
Presentation prepared for:
Dental Providers & Staff

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A National Vision and Dental Company

Avesis Staff in Georgia

- **Nichole Mitchell – Manager of Medicaid Services**
nmitchell@avesis.com (800) 522 – 0258, ext. 296
- **Carolyn Wright – Provider Relations/Utilization Management**
cwright@avesis.com (800) 522 – 0258, ext. 294
- **Shanaka Cameron – Provider Relations**
scameron@avesis.com (800) 522 – 0258, ext. 286
- **Dale Woodie –Provider Relations**
dwoodie@avesis.com (800) 522 – 0258, ext. 135
- **Robin Mays –Provider Relations**
rmays@avesis.com (800) 522 – 0258, ext. 136

Avesis Contact Information

- Executive Offices in Baltimore, MD
Phone: (800) 231 – 0979
 - Credentialing
 - Finance
- Operations located in Phoenix, AZ
Phone: (800) 522 – 0258
 - Customer Service
 - Claims
 - Pre-estimates/Prior Approval
- Southeast regional office in Atlanta, GA
Phone: (800) 231 – 0979
 - Provider Services
 - Utilization Management

Avesis Advisory Boards

- Committee of licensed GA Dentists and Avesis staff
- Act in an advisory capacity to Peach State Health Plan and Avesis in all matters pertaining to the Medicaid Dental Program in Georgia
- Help to ensure quality communications between GA provider community and Avesis and Peach State Health Plan
- Forum for providers to submit recommendations and feedback regarding the program and its administration

Avesis Dental Advisory Board

Dental Community Representatives include :

- Dr. George Baker
- Dr. Faith Bates
- Dr. Cathy Cook
- Dr. Timothy Grantham
- Dr. Elizabeth Lense
- Dr. Jim Shealy
- Dr. Antwan Treadway

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HB1234 – The Medicaid Managed Care Bill

- **Bill becomes Effective 7/01/08**
- **Affects all CMOs and Medicaid Fee For Service Plan**
- **All three Plans and DCH collaborating on implementation**
- **Rules will be applied retroactively to allow for implementation and system configuration and testing**
- **Bill will result in revisions to our Provider appeals process and procedures**
 - Specifically mandates that providers be allowed to batch like/similar issues into one appeal request
 - Higher interest (20%) paid for claims overturned on appeal
 - Interest must appear on remit
- **Changes appeals time frame**

HB1234 – The Medicaid Managed Care Bill

- Dictates time frames
 - Timely Filing – 180 days from DOS (no change)
 - Timely Resubmission – 90 days from date of RA (no change)
 - Clean Claim Payment – 15 business day of receipt (no change)
 - Appealed Claims – 30 days from date of denial
 - COB – 90 days from the date of primary carrier EOB
 - Covers claims with dates of service July 1, 2008

ELIGIBILITY

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Eligibility

It is strongly encouraged that you verify eligibility for each Member's appointment the business day prior to rendering services unless the next business day is the first day of a new month.

Please note that verification of benefits or eligibility is not a guarantee of payment: actual payment is based on the terms and conditions of the plan in force once the claim is received.

Avesis will continue to accept GHP web portal eligibility screen shots as source for verification of coverage only. Utilizations must be verified on the Avesis website.

Eligibility

You may obtain eligibility verification four ways:

1. IVR – Please bear in mind that this only provides you with information as to whether or not the member is eligible on the date of service. It does not provide utilization data
2. Website – Remember to choose the “coverage slice” that is applicable to the date of service for which you are seeking eligibility. Choose “Member Utilizations” to view the members utilization history.

Eligibility

3. Customer service – Customer service is able to provide you with both eligibility confirmation as well as utilization data.
4. Fax – You may utilize the form found of the following slide for eligibility confirmation. This form will provide you with both eligibility confirmation and utilization data.

BENEFITS

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Benefits

- During the course of the program, there have been some changes made to the benefit terms and conditions.

Benefit Changes

- **Prophys are covered for members from ages 2 – 20 one time every 181 days.**
 - D1120 – Child (ages 0 – 13) prophylaxis
 - D1110 – Adult (ages 14 – 20) prophylaxis
- **Fluoride is covered for members from ages 2 – 15 one time every 181 days.**
- **Codes D2161 and D2393 have been added to our fee schedule. The fees for these services will be the same fees as D2160 and D2392 respectively.**

Benefit Changes (cont.)

- **Benefits for pregnant women – These benefits will be covered in detail in the slides that follow.**
- **Enhanced adult benefits – These benefits will also be covered in detail in the slides that follow. Please bear in mind that these benefits are in addition to the benefits to which adult members have always been entitled as a result of need under “traditional” adult Medicaid**

Pregnancy Benefits

- Covered pregnant women codes will be covered by prior authorization only. The provider must submit a DMA – 635 form (see next slide) to the claims office in order for claims to be paid under the pregnancy benefit.
- Please make sure to place the member's identification number on the DMA – 635 form.
- Pregnancy benefits are in addition to the already existing benefits and those that are included in the enhanced adult benefit.

DMA – 635 Form

DMA 635 Form—Attestation of Pregnancy

Dear OBGYN, Primary Care Physician, or Public Health Department,

The **Attestation of Pregnancy** form serves to validate current pregnancy for the purpose of determining whether the member is eligible to obtain certain Medicaid dental service benefits. The member is directed to present completed and signed Attestation of Pregnancy statement to her dentist prior to seeking dental services.

Attestation of Pregnancy

_____ Is currently pregnant and under my care for related services.
Patient Name (please print)

The patient's estimated date of delivery is _____

Please advise of any medical limitations/or restrictions prohibiting the provision of dental care

None

Specify limitations/restrictions (if applicable): _____

I affirm the above information is factual to the best of my knowledge and under penalty of perjury.

Provider Name (please print)

Provider Signature

Signed this _____ day of _____
Date Month Year

DMA 635 Form 07/01/2006

- This form can be found on the GHP web portal. Click on the “Provider Information” tab and then the “Documents and Forms” box at the bottom right hand side of the page.
- Please include the member’s identification number on the form.

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Enhanced Adult Benefits

Avesis will cover the following enhanced adult benefits at the Member's request:

- **D0120 – Limited Exam - 2 per calendar year**
- **D1110 – Prophylaxis Adult (SW only)**
- **D0270 – Single Bitewing**
- **D0272 – Two Bitewings**
- **D0274 – Four Bitewings**
- **D7140 – Simple Extraction**

The benefits listed above are available to adult members in addition to their already existing benefits.

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Non-Covered Services

If a provider in their professional judgment deems that a member is in need of services that are not covered under the Avesis Peach State Health Plan Medicaid program, it is the provider's responsibility

- to insure that the member is full aware that he/she will be responsible for payment of such services.
- To collect from the member any payment due for such services
- To give the member a 20% discount (at a minimum) off of the provider's usual and customary fee

Non-Covered Services Disclosure Form

Non - Covered Services Disclosure Form

To be completed by Dentist Rendering Care

I am recommending that _____ receive services that are not covered by Medicaid or PeachCare. I am willing to accept a discounted fee of 80% of my Usual and Customary Fee as payment in full. The following procedure codes are recommended:

CODE	DESCRIPTION	FEES	80% of FEE

The total discounted amount for service(s) to be rendered is \$_____.

Doctor'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 Medicaid or PeachCare.

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

I agree to pay \$_____ per month. If I fail to make this payment I may be subject to collection action.

Patient's Signature (over eighteen (18) or Parent or Guardian) _____ Date _____

PH-D-GA v12.05 80

Member pays 80% of Usual and Customary Fees

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CLAIMS

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CLAIM SUBMISSION

Claims may be submitted one of three ways:

- Through your practice management software using a clearinghouse
- On a ADA claim form - please submit to the following address:

Avesis Dental Claims
PO Box 7777
Phoenix, AZ 85011 – 7777

- Utilizing our website at www.avesis.com

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CLAIMS FOLLOW UP

You may check the status of submitted claims on our website. In order to do so you must do the following:

- Be logged in under the provider of service that was submitted on the original submission
- Have either the members Medicaid number or their last name, first name and the last four digits of their social security number

CORRECTED CLAIMS

■ Submission

- If you are missing information (i.e. tooth number or quadrant number) you may refile the claim on the web for payment
- If you have submitted incorrect information (wrong code, wrong tooth number, etc) you will need to submit a corrected claim. To submit a corrected claim:
 - Please write corrected claim on the top of the ADA claim form in blue or black ink. The scanner does not read red ink
 - Please do not highlight notes on the claim in blue or green highlighter. The scanner reads these colors as black so what ever they highlight is blacked out.

CLAIMS PAYMENT

- Check runs WEEKLY
- CLEAN CLAIMS processed and adjudicated under 15 business days
- Electronic Funds Transfer available for electronic claims submission
- EFT payments deposited on Friday of each week

Electronic Funds Transfer Agreement

Electronic Funds Transfer Agreement

ACCOUNT REGISTRATION INFORMATION			
Name		Tax ID Number	
Address			
City, State, Zip Code			
BANK INFORMATION			
Bank Name	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	<input type="checkbox"/> Other _____
Address			
City, State, Zip Code			
Routing #		Account #	

I, _____, as the authorized party, allow Avesis to deposit funds into my Bank Account using Electronic Funds Transfer. This transfer is for my convenience and allows me to be reimbursed for claims filed with Avesis on my behalf. All claims filed are in accordance with the terms of the executed Avesis Agreement and the Avesis Provider Manual. All funds shall be deposited into my bank account at the banking institution(s) listed above. The bank shall provide to Avesis your most current address upon request.

I understand that:

1. The origination of electronic debits 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 effect these debits.
3. By signing this document, I agree to accept the terms of the Electronic Funds Transfer.

Printed Name of Account Holder	
Signature of Account Holder	Date
Printed Name of Joint Account Holder	
Signature of Joint Account Holder	Date
Telephone Number	

PRIOR AUTHORIZATION

REFERRALS & PRE-TREATMENT ESTIMATES

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Avesis Pre-Treatment Estimate/ Prior Approval

- Services requiring prior approval are listed in detail in the provider manual
- Please submit all pre-treatment estimates on an ADA claim form to our Phoenix address or via the Avesis website.
- If you are sending a pre-treatment estimate via USPS and submitting radiographs via NEA, please remember to notate your NEA attachment number on the claim.

Paper PTE: Faxing vs. Mailing

Requests that may be faxed

- Referrals to specialists
- Referrals to facilities
- Hospital authorizations
- IV Sedation authorizations

Requests that must be mailed

- Requests for services that require PTE
- Requests that have attachments (i.e. radiographs, cephs, etc)
- Post review documents of any sort

ADA Claim Form for Pre-Treatment Estimate

Dental Claim Form
American Dental Association, 1999 version 2000

1. Primary pre-treatment estimate Secondary (see backside)
 Medical Claim Pre-Authorization #
 PPSST

3. Carrier Name
4. Carrier Address
5. City
6. State
7. Zip

10. Patient Name (Last, First, Middle)
11. Date
12. Date of Birth (MM/DD/YYYY)
13. Patient ID #
14. Sex M F
15. Phone Number
16. Zip Code
17. Relationship to Subscriber/Employee
 Spouse Child Other
18. Employment Status
19. Employer/Subscriber Name

20. Submitter/Employee Name (Last, First, Middle)
21. Group #
22. Address
23. City
24. State
25. Zip Code
26. Date of Birth (MM/DD/YYYY)
27. Marked Status
 Married Single
 Divorced Widowed
28. Submitter/Employee Status
 Employed Retired Former Student Part-time Student
29. Have been notified of the treatment plan and associated cost. I agree to be responsible for all charges not covered by insurance and to pay for any dental services not covered by my dental benefit plan. Services not covered by dental plan have a pre-treatment agreement with my plan prohibiting all or a portion of such charges. I am not seeking reimbursement for any services not covered by my dental plan.
30. Signature (Subscriber/Employee) Date (MM/DD/YYYY)

31. Is Patient covered by another plan?
 No (skip 32-33) Yes Dental Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY)
35. Sex M F
36. Plan/Program Name
37. Employer/Subscriber Name
38. Date of Birth (MM/DD/YYYY)
39. Marked Status
 Married Single
 Divorced Widowed
40. Submitter/Employee Status
 Employed Retired Former Student Part-time Student
41. I hereby authorize payment of the dental benefits administered by this dental plan to the dentist to the extent of the dental benefit payable to the dentist by this dental plan.
42. Signature (Subscriber/Employee) Date (MM/DD/YYYY)

43. Name of Billing Dentist or Dental Entity
44. Phone Number
45. Dental License #
46. First Name Last Name Title or Occupation
47. Address
48. City
49. State 50. Zip Code
51. Is treatment for orthodontics?
 Yes, how many? No
52. Is treatment for orthodontics?
 Yes No
53. Is treatment for orthodontics?
 Yes No
54. Is treatment for orthodontics?
 Yes No
55. Is treatment for orthodontics?
 Yes No
56. Is treatment for orthodontics?
 Yes No
57. Is treatment for orthodontics?
 Yes No
58. Is treatment for orthodontics?
 Yes No
59. Is treatment for orthodontics?
 Yes No
60. Is treatment for orthodontics?
 Yes No
61. Is treatment for orthodontics?
 Yes No
62. Is treatment for orthodontics?
 Yes No
63. Is treatment for orthodontics?
 Yes No
64. Is treatment for orthodontics?
 Yes No
65. Is treatment for orthodontics?
 Yes No
66. Is treatment for orthodontics?
 Yes No
67. Is treatment for orthodontics?
 Yes No
68. Is treatment for orthodontics?
 Yes No
69. Is treatment for orthodontics?
 Yes No
70. Is treatment for orthodontics?
 Yes No
71. Is treatment for orthodontics?
 Yes No
72. Is treatment for orthodontics?
 Yes No
73. Is treatment for orthodontics?
 Yes No
74. Is treatment for orthodontics?
 Yes No
75. Is treatment for orthodontics?
 Yes No
76. Is treatment for orthodontics?
 Yes No
77. Is treatment for orthodontics?
 Yes No
78. Is treatment for orthodontics?
 Yes No
79. Is treatment for orthodontics?
 Yes No
80. Is treatment for orthodontics?
 Yes No
81. Is treatment for orthodontics?
 Yes No
82. Is treatment for orthodontics?
 Yes No
83. Is treatment for orthodontics?
 Yes No
84. Is treatment for orthodontics?
 Yes No
85. Is treatment for orthodontics?
 Yes No
86. Is treatment for orthodontics?
 Yes No
87. Is treatment for orthodontics?
 Yes No
88. Is treatment for orthodontics?
 Yes No
89. Is treatment for orthodontics?
 Yes No
90. Is treatment for orthodontics?
 Yes No
91. Is treatment for orthodontics?
 Yes No
92. Is treatment for orthodontics?
 Yes No
93. Is treatment for orthodontics?
 Yes No
94. Is treatment for orthodontics?
 Yes No
95. Is treatment for orthodontics?
 Yes No
96. Is treatment for orthodontics?
 Yes No
97. Is treatment for orthodontics?
 Yes No
98. Is treatment for orthodontics?
 Yes No
99. Is treatment for orthodontics?
 Yes No
100. Is treatment for orthodontics?
 Yes No

69. Diagnosis Code Index (optional)
70. Determination and treatment plan - List teeth in order
71. Verify all missing teeth with X
72. Remaining for orthodontic services
73. I hereby certify that the procedures as indicated by this form are in progress (for procedures that require multiple visits) or have been completed and that the fee submitted are the actual fees I have charged and intend to collect for these procedures.
74. Signature (Billing Dentist) License # Date (MM/DD/YYYY)
75. Address where treatment was performed
76. City 77. State 78. Zip Code

American Dental Association, 1999

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Avesis Medicaid Dental Specialty Referral Form

Avesis Medicaid Dental Specialty Referral Form

Authorization Number:		Authorization Expiration Date:	
Avesis Dental Consultant Signature:		Date: ___ Approved ___ Denied ___ Pending	
This request is for: <input type="checkbox"/> Endodontist <input type="checkbox"/> Periodontist <input type="checkbox"/> Orthodontist <input type="checkbox"/> Pregnancy		Services Requested: <input type="checkbox"/> Consultation with Treatment <input type="checkbox"/> Consultation Only	
Member Information			
Name of Member:		Date of Birth:	Member ID #
Address:		City:	State:
General/Pediatric Dentist Information		Signature:	Date:
			Circle Prognosis: Good Fair Poor
Required information for referral:			
Endodontics: Please submit tooth number and radiographs		Periodontics: Please submit probings and radiographs	
Orthodontics: Please submit qualifying condition		Pregnancy: Please submit DMA – 635	
Print Name of Referring General/Pediatric Dentist:	Avesis #:	Telephone #:	Fax #:
Address:	City:	State:	Zip Code:
Name of Specialist:	Avesis #:	Telephone #:	Fax #:
Address:	City:	State:	Zip Code:
Number of radiographs sent: _____	NEA Attachment Number: _____	Study models sent: Yes	No
Reason for Referral to include tooth number and treatment :			

CHART REVIEWS

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Chart Reviews

- Avesis is conducting office reviews for our Georgia Medicaid dental network
- Your office will be contacted in order for Avesis to schedule a time to come out
- In addition to a facility walk through, providers will be furnished a list of charts prior to the visit to have available for review
- After the visit, your office will be sent a letter regarding the findings of our review

PROVIDER SERVICES

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Services to Providers

- **Avesis is primary for Provider Services**
- **Members should contact Peach State Health Plan**
- **On-site assistance in your office when available**
- **Quarterly update sessions (as needed)**

Avenues for Additional Assistance

- **Schedule a conference call**
- **Schedule a web demo**
- **Schedule an onsite visit**

Committed to Technology

24/7 Access to information:

- **Web Based**
 - Eligibility
 - Pre-treatment Estimate/Prior Approval
 - Claims submission
 - Claims status
- **Interactive Voice Response (IVR)**
 - Eligibility
 - Benefits

THANK YOU

Thank you for your time & attention.

**We at Avesis look forward to
working with you and your team.**

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