling and root planing procedure shall:

(a) Not exceed one (1) per quadrant, per twelve (12) months, per recipient, per provider;
(b) Require prior authorization in accordance with Section 15(2) and (4) of this administrative regulation; and

(c) Require documentation to include:

1. A periapical film or bitewing x-ray; and

2. Periodontal charting of preoperative pocket depths.

(4) Coverage of a quadrant procedure shall require a minimum of a three (3) tooth area within the same quadrant.

(5) Periodontal scaling and root planing shall not be covered if performed in conjunction with dental prophylaxis.

(6)(a) A full mouth debridement shall only be covered for a pregnant woman.

(b) Only one (1) full mouth debridement per pregnancy shall be covered.

Section 10. Prosthodontic Service Coverage Limitations. (1) A removable prosthodontic or denture repair shall be limited to a recipient under age twenty-one (21).

(2) A denture repair in the following categories shall not exceed three (3) repairs per twelve (12) month period, per recipient:

(a) Repair resin denture base; or

(b) Repair cast framework.

(3) Coverage for the following services shall not exceed one (1) per twelve (12) month period, per recipient:

(a) Replacement of a broken tooth on a denture;

(b) Laboratory relining of:

1. Maxillary dentures; or

2. Mandibular dentures;

(c) An interim maxillary partial denture; or

(d) An interim mandibular partial denture.

(4) An interim maxillary or mandibular partial denture shall be limited to use:
(a) During a transition period from a primary dentition to a permanent dentition;
(b) For space maintenance or space management; or
(c) As interceptive or preventive orthodontics.

Section 11. Maxillofacial Prosthetic Service Coverage Limitations. The following services
shall be covered if provided by a board certified prosthodontist:

(1) A nasal prosthesis;
(2) An auricular prosthesis;
(3) A facial prosthesis;
(4) A mandibular resection prosthesis;
(5) A pediatric speech aid;
(6) An adult speech aid;
(7) A palatal augmentation prosthesis;
(8) A palatal lift prosthesis;
(9) An oral surgical splint; or
(10) An unspecified maxillofacial prothetic.

Section 12. Oral and Maxillofacial Service Coverage Limitations. (1) The simple use of a
dental elevator shall not constitute a surgical extraction.

(2) Root removal shall not be covered on the same date of service as the extraction of the
same tooth.

(3) Coverage of surgical access of an unerupted tooth shall:

(a) Be limited to exposure of the tooth for orthodontic treatment; and
(b) Require prepayment review.

(4) Coverage of alveoplasty shall:

(a) Be limited to one (1) per quadrant, per lifetime, per recipient; and
(b) Require a minimum of a three (3) tooth area within the same quadrant.

(5) An occlusal orthotic device shall:

(a) Be covered for tempormandibular joint therapy;

(b) Require prior authorization in accordance with Section 15(2) and (5) of this administrative regulation;

(c) Be limited to a recipient under age twenty-one (21); and

(d) Be limited to one (1) per lifetime, per recipient.

(6) Frenulectomy shall be limited to one (1) per date of service.

(7) Coverage shall be limited to one (1) per lifetime, per recipient, for removal of the following:

(a) Torus palatinus (maxillary arch);

(b) Torus mandibularis (lower left quadrant); or

(c) Torus mandibularis (lower right quadrant).

(8) Except as specified in subsection (9) of this section, a service provided by an oral surgeon shall be covered in accordance with 907 KAR 3:005.

(9) If performed by an oral surgeon, coverage of a service identified in CDT shall be limited to:

(a) Extractions;

(b) Impactions; and

(c) Surgical access of an unerupted tooth.

Section 13. Orthodontic Service Coverage Limitations. (1) Coverage of an orthodontic service shall:

(a) Be limited to a recipient under age twenty-one (21); and

(b) Require prior authorization.

(2) The combination of space maintainers and appliance therapy shall be limited to two (2) per twelve (12) month period, per recipient.
(3) Space maintainers and appliance therapy shall not be covered in conjunction with comprehensive orthodontics.

(4) The department shall only cover new orthodontic brackets or appliances.

(5) An appliance for minor tooth guidance shall not be covered for the control of harmful habits.

(6) In addition to the limitations specified in subsection (1) of this section, a comprehensive orthodontic service shall:

(a) Require a referral by a dentist; and

(b) Be limited to:

1. The correction of a disabling malocclusion; or

2. Transitional or full permanent dentition unless for treatment of a cleft palate or severe facial anomaly.

(7) A disabling malocclusion shall exist if a patient:

(a) Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors;

(b) Has a true anterior open bite that does not include:

1. One (1) or two (2) teeth slightly out of occlusion; or

2. Where the incisors have not fully erupted;

(c) Demonstrates a significant antero-posterior discrepancy (Class II or III malocclusion that is comparable to at least one (1) full tooth Class II or III, dental or skeletal);

(d) Has an anterior crossbite that involves:

1. More than two (2) teeth in crossbite;

2. Obvious gingival stripping; or

3. Recession related to the crossbite;

(e) Demonstrates handicapping posterior transverse discrepancies which:

1. May include several teeth, one (1) of which shall be a molar; and
2. Is handicapping in a function fashion as follows:

a. Functional shift;

b. Facial asymmetry;

c. Complete buccal or lingual crossbite; or

d. Speech concern;

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

1. Partially erupted teeth; or

2. One (1) or two (2) teeth slightly out of occlusion;

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

(h) Has extreme overjet in excess of eight (8) to nine (9) millimeters and one (1) of the skeletal conditions specified in paragraphs (a) through (g) of this subsection;

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

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

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

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

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

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

(a) A referral form, if applicable; and

(b) A letter detailing:

1. Treatment provided, including dates of service;
2. Current treatment status of the patient; and

3. Charges for the treatment provided.

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

(a) Is transferred to another provider; or

(b) Began prior to Medicaid eligibility.

Section 14. Adjunctive General Service Coverage Limitations. (1)(a) Coverage of palliative treatment for dental pain shall be limited to one (1) per date of service, per recipient, per provider.

(b) Palliative treatment for dental pain shall not be covered in conjunction with another service except radiographs.

(2)(a) Coverage of a hospital call shall be limited to one (1) per date of service, per recipient, per provider.

(b) A hospital call shall not be covered in conjunction with:

1. Limited oral evaluation;

2. Comprehensive oral evaluation; or


(3)(a) Coverage of intravenous sedation shall be limited to a recipient under age twenty-one (21).

(b) Intravenous sedation shall not be covered for local anesthesia or nitrous oxide.

Section 15. Prior Authorization. (1) Prior authorization shall be required for the following:

(a) A panoramic film for a recipient under age six (6);

(b) Periodontal scaling and root planing;

(c) An occlusal orthotic device;

(d) A preorthodontic treatment visit;
(e) Removable appliance therapy;

(f) Fixed appliance therapy; or

(g) A comprehensive orthodontic service.

(2) A provider shall request prior authorization by submitting the following information to the department:

(a) A MAP-9, Prior Authorization for Health Services;

(b) Additional forms or information as specified in subsections (3) through (7) of this section; and

(c) Additional information required to establish medical necessity if requested by the department.

(3) A request for prior authorization of a panoramic film shall include a letter of medical necessity.

(4) A request for prior authorization of periodontal scaling and root planing shall include periodontal charting of preoperative pocket depths.

(5) A request for prior authorization of an occlusal orthotic device shall include a MAP 306, Temporomandibular Joint (TMJ) Assessment Form.

(6) A request for prior authorization of removable and fixed appliance therapy shall include:

(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;

(b) Panoramic film or intraoral complete series; and

(c) Dental models.

(7) A request for prior authorization for comprehensive orthodontic services shall include:

(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;

(b) A MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement;

(c) Cephalometric x-rays with tracing;

(d) A panoramic x-ray;

(e) Intraoral and extraoral facial frontal and profile pictures;
(f) Occluded and trimmed dental models;

(g) An oral surgeon’s pretreatment work up notes if orthognathic surgery is required;

(h) After six (6) monthly visits are completed, but not later than twelve (12) months after the banding date of service:

1. A MAP 559, Six (6) Month Orthodontic Progress Report; and

2. An additional MAP 9, Prior Authorization for Health Services; and

(i) Within three (3) months following completion of the comprehensive orthodontic treatment:

1. Beginning and final records; and

2. A MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission.

(8) Upon receipt and review of the materials required in subsection (7)(a) through (g) of this section, the department may request a second opinion from another provider regarding the proposed comprehensive orthodontic treatment.

(9) If a service that requires prior authorization is provided before the prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.

(10) Prior authorization shall not be a guarantee of recipient eligibility. Eligibility verification shall be the responsibility of the provider.

(11) Upon review and determination by the department that removing prior authorization shall be in the best interest of Medicaid recipients, the prior authorization requirement for a specific covered benefit shall be discontinued, at which time the covered benefit shall be available to all recipients without prior authorization.

Section 16. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

Section 17. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) "MAP 9, Prior Authorization for Health Services", December 1995 edition;

(b) "MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement", December 1995 edition;

(c) "MAP 306, Temporomandibular Joint (TMJ) Assessment Form", December 1995 edition;

(d) "MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form", March 2001 edition;

(e) "MAP 559, Six (6) Month Orthodontic Progress Report", December 1995 edition; and

(f) "MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission", December 1995 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR 1:026, 5-6-86; Am. 14 Ky.R. 663; eff. 11-6-87; 16 Ky.R. 267; eff. 9-20-89; 21 Ky.R. 139; 930; eff. 8-17-94; 23 Ky.R. 3450; 3782; eff. 4-16-97; 25 Ky.R. 654; 1379; eff. 11-18-98; 30 Ky.R. 1630; 1939; eff. 2-16-2004; 33 Ky.R. 582; 1371; 1552; eff. 1-5-2007; 35 Ky.R. 436; 841; eff. 10-31-2008.)
The benefit grid can be found as a separate link on the website.