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A National Vision, Dental and Hearing Company

dental news

A Newsletter for Avesis Dental Care Providers

A Letter From Our Chief Dental Officer

Dear Avesis Doctor:

We recently held our annual Provider Education Sessions in six cities across Pennsylvania. Avesis representation was provided in Monroeville, Cranberry, Erie, Bedford, York, and Reading to allow a variety of options for dental offices to come and learn about Avesis. Attendance varied, but whether there were 12 or 60 participants, your feedback was very important to us.

We received many great suggestions for our website. For those of you that have not heard, we are working on building our own website so that we do not have to rely on a vendor to make changes and updates. That being said, we will be able to customize the site to be extremely user friendly for all of our participating dentists and their staff. We hope to roll this out during the fourth quarter of this year and will be looking for providers to be part of a focus group.

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

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

Sincerely,

Fred L Sharpe

Fred L Sharpe, DDS, JD | Chief Dental Officer

Recredentialing Through VerifPoint

VerifPoint is a Credential Verification Organization (CVO) that does all of the recredentialing of Avesis' participating dental providers. What this means to you is that approximately 30 months following your initial credentialing or latest recredentialing with Avesis you will receive notification from VerifPoint about recredentialing. We are contractually obligated to recredential providers every 36 months and your Provider Agreement requires your participation in this process. VerifPoint will send you notification of what is needed and we ask that you respond timely and completely. If anything is still missing, Verifpoint will follow-up twice after their initial request. We ask that you provide the requested information is a timely fashion so that your recredentialing may be completed within the required time limits. Failure to recredential may result in claims not being paid until the process is completed. **(continued on next page)**

Termination From Any Avesis Plan

Consistent with the terms of your Provider Agreement, notice of termination of participation must be submitted at least sixty (60) days prior to the termination effective date.

UPMC Plans That Have $69 Annual Max

Under the UPMC *for You* plan, including Adult, Children and Palliative, radiographs have a yearly maximum of $69.00 per patient per dentist or dental group. The $69.00 maximum is a paid amount, not a billable charge. Once the $69.00 maximum has been met, no other amount will be reimbursed for radiographs for that calendar year for that provider. If additional radiographs are required or requested, the provider may not bill the member unless the member has signed a Non-Covered Services Disclosure form prior to rendering the service(s). Only then may the provider charge the member the UPMC fee.

UPMC *For You* Children and UPMC *for Kids* Offer Orthodontic Coverage

UPMC *for You* Children will cover eligible members for orthodontics until the completion of the case provided the member remains an active member under the UPMC *for You* plan and was banded prior to age 21.

UPMC *for Kids* will cover members until the members reach the age of 19. After age 19, no further payments will be issued. UPMC *for Kids* has a lifetime orthodontic benefit of $5200.00.

Please note however, that under both UPMC *for You* Children and UPMC *for Kids* orthodontic cases are paid out to a maximum case rate of $3600.00 and reimbursed at $1000.00 for banding under D8080, at $350.00 for quarterly adjustments under D8670, and $150.00 for retention under D8680 for a total case reimbursement of $3600.00. **(continued on next page)**

UPMC For You Children and UPMC For Kids Offer Orthodontic Coverage (cont'd)

Record fees are only reimbursed when an orthodontic case has been denied and will automatically issue out at $35.00. There is no need to submit for reimbursement for records.

All orthodontic cases other than continuation of care (COCs) require a preauthorization prior to treatment. Interceptive treatment (Phase I) will not be reimbursed a records fee if the preauthorization is denied.

UPMC *for Kids* Guidelines

1. Comprehensive treatment of adolescent dentition. Limited to once per lifetime.
2. Comprehensive treatment also includes the following services: D8660 (Pre-orthodontic visit), D8670 (Periodic orthodontic treatment), and D8680 (Orthodontic retention).
3. Payments associated with this code are applied to the $5,200 comprehensive orthodontic lifetime benefit limit and **NOT** to the $1,500 annual dental program benefit limit.
4. UPMC *for Kids* does not allow interceptive treatment (Phase I).

UPMC *for You* Children Guidelines

1. Treatment must begin prior to the member's twenty-first birthday.
2. Termination of treatment for uncooperative behavior is up to the Provider.
3. Member must have severe functionally handicapping malocclusions.
4. UPMC *for You* Children can allow for interceptive treatment (Phase 1) only as an exception. Providers may request an exception for interceptive treatment (Phase 1) for a UPMC *for You* Children member under D8020 (3 to 6 months treatment) with a reimbursement of $1000.00 or D8060 (6 to 12 months of treatment) with a reimbursement of $1500.00.

Anti-Kickback Statute

The federal Anti-Kickback Statute ("Anti-Kickback Statute") is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business. See 42 U.S.C. § 1320a-7b. The Anti-Kickback Statute is broadly drafted and establishes penalties for individuals and entities on both sides of the prohibited transaction. Conviction for a single violation under the Anti-Kickback Statute may result in a fine of up to $25,000 and imprisonment for up to five (5) years. See 42 U.S.C. § 1320a-7b(b). In addition, conviction results in mandatory exclusion from participation in federal health care programs 42 U.S.C. § 1320a-7(a). Absent a conviction, individuals who violate the Anti-Kickback Statute may still face exclusion from federal health care programs at the discretion of the Secretary of Health and Human Services 42 U.S.C. § 1320a-7(b). The government may also assess civil money penalties, which could result in treble damages plus $50,000 for each violation of the Anti-Kickback Statute.

http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Anti-Kickback%20Statute.aspx

Self-Audit / Self Reporting

Definitions

Abuse/Waste – Any provider practices that are inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Bureau of Program Integrity – a department of the Department of Public Welfare tasked with Program Integrity for the Pennsylvania Medicaid Program.

The False Claims Act (31 U.S.C. sub sec 3729) makes

it illegal to present or cause to be presented to the federal or state government false or fraudulent claims for payment. This applies to U.S. government programs such as Medicaid, Medicare, Medicare Part D, and the Federal Employees Health Benefit Plan (FEHBP). Any person in violation of this act could be subjected to fines and penalties.

Fraud – Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The fraud can be committed by many entities, including the contractor, a subcontractor, a provider, a state employee, or a member, among others.

MEDIC (Medicare Drug Integrity Contractor) – Entities responsible for the investigation of any allegations of fraud, waste and abuse (FWA) associated with the Part D program

Statistically Valid Random Sample (SVRD) – A sample of data that represents a valid sample of the universe. An audit of a statistically valid random sample provides a percentage representation if the audit was conducted of the whole universe.

Self-Audits

When, either in the course of regular business or by using one of the options specified below, providers believe that they have been inappropriately paid, they should promptly contact Avesis to expedite the return of the inappropriate payment.

Refunds

For identified overpayments, providers should send refund checks made payable to the Avesis to the following address:

Avesis
Claims Refund
P.O. Box 7777
Phoenix, AZ 85011

Payments can also be returned through the claim offsetting process, whereby, future claims submissions are offset until the overpayment amount is recovered.

Refund checks should be accompanied by a cover letter with detailed support that provides an overview of the issues identified, the time period covered by the review including the reason for the time period selected, and the actions that have been or are being taken to assure

that these errors do not reoccur in the future. Note that providers may be asked to work with Avesis to verify that we maintain correct paid claims information. Acceptance of payment by the Avesis does not constitute agreement as to the amount of loss suffered.

Restricted Employees

If you are a provider submitting claims to the UPMC *for You* (Medicaid), UPMC *for Kids* (CHIP), or UPMC *for Life* (Medicare or Special Needs Program,) or you provide services to Federal Employee Healthcare Program participants, it is important to screen your employees and contractors monthly to make sure they have not been excluded from participating in Medicare, Medicaid, or any other federal health care program. Medicaid, CHIP or Medicare providers who employ or enter into contracts with excluded individuals or entities are:

- Subject to termination from the Medicaid, Medicare, and CHIP programs, including all federal health care programs
- Responsible for refunding monies paid for services provided by an excluded individual or entity
- Subject to civil monetary penalties

Exclusion from Medicaid, Medicare, CHIP or a federal healthcare program applies not only to individuals who provide clinical services, but also to individuals who provide administrative services, such as billing and claims processing. Thus, a provider who employs an excluded individual is not entitled to reimbursement for services provided by the excluded individual, including claims for clinical services provided by the individual, as well as claims for which the individual only provided billing services.

If you discover you have utilized the services of an excluded employee or contractor, you will need to self-report any affected payments to the UPMC Health Plan Fraud, Waste & Abuse department at 1-866-372-8301.

For Medicaid recipients, you may also report this to the Bureau of Program Integrity via:

- Email through the Medical Assistance Self-Audit Protocol at: **http://www.dpw.state.pa.us/learnaboutdpw**
- U.S. mail at the following address: **Bureau of Program Integrity Commonwealth of Pennsylvania**
  P.O. Box 2675 Harrisburg, PA 17105-2675
- Fax at: **1-717-772-4655** or **1-717-772-4638**

Facts About False Claims

The False Claims Act (FCA) has been federal law since 1863. The passage of time and amendments has not changed its purpose, which is to discourage people and companies from defrauding government programs. The FCA holds people and companies responsible when:

- They submit a claim they know (or should know) is false.
- They submit records they know (or should know) are false to obtain payment from the government.
- They use false statements or records to keep government money to which they may not be entitled. In addition to penalizing those responsible for false claims, the FCA allows whistle blowers to file actions and receive a portion of any recovered money. You can find more information and the complete text of the FCA (31 U.S.C. §§ 3729–3733) at **www.justice.gov**.

Best Practices for Prescribing Pain Medication

Physicians face many challenges in treating their patients – one of the biggest can be managing prescriptions, especially for pain medications and other controlled substances. Abuse of opiate-derived medications has dramatically increased in the past few years. According to the CDC, Prescription drugs, including opioids and antidepressants, are now responsible for more overdose deaths than “street drugs” like cocaine, heroin, and amphetamines. Here are some things to consider when prescribing opiates:

1. Is there a clear indication for the initial and ongoing use of opiates?
2. Establish that the goal of therapy is to improve function, not just pain scores.
3. Consider use of an Opioid Risk Tool to identify people at “high risk” for addiction. You can find one at **www.opioidrisk.com/node/887.2**
4. Exercise caution before you prescribe opiate pain drugs to unfamiliar or new patients.
5. Make sure the patient is adequately informed about the drugs, their risks, and how to identify adverse effects of the drugs.
6. Have a treatment plan for the patient. Once you start a treatment with opiate drugs, know where you expect to take it.
7. Have the patient sign a Pain Management contract to ensure compliance with and increased safety around prescription drug treatment protocols.
8. Look for “red flags” such as requests for early refills, lost/stolen prescriptions, and frequent ED visits for pain.
9. Instruct the patient on the importance of safeguarding the drugs from children, friends, and family members. Ask the patient to consider obtaining a lockbox to safely store the prescriptions.

Medical Record Requests

As part of your contract with Avesis, you agree to comply with the quality audit and utilization review programs. We require — and greatly value —your participation in these programs. Your participation shows commitment to patient care and quality improvement. Avesis has certain rights to member information. With reasonable advance notice, Avesis can inspect and copy member information. This includes medical records as well as relevant accounting and administrative information. We may need member records for:

- Claims payment
- Availability of benefits
- Utilization
- Quality improvement and management programs. Providers must supply member records to the requesting Avesis department or our authorized representative. You can submit copies or arrange for an on-site review. The HIPAA Privacy Rule counts this type of disclosure as a core health care activity. Therefore, it does not require the member’s Authorization. See 45 CFR 164.506(c)(3)-(4) for details.
  (Source: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/sharingfortpo.pdf)

Can You Charge the Member for X-Rays?

NO. It is the responsibility of the General Dentist to provide a copy of diagnostic quality radiographs to any Successor Dental Provider. If radiographs cannot be obtained from the General Dentist, the Successor Dental Provider shall contact Avesis to advise. Avesis shall notify the General Dentist, in writing, within thirty (30) calendar days, that the Successor Dental Provider did not receive diagnostic quality radiographs. Avesis will charge the General Dentist for radiographs that the Successor Dental Provider must retake for appropriate care if:

1. The General 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 the original General/Pediatric Dentist.

UPMC Provider Session Feedback

1. **Q:** If a provider doesn't have an eligibility printout, do they have a "leg to stand on"?

   A: If we receive notification from the Health Plan that the member has been retroactively terminated, we are required by law to recoup the monies paid for any claims for the member who was retroactively terminated. The eligibility printout, while it does show the member's eligibility when it is verified, is not a guarantee of payment.

2. **Q:** Are there plans to change preauthorization requirements for extractions, partials, full dentures?

   A: No, we are unaware of any plans to change the current preauthorization requirements.

3. **Q:** What percentages of BLEs are approved?

   A: Less than 10% in the Commonwealth of Pennsylvania.

4. **Q:** Are radiograph limits per doctor?

   A: Yes, panorex radiographs are by doctor/dental group.

5. **Q:** If Ortho doesn't meet criteria for the specific patient, is it necessary to submit a preauth?

   A: Yes, you must have the denial in order to have the member sign the "Non-Covered Services Disclosure form. You can then charge the member.

6. **Q:** What happens when an ortho member terms due to age?

   A: Under UPMC for You only, if the member remains active under UPMC for You, children to adult, quarterly adjustments will continue to be paid. Member must be effective.

7. **Q:** Are study models necessary when submitting a preauthorization for ortho case?

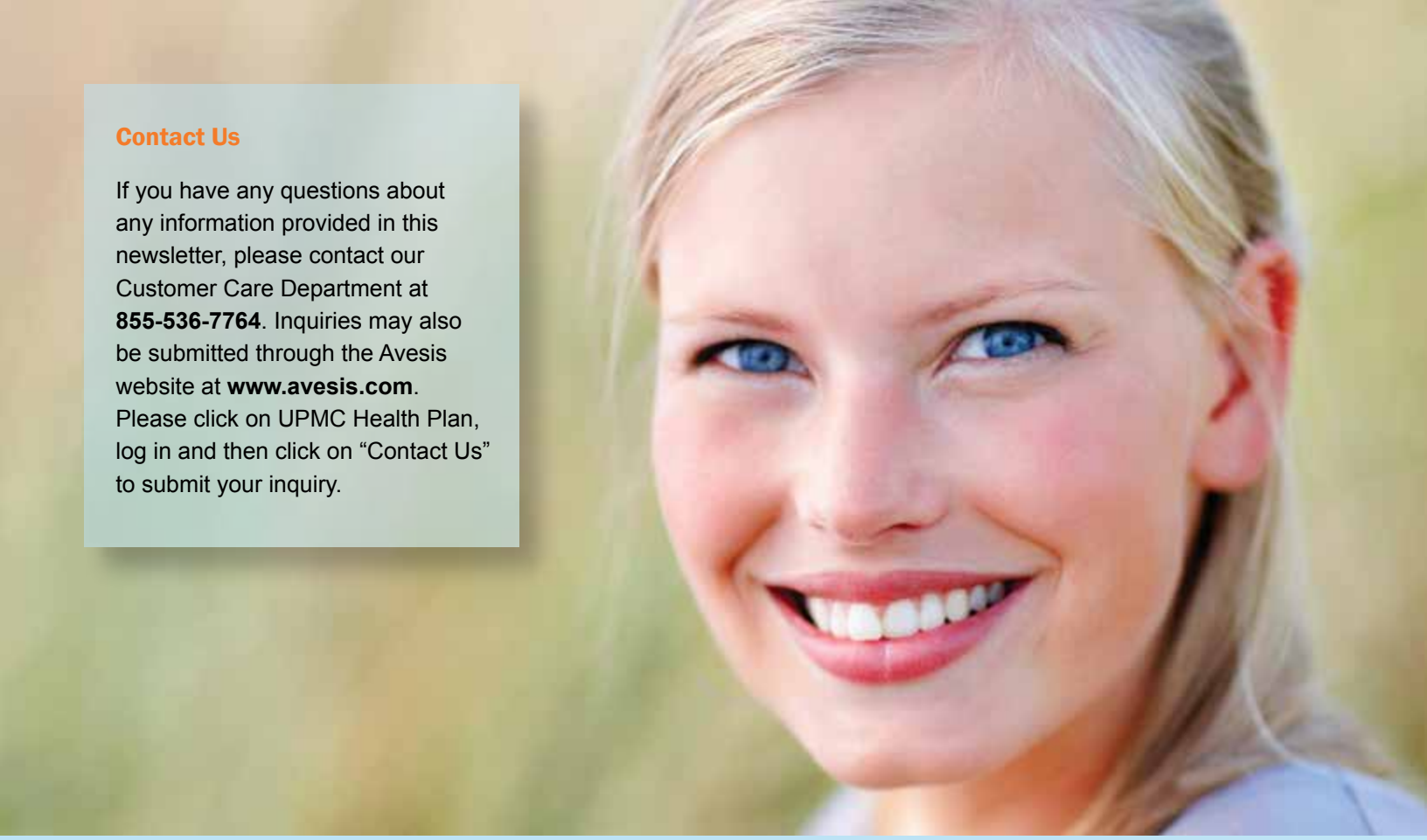
   A: No, you may use photographs in lieu of models. Photographs should be of the, facial, lingual, left and right of occlusion and occluded models from posterior.

8. **Q:** Is the dollar incentive for EPSDT applied to the exam charge only?

   A: A dollar incentive will be paid out for every recall exam billed under UPMC for You Children members on a quarterly basis and will show on the EOB as "P&P". is "P&P" accurate?

9. **Q:** Is there a fee for CPS?

   A: Yes, the fee is whatever your Master Card company charges. This fee is deducted directly from the payment by the Master Card Company.



Contact Us

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

Avesis

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