



Dental Provider Manual

UPMCHP

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PROPERTY OF:
Avesis Third Party Administrators, Inc.

3030 North Central Avenue, Suite 300
Phoenix, Arizona 85012

Phone: (888) 209-1243 | Fax: (866) 653-5544 | IVR: (866) 234-4806

www.avesis.com

Dear Avesis Provider:

Avesis Third Party Administrators, Inc. (Avesis) would like to take this opportunity to welcome you and your staff as participants in our national network of preferred Providers. We are pleased that you have chosen to participate with us.

Throughout your ongoing relationship with Avesis, this Dental Provider Manual will provide you with useful information concerning the Avesis Dental Program.

When communicating with our Participating Providers, we make every effort to be clear and concise. Our expectation is to answer questions promptly when they arise. We want to provide accurate and effective information that will allow you and your dental team to understand which American Dental Association (ADA) Current Dental Terminology (CDT) codes are covered and what to expect from Avesis.

If you require assistance or information that is not included within this Provider Manual, please contact our Provider Services Department at the following number:

Provider Services: **(888) 209-1243**

Monday – Friday 8:00 AM to 5:00 PM (EST)

A Quick Reference Guide is also provided within this Manual. This easy to read Reference Guide is intended to give you the most important information in one place. Please place this Guide in a convenient location at your front desk so that it may be used as a reference to answer questions regarding the UPMC Health Plan, Inc. (“UPMCHP”) Dental Programs.

Specific details regarding the Programs can be found throughout this Provider Manual. Please visit the Avesis website at www.avesis.com periodically to ensure that your Provider Manual is up to date.

Again, we welcome you and your staff to the growing list of Avesis Providers. We look forward to a successful relationship with you and your practice.

Sincerely,

Avesis Provider Services

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Avesis Contact Information

Avesis Executive Offices

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

Avesis Provider Services

Provider Services
(888) 209-1243

Avesis Chief Dental Officer

Fred L. Sharpe, DDS, JD
fsharp@avesis.com

Avesis Pennsylvania Dental Director

Richard Celko, DMD, MBA
(800) 522-0258
rcelko@avesis.com

Avesis Pre-Treatment Estimate

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

Avesis Specialty Referral Form

Avesis Third Party Administrators, Inc.
Attn: Dental UPMCHP Specialty Referrals/Authorizations
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

Avesis Member Services

UPMC for You Dental: (888) 257-0474
UPMC for Life Dental: (888) 257-0066
UPMC for Life Specialty Plan Dental: (888) 729-7951
UPMC for Life Options Dental: (888) 729-7951
UPMC for You Advantage Dental: (888) 729-7951
UPMC for Kids Dental: (888) 257-0350
UPMCHP Federal Commercial Dental: (888) 729-7949
TTY: (800) 201-7165

Avesis Corporate Offices

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

Avesis Utilization Management

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

Avesis EFT Contact

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

Avesis Post Review

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

To Correct Claims

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

Other Contact Information

Pennsylvania Department of Public Welfare

General Information: (717) 772-6181

Provider Hotline: (800) 537-8862

Electronic Verification System: (800) 766-5387

Pennsylvania Health Law Project

(800) 274-3258

Medical Assistance Clinical Sentinel Hotline

(866) 542-3015

Pennsylvania Legal Aid Network

(800) 322-7572

Avesis makes every effort to maintain the accuracy of information contained in this Provider Manual. If any typographical errors are found please contact Avesis at **(800) 327-4462**. Avesis is not liable for any damages, directly or indirectly, that may occur from a typographical error.

Statement of Providers' Rights and Responsibilities

Providers shall have the right and responsibility to:

- Communicate openly and freely with Avesis
- Communicate openly and freely with Member(s)
- Suggest dental treatment option(s) to Member(s)
- Recommend non-covered service(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
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Ensure disclosure form is signed for non-covered service(s) by all parties prior to rendering service(s)
- Obtain information regarding the status of claims
- Receive prompt payments from Avesis for clean claims
- Resubmit a claim with additional information
- Make a complaint or file an appeal with Avesis on behalf of a Member with the Member's consent
- Inform a Member of appeal status
- Question policies and/or procedures that Avesis has implemented
- Request Pre-Treatment Estimate for services to be rendered in the General/Pediatric Dentist's office
- Request that referrals be performed in a setting other than the General/Pediatric Dentist's office
- Inquire about re-credentialing
- Update credentialing materials including State licensure, DEA and professional liability insurance
- Abide by the rules and regulations set forth under the General Provision of 55PA Code, Chapter 1101

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
- 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 UPMCHP Members for services provided under the UPMCHP 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

Statement of Members' Rights

Members shall have the right to:

- Communicate openly and freely with Avesis without retribution
- Communicate openly and freely with their Avesis Providers without retribution
- Expect privacy according to HIPAA and other State or Federal guidelines
- Be treated with respect and dignity
- Be treated the same as all other patients
- Be treated without discrimination based on race, religion, color, sex, national origin or disability
- Be informed of their oral health status
- Participate in choosing treatment option(s)
- Receive information on treatment options in a manner that Members understand
- Participate with parent(s) or guardian in making a decision(s) regarding their oral health
- Know whether treatment is medically necessary
- Be provided with a phone number to call the provider in case of an emergency
- Obtain non-covered service(s) only when a disclosure form is signed by all parties
- File a complaint or grievance against a provider
- Be informed of any appeal filed on their behalf
- Access their records to review and/or change
- Prior notice of and participation in a fair hearing to contest any adverse determination made on the Member's behalf (only applicable to certain products)
- Change Providers
- Receive materials translated into Member's language, upon request

Statement of Members' Responsibility

The Members shall to the best of their ability:

- Choose Providers who are participating in the Avesis network
- Choose specialists who are participating in the Avesis network
- Be honest with Providers
- Provide accurate information to the Providers
- Behave in a respectful manner
- Understand the status of their oral health
- Choose a mutually agreed upon treatment plan with option(s) that they believe is in the best interest of their oral health
- Have Providers explain fees associated with non-covered services and payment arrangements agreed upon in advance for services being rendered
- Use best efforts to not miss or be late for an appointment
- Cancel appointments in advance, if unable to make scheduled appointment
- Supply the providers with emergency contact information
- Follow home care instructions
- Call the dentist of record in the event of an emergency

Definitions:

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.

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.

Medically Necessary – Except as otherwise defined for Medicare Advantage, 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

Medically Necessary (UPMC for Life): For purposes of determinations of medical necessity of services provided to Members in Medicare Advantage Products, Avesis will utilize the following definition in accordance with CMS regulations:

Medical Necessity or Medically Necessary means medical or hospital services that are determined by Company to be:

1. Rendered for the treatment or diagnosis of an injury or illness; and
2. Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
3. Not furnished primarily for the convenience of the Member, the attending physician or other provider of service.

Whether there is “sufficient scientific evidence” shall be determined by Avesis based on the following: peer reviewed medical literature; publications; reports; evaluations and regulations issued by state and federal government agencies, Medicare Advantage local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Avesis.

Medically Necessary (UPMC for You): For purposes of determinations of medical necessity of services provided to Members in a Medical Assistance Product, Avesis will utilize DPW’s definition of medically necessary:

A service or benefit is Medically Necessary if it is compensable under the Medical Assistance Program and if it meets any one of the following standards:

1. The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
2. The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
3. The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account

both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determinations of Medical Necessity for covered care and services, whether made on a prior authorization, concurrent review, post-utilization, or exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member's family/caretaker and the Primary Care Provider, as well as any other Providers, programs, agencies that have evaluated the Member. All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

Medically Necessary (UPMC for Kids): For purposes of determinations of Medical Necessity of services provided to Members in a CHIP Product, Avesis will utilize the PID's definition:

Services or supplies provided by a health care provider that Avesis determines are:

1. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury; and
2. provided for the diagnosis, or the direct care and treatment of the Member's condition, illness, disease or injury; and
3. provided in accordance with standards of good medical practice and consistent in type, frequency and duration of treatment with scientifically based guidelines from medical research or health care coverage organizations or governmental agencies that are accepted by Avesis; and
4. not provided as a convenience.

Avesis reserves the right to determine in its judgment whether a service is Medically Necessary. No benefits hereunder will be provided unless Avesis determines that the service or supply is Medically Necessary. Authorization decisions shall be made by Avesis with input from the member's PCP, or other health care provider providing service at the direction of the PCP, constituting proof of Medical Necessity for purposes of determining the Member's potential liability.

Primary Care Practitioner (PCP) – A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services 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.

Referral – a request for dental services to be performed by an Avesis network specialist.

General Information

Avesis Incorporated, the parent company of Avesis Third Party Administrators, Inc., has been providing fully insured dental and vision services since 1978. Recognizing that every client is unique, Avesis has built a network of general and specialty providers to support the constantly growing needs of the Commercial / Medical Assistance / Medicare Advantage and indigent populations. Avesis believes that a successful dental program is one where the Members receive the best possible care and the network providers are satisfied with the support that they receive.

Avesis prides itself on providing excellent account management and provider services in order to support you and your staff. To minimize your administrative responsibilities, Avesis maintains a web based processing system allowing for verification of eligibility and claims submission. The staff of Avesis includes the Chief Dental Officer, Pennsylvania Dental Director and representatives of the Avesis Provider Services Department who are your key contacts. If you would like to speak to the Avesis Chief Dental Officer or Provider Services, please call Provider Services at the number listed below. There is also a Pennsylvania Dental Director in your region who is available by calling the Provider Services number below.

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: **(888) 209-1243**

Monday - Friday 8:00 AM to 5:00 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)

Please note the document numbers at the bottom left of the page. PM-D refers to Provider Manual – Dental and the “v” stands for version which refers to the date. If you are in doubt as to whether you have the latest revision, please check the Avesis website at www.avesis.com for the most current version of a form. You will be able to download individual pages.

Promptly inserting revisions will keep your Provider Manual current and accurate.

Descriptions of Coverage Types

Coverage limitations and reimbursement guidelines are outlined in the Covered Benefits Schedule. Details for this program can be found throughout this Provider Manual. The descriptions of the various UPMCHP products are:

UPMC for You

UPMC for You, affiliate program of UPMC Health Plan, offers high-quality care to eligible Medical Assistance recipients in the UPMCHP service areas.

UPMC for Kids (ages birth to 19)

UPMC for Kids is available through a contract with the Children's Health Insurance Program (CHIP) of Pennsylvania. CHIP is a State and Federally funded program to provide health insurance for uninsured children from birth until they reach the age of 19. In 2007, Pennsylvania CHIP was expanded to offer health insurance to children and teens who are not eligible for Medical Assistance, regardless of family income. Enrollment eligibility is evaluated every 12 months.

UPMC for Life

UPMC for Life HMO and PPO offer choices for more enhanced services and care options than are available through traditional Medicare Advantage, including routine dental care.

UPMC for Life Options

UPMC for Life Options offers dual eligible Members (Medical Assistance/Medicare Advantage) choices for more enhanced services and care options than are available through traditional Medicare Advantage, including routine dental care.

UPMC for Life Specialty Plan

UPMC for Life Specialty Plan offers dual eligible Members (Medical Assistance/Medicare Advantage) choices for more enhanced services and care options than are available through traditional Medicare Advantage, including routine dental care.

UPMC for You Advantage

UPMC for You Advantage offers dual eligible Members (Medical Assistance/Medicare Advantage) choices for more enhanced services and care options than are available through traditional Medicare Advantage, including routine dental care.

Federal & Postal Employee Health Benefits (FEHB) Discount Dental Program

UPMCHP is offering limited dental coverage to Members enrolled in the **Federal & Postal Employee Health Benefits (FEHB) Discount Dental Program**. These groups are offered two levels of benefits. The first level includes routine, diagnostic and preventive services that are provided at no cost to the Member. The second level lists all of the other covered services and the corresponding fee due from the Member according to standing office policies. Procedures not listed are the responsibility of the Member. Both levels of benefits are also listed in this manual.

Frequently Asked Questions

General Information

With which Managed Care Organization(s) (MCO) is Avesis associated?

Avesis is associated with UPMCHP. Throughout this Manual we have referred to UPMC Health Plan, Inc. as UPMCHP.

What is the relationship between Avesis and UPMCHP?

Avesis has contracted with UPMCHP to arrange for the provision of dental services to their eligible Members as well as to adjudicate, process and pay claims to providers.

Do I contract with Avesis or UPMCHP?

You will contract directly with Avesis.

Will third party liability still be the same?

For Centers of Medicaid and Medicare Services programs and CHIP programs, Avesis, on behalf of UPMCHP, is always the payer of last resort. If the Member has other health insurance, claims must be filed with that payer 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.

However, for UPMC *for You*, Avesis agrees to pay all Clean Claims for EPSDT services to children. Avesis recognizes that cost avoidance of these Claims is prohibited.

Will we get new PROMISe (Medical Assistance) provider numbers?

You will keep your current PROMISe Provider number. If you do not have a PROMISe Provider number, you will need to apply for one. You should apply for your PROMISe Provider number through the Commonwealth's website. The application can also be found on the Avesis website at www.avesis.com. Please note that you will 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.

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.

Source: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0528.pdf>
<http://www.ada.org/prof/resources/topics/npi.asp>

Does Avesis 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 Avesis provider network.

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

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

Provider Services**Is there a number to call where you can speak to a representative?**

Avesis Provider Services is available to assist you at (888) 209-1243 Monday through Friday from 8 AM until 5 PM EST, except observed holidays.

Eligibility

How will I know that the Member has chosen to participate with UPMCHP?

The Member will present with a UPMCHP identification card or Providers may verify eligibility 24 hours a day 7 days a week with Avesis for any UPMCHP Member by calling our IVR or checking the Avesis website at www.avesis.com. Medical Assistance Members may also produce their Medical Assistance issued ACCESS card to Providers to verify eligibility.

For Medical Assistance, when are children considered adults under this program?

The first day of the month following their 21st birthday.

How will I obtain eligibility and benefits information?

Your office can:

- Visit the Avesis website anytime at www.avesis.com
- Utilize Avesis IVR anytime at: (866) 234-4806
- Call Avesis Customer Service Center during normal business hours at: (888) 209-1243

Do I need to verify eligibility each time a Member presents?

Yes, it is required that you verify eligibility prior to each visit.

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.

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.

Does Avesis require radiographs?

The Covered Benefits Schedule clearly states when radiographs are required.

Billing and Claims

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

Avesis is the dental program administrator for UPMCHP. Avesis is a licensed third party administrator in Pennsylvania and will work closely with UPMCHP to ensure that claims are paid correctly and in a timely manner. Under Pennsylvania insurance law, managed care subcontractors are required to meet specific standards for claims payment. The parent insurance company is, however, ultimately responsible for claims payment.

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, the Non-Covered Services Form provided herein should be completed and signed by you and the Member.

For UPMC *for You* Members only, 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.

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.

Is orthodontics a covered benefit? How do I bill for orthodontics?

Orthodontics is covered by prior authorization only. Information as to how to request prior authorization and bill for orthodontics is outlined in detail in this provider manual.

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

Quick Reference Guide

Identification Card

Members should present with a UPMCHP Member identification card. Medical Assistance Members may also produce their Medical Assistance issued ACCESS card to Providers to verify eligibility.

Eligibility Verification

Providers are required to verify Member eligibility. It is required that you verify eligibility for each Member's appointment the business day prior to rendering services. See Eligibility Section for details.

Using your Avesis provider PIN and the Member's identification number you may:

- Call the Interactive Voice Response (IVR) at: (866) 234-4806; or
- Visit the Avesis website at: www.avesis.com; or
- Submit an Eligibility Verification Fax Form to the Avesis secure fax line at: (866) 332-1632. The form will be returned to you via fax no later than one (1) business day after receipt; or
- Call Avesis Provider Services at: (888) 209-1243

For more details refer to the Eligibility Verification and Confirmation section.

Provider Services

- Check Re-credentialing Status
- Request Provider PIN number
- Verify Eligibility
- Check Claims Status
- Ask General Questions

Fax: (866) 653-5544 (secure fax)

Provider Service Hours

Monday - Friday 8:00 AM to 5:00 PM (EST)

Observed Holidays

Avesis observes the following holidays: New Year's Day, Presidents Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, and Christmas Day (may vary when holiday falls on a weekend).

Approval Policy

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

Claims

Electronic claims may be submitted to Avesis:

- Through EDI (arrangements must be made with the Avesis IT Department prior to submission); or
- On our website at: www.avesis.com; or
- Submitting paper claims sing the current ADA claim form to:

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

To Correct Information

You have the right to correct information submitted incorrectly within ninety (90) days from the date of service. You must include the reason for the change and a copy of the Remittance Advice. Change(s) must be made in writing and submitted to:

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

If you prefer, corrections can be made directly on the Avesis website.

Claims Appeals

If payment for services is denied in whole or in part, you may appeal the decision by requesting a review in writing. All claim reviews are handled in accordance with the Avesis Complaint, Appeal and Grievance (CAG) policies and procedures as well as applicable Department, State and Sponsor guidelines. All appeals must be submitted within thirty (30) business days from date of receipt of the denial notification. For more details please refer to the Appeals Process section.

Payment

Avesis providers who use our Internet site for Member eligibility and claim submission functions are eligible to receive payments from Avesis via Electronic Funds Transfer thereby enabling your practice to maintain a positive cash flow.

Emergency Care

You are responsible for facilitating emergency treatment, as needed.

Members may need to be directed to their medical provider. Assistance is available as follows:

UPMC for Life

Call the Member Services Department at (877) 539-3080; TTY users can call toll-free (800) 361-2629. Member Services is available from 8 AM to 8 PM, seven days a week. From February 15 through October 14, we are available from 8 a.m. to 8 p.m., Monday through Friday, and from 8 a.m. to 3 p.m. on Saturday.

UPMC for You

Call the Member Services Department at 1-800-286-4242 for Southwest, 1-866-353-4345 for Lehigh Capital (Lehigh Valley and Capital Region) or 1-855-425-8762 for New West. TTY users should call toll-free at 1-800-361-2629. Member Services is available Monday, Tuesday, Thursday and Friday from 7 a.m. to 7 p.m., Wednesday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

UPMC for Kids

Call the Member Services Department at (800) 650-8762; TTY users can call toll-free (800) 361-2629. Member Services is available Monday through Friday from 7 AM to 7 PM and on Saturdays from 8 AM to 3 PM.

UPMC for Life Specialty Plan, UPMC for Life Options, UPMC for You Advantage

Call the Member Services Department at (800) 606-8648; TTY users can call toll-free (866) 407-8762. Member Services is available from 8 AM to 8 PM, seven days a week. From February 15 through October 14, we are available from 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 3 p.m. on Saturday.

FEHB

Call our Member Services Department at (888) 876-2756; TTY users can call toll-free (800) 361-2629. Member Services is available Monday through Friday from 7 AM to 7 PM and Saturday from 8 AM to 3 PM.

Eligibility and Confirmation

The confirmation of eligibility is an important step for every dental appointment. Avesis strongly recommends that you verify eligibility for each Member *prior* to the visit. Eligibility verification is not a guarantee of payment. Benefits are determined at the time the claim is received for payment. Avesis will update the eligibility files monthly or as provided by UPMCHP.

Avesis Provides four options for eligibility verification:

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 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
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: (888) 209-1243
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.

Avesis Eligibility Verification Fax Form

Provider Name: _____

Provider PIN#: _____

Provider Tax ID #: _____

Fax Number: _____

[illegible]

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.

Samples of Accepted Identification Form

These cards are samples of the UPMCHP issued cards.

UPMC for You
Affiliate of UPMC Health Plan

ID# [REDACTED]
PCP: [REDACTED]
Phone: [REDACTED]

Not Therapeutic

Member Services: 1-800-286-4242; TTY call toll free: 1-800-361-2629.
Dental Member Services: 1-866-257-9474.
Vision Member Services: 1-866-458-2138.
Pharmacist Helpdesk: 1-800-396-4139.

www.upmchealthplan.com

Medicine: Present this card at the drug store with a prescription from your PCP or other healthcare providers.

Emergencies: Go to the nearest emergency room when your medical situation is very serious – when it may be life or death. Call your PCP as soon as you can.

Provider Information: PROVIDERS and HOSPITALS must call 1-800-286-4242 to verify eligibility prior to any service or admission. Emergency Departments must call PCP for authorization of non-emergency treatment.

To request PRE-CERTIFICATIONS and PRIOR AUTHORIZATION, call 1-800-242-3544.

Mental Health/Substance Abuse: Call your Behavioral Health Managed Care Organization.

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UPMC for Kids
A Product of UPMC Health Plan

TEST MEMBER
ID#: 00000004601
PCP: PEDIATRIC ALLIANCE ST CLAIR PE
Phone: (412)221-2121

COPAYMENTS:
PCP Visits: \$15/15
Specialists: \$25
ER: \$50
Behavioral Health: \$25
RX: \$10/18

Member Services: 1-800-650-8762

www.upmchealthplan.com/UPMCforKids

Member Services: 1-800-650-8762. Weekdays: 8 a.m. to 8 p.m. Saturdays: 8 a.m. to 3 p.m. TTY: 1-800-361-2629.

Emergencies: Go to the nearest medical facility/provider. If admitted, hospital must notify UPMC Health Plan.

Out-of-Area: For urgent care outside the primary service area, call Member Services to locate a participating PHOS or MultiPlan provider. In Ohio, call 1-800-601-9208.

Pharmacist Helpdesk: 1-800-396-4139

UPMC Health Plan Behavioral Health Services Prior Auth: 1-888-251-2224.

Pre-Certifications and Prior Authorizations: 1-800-425-7800.

Claims Submissions: PO Box 2999, Pittsburgh, PA 15230.

Ohio SuperMed Plus Providers: Submit to PO Box 94648, Cleveland, OH 44101.

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UPMC for Life
Specialty Plan
UPMC Health Plan Medicare Program

Medicare Special Needs Plan
TEST MEMBER
ID#: 00000003701 GRP#: MCSNP1-500
PCP: FAMILY MEDICAL CENTER
Phone: (814)634-9106

Rx BIN: 003858
Rx PCN: A4
Rx GRP: PMDA
Issuer: (80840)

CMS: H3907-020
MedicareRx
Prescription Drug Coverage

www.upmchealthplan.com

Member Services: 1-800-606-8648; TTY/TDD: 1-866-407-8762

Provider Services: 1-866-918-1595

Emergencies: Go to the nearest medical facility/provider or call 911. If admitted, UPMC Health Plan must be notified.

24-Hour Nurse Advice Line: 1-866-918-1591

Claims Submissions: UPMC Health Plan, PO Box 2997, Pgh, PA 15230

Pharmacist Helpdesk: 1-800-396-4139

Prescriptions processed by Express Scripts, Inc.

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UPMC for Life
UPMC Health Plan Medicare Program

MEDICARE HMO
TEST MEMBER
ID#: 00000004501 GRP#: MC0011-500
PCP: EXCELA HEALTH CHESTNUT RIDGE L
Phone: (724)694-2723

Rx BIN: 003858 Rx GRP: PMDA
Rx PCN: A4 Issuer: (80840)

Medical Copays:
Medical: PCP:\$5/5 SPEC:\$20/20 ER: \$50

www.upmchealthplan.com

MedicareRx
Prescription Drug Coverage

Member Services: 1-877-539-3080; TTY/TDD: 1-800-361-2629

Provider Services: 1-866-918-1595

UPMC Health Plan Behavioral Health Services: 1-888-251-0083;

TTY/TDD: 1-877-877-3580

Emergencies: Go to the nearest medical facility/provider or call 911.

24-Hour Nurse Advice Line: 1-866-918-1591

Claims Submissions: UPMC Health Plan, PO Box 2997, Pgh, PA 15230

Pharmacist Helpdesk: 1-800-396-4139

Prescriptions processed by Express Scripts, Inc.

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UPMC for Life
Options (HMO SNP)
UPMC Health Plan Medicare Program

UPMC for Life Options Plan
SAMPLE MEMBER
ID#: 00000008601 GRP#: MC0011-502
PCP: SAMPLE PCP
Phone: (555)555-5555

Rx BIN: 003858
Rx PCN: A4
Rx GRP: PMDA
Issuer: (80840)

CMS: H3907-032
MedicareRx
Prescription Drug Coverage

www.upmchealthplan.com

Member Services: 1-800-606-8648; TTY/TDD: 1-866-407-8762

Provider Services: 1-866-918-1595

Emergencies: Go to the nearest medical facility/provider or call 911. If admitted, UPMC Health Plan must be notified.

24-Hour Nurse Advice Line: 1-866-918-1591

Claims Submissions: UPMC Health Plan, PO Box 2997, Pgh, PA 15230

Pharmacist Helpdesk: 1-800-396-4139

Prescriptions processed by Express Scripts, Inc.

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UPMC for You
Advantage (HMO SNP)
Affiliate of UPMC Health Plan

UPMC for You Advantage Plan
SAMPLE MEMBER
ID#: 00000008701 GRP#: MC0011-500
PCP: SAMPLE PCP
Phone: (555)555-5555

Rx BIN: 003858
Rx PCN: A4
Rx GRP: PMDA
Issuer: (80840)

CMS: H4279-001
MedicareRx
Prescription Drug Coverage

www.upmchealthplan.com

Member Services: 1-800-606-8648; TTY/TDD: 1-866-407-8762

Provider Services: 1-866-918-1595

Emergencies: Go to the nearest medical facility/provider or call 911. If admitted, UPMC Health Plan must be notified.

24-Hour Nurse Advice Line: 1-866-918-1591

Claims Submissions: UPMC Health Plan, PO Box 2997, Pgh, PA 15230

Pharmacist Helpdesk: 1-800-396-4139

Prescriptions processed by Express Scripts, Inc.

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CDT Codes for UPMCHP 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 dental practices. You understand that the omission of 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. There must be no other effective and more conservative or substantially less costly treatment available.

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

Non - Covered Items or 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 Pennsylvania 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. Avesis requires that you and the Member complete the 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.

Benefit Exception Process

The benefit exception process occurs when a provider requests review of a service that is not a covered benefit to determine if an exception should be made based on medical necessity. The process also applies to benefit limitations, or when a provider requests additional treatment for a member who has exhausted the benefit limit (i.e., duration or quantity) of a particular service.

Key Principles

- The UPMC *for Kids*, UPMC *for Life*, UPMC *for Life Options*, UPMC *for Life Specialty Plan*, UPMC *for You Advantage* and FEHB product benefit plans do not provide any provision for benefit exceptions.
- UPMC *for You* requires consideration of written provider requests for a benefit exception if the member is 20 years of age or younger. For members greater than 20 years of age, benefit exceptions may be reviewed by Avesis on a case-by-case basis.

Process. If a UPMC *for You* member or a provider contacts Avesis and requests coverage of a non-covered item or service or a “benefit exception,” the following procedure should be followed:

1. Requests for benefit exceptions must delineate the medical necessity for the exception via a Letter of Medical Necessity from an Avesis provider or a UPMCHP physician.
2. Letters of Medical Necessity must be forwarded to the attention of “Avesis Utilization Management-UPMC *for You*” via fax # (866) 653-5544.”
3. Requests will be reviewed for medical necessity and appropriateness.
4. Avesis must make a determination and notify the provider and member verbally within two (2) business days of receipt if all of the information needed to make the determination is available. Written notification must be sent within two (2) business days of the verbal notification to the Provider and Member. If all of the information is not available, additional information must be requested within two (2) business days. If we do not receive the additional information within 14 days, the decision to approve or deny the service will be made, based on the available information.

Benefit Limit Exception Process (UPMC for You Members 21 and over)

UPMC for You adult members (age 21 and older) will experience a benefit change that result in their being limited to the following dental services effective May 1, 2012.

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

Effective May 1, 2012, UPMC for You adult members (age 21 and older) will be eligible for the following services only if Avesis approves a BLE request:

- Crowns and adjunctive services (D2710, D2721, D2740, D2751, D2791, D2910, D2915, D2920, D2952, D2954, D2980)
- Periodontic services (D4210, D4341, D4355, D4910)
- Endodontic services (D3310, D3320, D3330, D3410, D3421, D3425, D3426)

Also effective May 1, 2012, members with limited dental benefits (who are 21 years of age and older and do not reside in a nursing home or intermediate care facility) will only be eligible for the following services:

- Palliative care, (the emergency treatment of dental pain).
- Dental Care provided in a Short Procedure Unit (SPU), Ambulatory Surgical Center (ASC) or Inpatient Hospital. The following dental care may be covered:
 1. Oral surgery and impacted teeth removal if the nature of the procedure or the member's compromising condition would cause undue risk if performed on an outpatient basis; or
 2. Teeth extraction and dental restorative services for a member who is unmanageable and requires general anesthesia by an anesthesiologist, not the dentist, due to a severe mental and/or physical condition.

Services provided beyond a Member's benefit limits are not covered unless a BLE is requested and approved by Avesis.

NOTE: The dental benefit changes do not apply to children under 21 years of age or to adults who reside in a nursing facility, an intermediate care facility for persons with mental retardation (ICF/MR) or an intermediate care facility for persons with other related conditions (ICF/ORC).

The dental benefit changes apply to adult Members 21 years of age and older who are enrolled in UPMC *for You* and reside in personal care homes and assisted living facilities.

BENEFIT LIMIT EXCEPTIONS

Avesis will grant benefit limit exceptions to the dental benefits when one of the following criteria is met:

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

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

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

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

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

Providers may require a BLE prospectively (prior to services being rendered) or retrospectively (after services are rendered). Retrospective BLE requests must be submitted no later than 60 days from the date Avesis denies the claim because the service is over the benefit limit. Retrospective BLE requests received on or after the 61st day from the date of the claim rejection will be denied.

Avesis will respond to prospective BLE requests within 21 days after the request is received. For prospective BLE requests, if the provider or Member are not notified of the decision within 21 days of the date the request is received by Avesis, the request will be automatically approved. Avesis will respond to a retrospective BLE request within 30 days after the request is received. Both the provider and Member will receive a written notice of the approval or denial of the dental BLE request. When Avesis denies a BLE request, both the provider and Member will receive a written notice of the decision that explains the reason for the denial. If a Member has agreed to assume financial responsibility when a BLE request has been denied, no fees for services provided may

be collected by the provider until a notification of denial of the BLE request has been received by the provider and Member.

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

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

Members may appeal both prospective and retrospective BLE request denials within 30 days from the date of the denial notice by submitting an appeal in writing to the address listed on the notice. Providers may only appeal the denial of a retrospective BLE request. Providers may file an appeal of a denial of a retrospective BLE request within 30 days from the date of the denial notice to the address listed on the notice.

Non - Covered Services Disclosure Form

To be completed by Dentist Rendering Care

I am recommending that _____ receive
Member Name and Identification Number
 services that are **not** covered by the UPMCHP Avesis Covered Benefits Schedule. I am willing to accept my Usual and Customary Fee as payment in full. The following procedure codes are recommended:

CODE	DESCRIPTION	FEES	

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

Doctor's Signature

Date

To be completed by Member

I _____, have been told
Print Your Name
 that I require services or have requested services that are not covered by the UPMC Avesis Covered Benefits Schedule.

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 UPMCHP.		
I am aware that I am financially responsible for paying for these services.		
I am aware that UPMCHP 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.**

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

Date

Services Performed by the General/Pediatric Dentist

The Avesis UPMCHP Dental programs are intended to be General/Pediatric Dentistry programs. Avesis considers the General/Pediatric Dentist to be the provider responsible for rendering all primary care to the 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:

1. Preliminary diagnostic and all preventative care
2. Simple forceps extractions (D7140)
3. All anterior (D3310) and bicuspid (D3320) root canal therapy
4. Initial root planing, scaling and follow-up evaluation for all periodontal cases
5. Endodontics require a request for Prior Authorization along with radiographs and is not considered for cases with rampant cavities or multiple missing teeth.
6. Routine restorative dentistry for children.

The aforementioned procedures should not be referred to a specialist unless they present with an unusual complication 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. If radiographs cannot be obtained from the General/Pediatric Dentist, the Successor Dental Provider shall contact Avesis to advise. Avesis shall notify the General/Pediatric Dentist, in writing, within thirty (30) calendar days, that the Successor Dental Provider did not receive diagnostic quality radiographs. 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.

Prior Approval for Non-Emergency Situations

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

You will receive an authorization number within two (2) business days of receipt of all required and/or requested information necessary to complete the request from Avesis, if the clinical reviewer deems the service(s) to be necessary. Should the Pennsylvania Dental Director, in conjunction with the Avesis Medical Director, determine that the service is not necessary you will be notified within two (2) business days of receipt of all required information. If additional documentation is required to make a determination, you will be notified within forty-eight (48) hours. If we do not receive the additional information within 14 days, the decision to approve or deny the service will be made, based on the available information. Authorization determinations communicated to you will also be sent in writing within two (2) business days of the initial communication. Once the determination has been communicated to you, you are responsible for advising the member of the review decision, both approvals and denials within 2 business days.

Services that require Prior Approval for non emergency care can be found in the Covered Benefits Schedule at the end of this Manual.

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 oral hygiene of the mouth
- all proposed dental work
- identification of existing crowns, periodontal services, etc.
- identification of the existence of full and/or partial denture(s), with the date of initial insertion
- 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 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.

UPMCHP Participating Hospitals

<http://www.upmchealthplan.com/doctor/Hospital.aspx>

Specialty Referral Process

A member requiring a referral to a dental specialist can be referred directly to any specialist contracted with Avesis 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.

Emergency Care

In the event that the emergency cannot be treated within twenty-four (24) hours, you must contact Avesis at (888) 209-1243 to allow Avesis the opportunity to arrange for timely emergency care. Avesis requires that you provide sufficient access to ensure that Members can receive services in your office rather than in a hospital emergency room.

Emergency Access and Authorizations

All Avesis 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 must 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 or 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.

Patient of Record

If the Member telephones with an emergency before 12 Noon, you must treat the Member that business day, if possible. If the Member telephones after 12 Noon, the Member must be treated 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 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 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.

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 a treatment plan be submitted after treatment to the Avesis Pennsylvania Dental Director along with supporting documentation 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
4. Hospital records, if admitted to hospital
5. Anesthesia records, if general anesthesia was administered
6. Claims and accompanying information must be submitted within thirty (30) calendar days of the issuance of temporary referral approval number. If the procedure does not occur within thirty (30) calendar days, Avesis will terminate the temporary referral approval and require that a new referral approval number be issued.

The Avesis clinical reviewer and Pennsylvania 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 can not treat the Member within twenty-four (24) hours, you must contact Avesis at (888) 209-1243 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

Post Treatment Review

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 may take-back future claim payments.

If the Avesis Pennsylvania 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.

Dental service codes requiring post treatment review are indicated in detail in the Avesis UPMCHP 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.

Claims Process

All claims submitted will be processed and paid according to the Avesis Covered Benefits Schedule. Avesis 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. Claims for UPMC *for You* members must be received within one hundred eighty (180) days. Claims for UPMC *for Life*, UPMC *for Life* Specialty Plan, UPMC *for Kids* and the FEHB Discount Dental Program must be received within three hundred sixty five (365) days from the date of service. 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

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 them directly at (877) 469-3263. If you have any questions regarding EHG, please contact them directly at (800) 576-6412.

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.

Avesis providers using the Avesis website for claim submission or other electronic filings are eligible to receive payments from Avesis via Electronic Funds Transfer.

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. **A voided check is faxed along with this agreement to 800-663-7441 to facilitate this process.** 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 shown above. The bank shall provide to Avesis my 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.

Printed Name of Account Holder

Signature of Account Holder

Date

Printed Name of Joint Account Holder

Signature of Joint Account Holder

Date

Telephone Number: _____

P.O. Box 782 | Owings Mills, Maryland 21117 | Phone 800-952-6674 | Fax 800-663-7441

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 ninety (90) days from the date of the remittance advice.

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

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 Re-Submission at the top of the form to ensure proper handling of the claim in the Processing Department.

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.

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
7. Provider’s signature

Missing or incorrect information will cause delays in your payment or the claim may be returned to you unpaid. Applicable Member co-payments will be deducted from billed amounts.

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.

Coordination of Benefits

Primary vs. Secondary Insurance

Avesis, on behalf of UPMCHP, is the payor of last resort for UPMC *for You* and UPMC *for Kids* 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 UPMC *for You* and UPMC *for Kids* Members.

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 Avesis for the balance. You must enclose the Remittance Advice from the primary payor. Avesis must receive the claim within ninety (90) calendar days of the date of the primary payer's Remittance Advice. Remaining charges will be reimbursed up to the maximum allowed amount had Avesis paid as the primary payer. However, for UPMC *for You*, Avesis agrees to pay all Clean Claims for EPSDT services to children. Avesis recognizes that cost avoidance of these Claims is prohibited.

Since the Avesis UPMCHP program is an individual program, each Member has a unique Member identification number.

Member Inquiries, Complaints, Grievances and Appeals

Upon enrollment, UPMCHP 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 Pennsylvania Act 68.

DEFINITIONS

An ***inquiry*** is a request for administrative service or information, or an expression of an opinion regarding services received or benefits available from UPMCHP.

A ***complaint*** is an issue that a provider or Member presents to UPMCHP or Avesis, either verbally or in writing, that is subject to informal resolution within 30 days. A complaint involves dissatisfaction regarding a provider, benefits, exclusions, operations or management. Complaints include issues of contract exclusions and non-covered benefit disputes.

The Department of Public Welfare defines a complaint as: A dispute or objection regarding a Provider which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with the Department of Health or the Insurance Department of the Commonwealth, including but not limited to:

- i. a denial because the requested service/item is not a covered benefit; or
- ii. a failure to meet the required timeframes for providing a service/item; or
- iii. a failure of Avesis or UPMCHP to decide a Complaint or Grievance within the specified timeframes; or
- iv. a denial of payment by Avesis after a service has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or
- v. A denial of payment by Avesis after a service has been delivered because the service/item provided is not a covered service/item for the Member.

A ***grievance*** is a Member's request for reconsideration of a decision regarding the medical necessity and appropriateness of services. A grievance must be resolved within the 30-day resolution period.

The Department of Public Welfare defines a grievance as: A request to have a PH-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a PH-MCO decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item.

An ***Appeal*** is 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 UPMCHP and if necessary, an independent review organization, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), or judicial review.

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.

Procedure Levels

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.
2. The Claims Manager will review the appeal within sixty (60) 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 thirty (30) 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.

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

Level One:

1. Provider sends a written notice of appeal to Avesis within thirty (30) business days of receipt of the adverse determination. The appeal should include documentation in support of the appeal not previously provided.
2. The Pennsylvania Dental Director will review the appeal and, if necessary, speak directly with the Provider. If the Pennsylvania Dental Director made the initial determination, the appeal will be reviewed by a member of the Avesis Dental Advisory Board.
3. Within thirty (30) business 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 thirty (30) business days.

Level Two:

1. If the adverse determination is upheld at Level One, the Provider may file for a Level Two appeal, following the procedures outlined for Level One.
2. The Level Two appeal will be reviewed by another member of the Dental Advisory Board who was not involved in either the initial or Level One determination.
3. Upon review, a Committee consisting of the Chief Dental Officer, Pennsylvania Dental Director, Medical Director and members of the Dental Advisory Board will meet to make a final determination.
4. If the adverse determination decision is upheld, the Provider will be notified in writing within ten (10) business days. The notification will include information regarding the requesting of a fair hearing or an external independent review. If the determination is reversed, the claim will be processed and paid within thirty (30) calendar days of the determination.

Provider Complaints

Avesis has designated personnel for the program who shall be available to receive phone calls, emails or in-person 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 EOP sent to the provider.

Standards of Care for Dental Offices

The Avesis / UPMCHP Dental Program has established standards that our provider offices are expected to fulfill. The following are the summaries of those standards:

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 their state. 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.

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, Avesis 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.

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 53 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.

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 handpieces. 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.

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.

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 UPMCHP Medical Assistance, Medicare Advantage and FEHB Dental program.

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).

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.

Standard for Services not covered under Avesis UPMCHP Dental Programs

Your office should be aware of those dental services that are not covered under the Avesis UPMCHP 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 Avesis Non-Covered Services Disclosure Form included herein and maintain such form in the Member's record.

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.

EPSDT Program

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.

Reminder, Follow-up and Outreach Call Policy and Procedures

CMS comprehensive and preventive child health program for individuals under the age of twenty one (21) 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 Avesis provider office is required to maintain and document the following Member recall policy and procedures for all UPMC *for You* and UPMC *for Kids* Members:

- For Members of record (under age 21) Providers must attempt to make contact at least two (2) times per year
- For Adult Members of record (over age 21) Providers must attempt to make contact at least one (1) time per year

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

FOLLOW-UP PROCEDURE

The dentist or specialist shall conduct affirmative outreach whenever a Member misses an appointment. This outreach should be documented in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

Periodicity Schedule

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE

Commonwealth of Pennsylvania, Department of Public Welfare, Office of Medical Assistance Programs
(Adapted from the American Academy of Pediatric Dentistry)

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

**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 (5,6), 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.

1. Initially, responsibility of parent; as child develops jointly with parents, and then by age 12 responsibility of the child only.
2. Initially play objects, pacifiers, car seats; then when learning to walk; sports, routine playing and intraoral/perioral piercing.
3. At every appointment discuss role of refined carbohydrates; frequency of snacking.
4. At first discuss need for additional sucking; digits vs. pacifiers; then the need to wean from habit before eruption of a permanent incisor.
5. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
6. Up to at least 16 years.
7. By clinical examination.

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 current health history
- 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 include pediatric Dentist and occlusal status
- Must have all entries signed or initialed by the Provider
- Must have all entries dated
- 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
- 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

Review:

An Avesis representative may visit your office to review the medical records of UPMCHP Members. The Member's record must:

1. Contain a signed consent to permit Avesis to access medical 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 as required by your State law.

Access:

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

1. The following parties access to the Member's medical records: Avesis representatives or their delegates, the Member's subsequent physician(s), or any authorized third party including employees or agents of the Department of Public Welfare, CMS, the Department of Insurance or Sponsor.
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.

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.

Credentialing and Routine Periodic Office Review

Avesis is required to confirm the professional qualifications of the dentists and specialists who treat our patients. That process began with the initial application completed and submitted by you and continues on a regular basis. Routine periodic office reviews may be conducted on a triennial basis.

Credentialing Process

The credentialing process began with the gathering of documentation from you. Requirements for credentialing included the specific background information necessary to perform a comprehensive review of your credentials in accordance with applicable provisions of the National Committee for Quality Assurance (NCQA) including your education, licensure and other qualifications. Avesis contracts with a NCQA certified credentialing verification organization (CVO) to complete the primary source verification of each provider's credentials. The details of the credentialing process are focused upon ten (10) specific elements within the NCQA and Avesis process. Those elements are as follows:

- License to Practice – State dental license
- Hospital privileges, if applicable
- DEA/CDS Registration, if applicable
- Board Certification / Residency Completion / Medical School, if applicable
- Professional Liability Insurance Coverage Limits
- Professional Liability Claims History including previous lawsuits, if any
- Application Processing – Professional questions and Attestation
- NPDB – National Practitioner Data Base information
- Medicare Advantage/Medical Assistance sanctions
- Sanctions Against Licensure – State license limitations
- Prior work history

After completion of the credentials confirmation process, your completed application was reviewed by the Avesis Credentialing Committee. The Credentialing Committee confirms the successful completion of the information gathering, reviewed any specific information obtained and approved you for participation into the network. If issues were found during the credentialing process, you were given an opportunity to further explain the circumstances.

This credentialing process for each dentist practicing in your office will be repeated every thirty six (36) months. Any new dentists joining the practice must be credentialed by Avesis prior to treating any UPMCHP Members. Failure to participate in recredentialing or continuous credentialing activities may result in the suspension of claims payments to your office and/or termination from the program.

Once fully credentialed, participating providers agree to bill Avesis for **only** those services rendered by them personally, or under their direct supervision by salaried employees such as licensed hygienists, or assistants duly certified pursuant to State law. Direct supervision includes, at a minimum, periodic review of the patient's records and immediate availability of the provider to confer with the salaried employee performing the service regarding a Member's condition. This does not mean the enrolled provider must be present in the same room; however, the enrolled provider must be present at the site of these services, e.g., office suite, hospital, clinic, etc. at the time they are performed.

Note: Under no circumstances may a provider bill for services rendered by another individual practitioner who is enrolled or eligible to enroll as a provider of services in the Avesis dental program or who is not duly licensed in the state wherein services are being rendered. In a group practice, each provider must enroll separately and bill for services he/she provided under his/her own provider number. For purposes of this policy, a group practice is defined as a partnership, a corporation, or an assemblage of providers in a space-sharing arrangement in which the physicians each maintain offices and the majority of their treatment facilities in a contiguous space. Services performed by non-enrolled providers in a group practice are not covered, unless as a locum tenens, as defined in the Provider Agreement.

Indiscriminate billing under one provider's name or provider number without regard to the specific circumstances of rendition of the services is specifically prohibited and will be grounds for recoupment of funds for services billed under a provider other than the provider rendering service, or claim denial.

The common practice of one provider covering for another will not be construed as a violation of this Section when the covering provider is on call and provides emergency or unscheduled services for a period of time not to exceed sixty (60) continuous days during a twelve month period.

Participating providers agree to notify Avesis in writing should any changes(s) in participation status occur such as: new address and/or telephone number, additional practice/ office location(s) or change in payee. Each change in participation status must be reported to the Avesis Credentialing Department as soon as possible.

Re-Credentialing

Avesis will initiate the re-credentialing process approximately thirty (30) months of your initial credentialing date and every third year on that date. Our process is to send a re-credentialing information request sixty (60) to ninety (90) days prior to your credentialing date. That information should be completed and returned to Avesis promptly in order for us to work with our CVO to perform primary source verification on the data.

Our Credentialing Committee will review the completed re-credentialing information. If there are any significant issues prior to that review, they will be reviewed by the Chief Dental Officer, Members of the Credentialing Committee and the Pennsylvania Dental Director.

The credentialing and re-credentialing process is necessary in order to confirm that the dentists participating with Avesis are properly licensed and have no sanctions or license limitations that would impact their ability to treat our Members.

IMPORTANT

Re-Credentialing

It is the sole responsibility of Avesis providers to submit required materials to the Avesis Credentialing or Provider Relations Department upon renewal of such documents to ensure continued participation on the Avesis Provider Network.

Quarterly Statistical Provider Review

At the end of each quarter, Avesis will compile and review total services rendered by all dental providers in the Avesis UPMCHP Dental Program. The objective of the utilization review process is intended to provide Avesis and/or UPMCHP feedback regarding the demand for dental services and appropriateness of care. Each code will be analyzed against the number of total UPMCHP Dental Members being treated. The result will be an average frequency of services per 100 recipients treated in the Avesis UPMCHP Dental Program. Providers' per Member cost will be calculated for the quarter. An average statewide per Member cost income will be the result. The following items formulate the basis of the 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 UPMCHP 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 under-treatment 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 under utilization.
3. **Total Quarterly Per Member Cost** – Avesis shall calculate the per Member cost for all network 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.

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 UPMCHP, CMS or the Commonwealth 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 UPMCHP, CMS, or the Commonwealth 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.

Avesis Dental Committees

Avesis welcomes involvement from the dentists who participate in the Avesis / UPMCHP 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 volunteer dentists.

Committee Structure for Avesis Dental Programs

CREDENTIALING COMMITTEE

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

Responsibilities: Credentialing of new network Providers; review of credentials upon re-credentialing every thirty-six 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.

QUALITY ASSURANCE COMMITTEE

Members: Director of Quality Assurance, Chief Operating Officer, Director of Operations, Chief Information Officer, Vice President Operations, Director Government Services, Chief Eye Care Officer, Pennsylvania Dental Director, 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 Avesis' program to focus on for improvement.

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.

DENTAL DIRECTOR ROLE

The Pennsylvania Dental Director is an employee or contractor with Avesis who is your local contact as a dental professional. We intend to have the Pennsylvania Dental Director represent you, as an Avesis dental provider, in Avesis' role as administrator of the UPMCHP Dental program in your Commonwealth.

The Pennsylvania Dental Director will represent Avesis at meetings of the local Dental Association and its component societies and at meetings with our MCO. The State Dental Director will be available for discussion and consultation concerning issues of importance to our Avesis dental network Providers. If you wish to speak the Pennsylvania Dental Director, please call Provider Services at: (888) 209-1243.

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

Quality Assurance and Utilization Management Programs

In order to ensure that the highest quality services are consistently provided to our Members and that providers continue to perform only those services that are necessary for the welfare of the Members, Avesis maintains two programs designed to achieve these goals.

Quality Assurance Program

The Quality Assurance Program is reviewed and updated annually by the Quality Assurance Committee. The Committee is comprised of senior staff of Avesis as well as clinical staff including the Chief Dental Officer and State Dental Director. Members of the Dental Advisory Board are also permitted the opportunity to participate.

The goal of the Quality Assurance Program is to ensure the quality of the services rendered to members. This is achieved through various programs including the credentialing and recredentialing of our providers; on-site visits to offices both random and in situations where complaints are received; annual review of policies and procedures; annual review of clinical criteria and protocols; on-going monitoring of the satisfaction of our members and providers; and development of quality initiative programs and plans to constantly increase and improve the quality of our services.

Utilization Review Program

The Utilization Review Program is reviewed annually by the Utilization Review Committee, a sub-committee of the Quality Assurance Committee. The Utilization Review Program sets the standards and benchmarks for reviewing the utilization patterns of our providers. Under the auspices of the Utilization Review Committee, claims submission patterns, prior authorization requests, medical records, and utilization patterns are reported and reviewed, at a minimum, on a monthly basis. When possible aberrant billing practices are detected or if other potentially negative processes are uncovered, Avesis administrative personnel or a clinical representative will speak or meet with the Provider to address the problem and help develop a program to resolve the issue.

As a Participating Provider you are welcome to review and contribute to either of these programs. For a complete copy of the Quality Assurance Program or Utilization Review Program, please contact Avesis Provider Services at the number in the front of this Provider Manual.

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 Avesis. Avesis will then work with UPMCHP or Health Partners, their fraud units 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 Medical Assistance 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 Avesis 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/>.

The Department of Public Welfare has established a Medical Assistance Provider Compliance Hotline to report suspected fraud and abuse committed by any person or entity providing services to Medical Assistance recipients.

The hotline number is 1-866-DPW-TIPS (866-379-8477) and operates Monday through Friday from 8:30 AM to 3:30 PM. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Providers may also call the **Office of Inspector General Welfare Fraud Tip Line** at 1-800-932-0582 to report suspected fraud and abuse committed by a Medical Assistance recipient. Members may knowingly make false statements or representations to become eligible for Medical Assistance or fail to provide all required information such as other insurance coverage. Members who commit fraud may be prosecuted under state criminal laws and federal fraud and abuse laws.

Suspected fraud and abuse may also be reported via the website at:
www.dpw.state.pa.us or e-mailed to omaptips@state.pa.us.

Information reported via the website or e-mail also may be done anonymously. The website contains additional information on reporting fraud and abuse.

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. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Recipient Restriction Program

DPW's Recipient Restriction/Centralized Lock-In Program restricts those recipients who have been determined to be abusing and/or misusing Medical Assistance services, or who may be defrauding the Medical Assistance Program. The restriction process involves an evaluation of the degree of abuse, a determination as to whether or not the recipient should be restricted, notification of the restriction, and evaluation of subsequent medical assistance services. DPW may not pay for a service rendered by any provider other than the one to whom the recipient is restricted, unless the services are furnished in response to an emergency or a Medical Assistance Recipient Referral Form (MA 45) is completed and submitted with the claim. The MA 45 must be obtained from the practitioner to whom the recipient is restricted.

A recipient placed in this program can be locked-in to any number of providers at one time. Restrictions are removed after a period of five years if improvement in use of services is demonstrated.

If a recipient is restricted to a provider within your provider type, the EVS will notify you if the recipient is locked into you or another provider. The EVS will also indicate all type(s) of provider(s) to which the recipient is restricted.

Note: Valid emergency services are excluded from the lock-in process.

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.

Foreign Language Translation Services/Special Needs Assistance

Communication with Avesis – There is a Spanish language queue set up in Customer Service that Members can access as they call into Customer Service. Avesis employs customer service representatives who speak Spanish. In addition, Avesis uses Language Line for interpreter services as needed to communicate with Members who have limited English proficiency. Avesis pays all costs for the Language Line interpreting services.

Special Services for Persons with Hearing Impairments – Members who are hearing impaired may require devices or services to aid them in communicating effectively with their providers. Customer Service Representatives ask Members who are hearing impaired if they would like a certified interpreter—such as a computer assisted real-time reporter, oral interpreter, cued speech interpreter, or sign-language interpreter—to be present during a visit to the provider. Customer Service maintains a list of phone numbers and locations of interpreter services, by county. If the use of an interpreter is not requested by the Member, Customer Service will offer the Member the chance to specify what other type of auxiliary aid or service they prefer.

Also, Provider Services and Provider Relations staff will educate Providers on what they can do to make facilities more accessible for individuals with hearing impairments, such as the following:

- Ensure a quiet background for the patient
- Reduce echoes to enhance sound quality
- Add lighting to enhance visibility
- Install flashing lights that work in conjunction with auditory safety alarms
- Clearly identify all buildings, floors, offices and room numbers
- Include a TTY (teletypewriter) or TDD (telecommunications devices for deaf persons) in the office

Should the Member require an interpreter on-site during or following the examination, please contact the appropriate UPMC Health Plan Special Needs Unit to make the necessary arrangements.

Functional Illiteracy – Often hidden from view is the fact that certain Members who speak English as their native language cannot read at levels that permits them to perform basic tasks such as filling out forms used in everyday transactions. Fearing embarrassment, seldom do such Members identify themselves to staff or to network providers. Nevertheless, we are committed to making best efforts to help these individuals so that they can get the most out of their health care plan.

We begin by encouraging our staff and providers' office staffs to look for telltale signs of literacy problems. These personnel then attempt, with sensitivity and discretion, to help the Member with the immediate need, such as completing a form. We will also try to guide the Member to appropriate community resources that can help the Member improve his or her literacy skills.

Website adaptations – Avesis' website has been updated to improve the content and interactive capabilities available to Members and prospective Members.

Agreement and Amendments

Please place any amendments you receive from Avesis in this section.

Covered Benefits and Fees

Covered benefits and fee schedules for the following products are available on the secure Avesis website, after logging in:

- UPMC *for You – Children*
- UPMC *for You – Adult Full Benefit*
- UPMC *for You – Adult Partial Benefit*
- UPMC *for Kids*
- UPMC *for Life*
- UPMC *for Life Specialty Plan*
- UPMC *for Life Options*
- UPMC *for You Advantage*
- UPMC *FEHBP*

Clinical Criteria

Documentation requests for information regarding treatment using are evaluated using codes as defined in the American Dental Association's Code Manuals. 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.

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, subject to consultant review.
- 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.
- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with extractions, four or more teeth or tooth spaces, per quadrant will be covered subject to consultant review.

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 must 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.

Criteria for Endodontics

- Tooth must be damaged as a result of trauma or carious exposure.
- Fill must be properly condensed/obtured. 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 below the crestal bone or into the furcation, deeming the tooth non-restorable.
- The generally poor oral condition does not justify root canal therapy
- Endodontic therapy is for third molars, unless they are an abutment for a partial denture.
- The tooth has advanced periodontal disease and/or pocket depths greater than 5mm.
- Endodontic therapy is in anticipation of placement of an overdenture.
- A endodontic filling material not accepted by the Federal Food and Drug Administration is used.

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.

Criteria for Periodontal Treatment

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).

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.

Full mouth debridement:

Criteria for approval of full mouth debridement includes evidence of one or more of the following:

- Pre-operative radiographs demonstrating evidence of gross calculus buildup (radiographically visible calculus involving at least 75% of the remaining dentition)
- Documentation that treatment was rendered under GA, IV, or radiographs were not possible due to a patient's medical status (description of medical condition).

Periodontal maintenance procedures:

Criteria for approval of periodontal maintenance includes evidence of one or more of the following:

- Documentation of previous periodontal treatment dates
- Continuous documentation of significant hard and soft tissue changes

UPMC for You Orthodontic Coverage Criteria

UPMC for You 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.

The Salzmann Evaluation Criteria Index Form is used as the basis for determining whether a Member qualifies for orthodontic treatment. A member must score a minimum of 25 points to qualify for coverage – points are not awarded for esthetics, therefore additional points for handicapping esthetics will not be considered as part of the determination.

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.

UPMC for You 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 this date of service.

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

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.

UPMC for You 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 claims for periodic treatment visits (Code D8670). The member must be eligible on the date of the visit.
- The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and 23 periodic orthodontic treatment visits (D8670). Additional periodic orthodontic treatment visits beyond 23 will be the Provider's financial responsibility and not the Member's. Members may not be billed for broken, repaired, or replacement of brackets or wires.
- The Member must be eligible with their Health Plan in order for payments to be made. Whenever the Member becomes ineligible, the Member is responsible for payment during that time period.
- 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

UPMC for Kids Orthodontic Coverage Criteria

UPMC for Kids 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.

The Salzmann Evaluation Criteria Index Form is used as the basis for determining whether a Member qualifies for orthodontic treatment. A member must score a minimum of 25 points to qualify for coverage – points are not awarded for esthetics, therefore additional points for handicapping esthetics will not be considered as part of the determination.

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.

UPMC for Kids 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 this date of service.

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

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.

UPMC for Kids Orthodontic Payment Information

- Payment for orthodontics (code D8080) includes pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, 24 months of orthodontic adjustments, debanding, 1 set of retainers, and 12 months of retainer adjustments (If retainer fees are not separate).
- Once Avesis receives the banding date, a single case payment for code D8080 will be set to pay out.
- The Member must be eligible with their Health Plan on the date they are banded in order for payment to be made. If the Member is ineligible on the banding date, the Member is responsible for payment.
- 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

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.

First Review _____
Second Review _____

Models _____
Orthocad _____
Ceph Films _____
X-Rays _____
Photos _____
Narrative _____

ORTHODONTIC CRITERIA INDEX FORM - COMPREHENSIVE D8080

Patient Name: _____ DOB: _____

ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior open bite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
AP	Demonstrates a large anterior -posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III)		
AX	Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).		
PX	Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, one of which must be a molar).		
PO	Significant posterior open bites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion).		
IMP	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).		
CR	Crowding of 7 - 8 mm in either the maxillary or mandibular arch.		
OJ	Overjet in excess of 9 mm.		
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

First Review _____
Second Review _____

Models _____
Orthocad _____
Ceph Films _____
X-Rays _____
Photos _____
Narrative _____

MALOCCLUSION SEVERITY ASSESSMENT BY J. A. SALZMANN, DS, FAPHA

Patient Name: _____ DOB: _____

ID# _____ Health Plan _____

Intra – Arch Deviation

Score Affected Teeth Only	Missing	Crowded	Rotated	Spacing Open	Spacing Closed	No.	Point Value	Score
Maxilla	Ant						X2	
	Post						X1	
Mandible	Ant						X1	
	Post						X1	
Total Score								

Ant = anterior teeth (4 incisors); Post = posterior teeth (include canine, premolars and first molar); No. = number of teeth affected

A. Intra – Arch Deviation

1. Anterior Segment

Score Maxillary Teeth Affected Only Except Overbite*	Overjet	Overbite	Crossbite	Openbite	No.	Point Value	Score
						X2	
Total Score							

*Score maxillary or mandibular incisors.
No. = number of teeth affected

2. Posterior Segment

Score Teeth Affected Only	Related Mandibular to Maxillary Teeth				Score Affected Maxillary Teeth Only				No.	Point Value	Score
	Distal		Mesial		Crossbite		Open Bite				
	Right	Left	Right	Left	Right	Left	Right	Left			
Canine											
1 st Premolar											
2 nd Premolar											
1 st Molar											
Total Score											
Grand Total											

No. = number

Malocclusion Severity Assessment
By J.A. Salzmann, DDS, F.A.P.H.A.

SUMMARY OF INSTRUCTIONS

Score: 2 points for each maxillary anterior tooth affected.

1 point for each mandibular incisor and all posterior teeth affected.

1. Missing teeth. Count the teeth; remaining roots of teeth are scored as a missing tooth.
2. Crowding. Score the points when there is not sufficient space to align a tooth without moving other teeth in the same arch.
3. Rotation. Score the points when one or both proximal surfaces are seen in anterior teeth, or all or part of the buccal or lingual surface in posterior teeth are turned to a proximal surface of an adjacent tooth. The space needed for tooth alignment is sufficient in rotated teeth for their proper alignment.
4. Spacing. Score teeth, not spacing. Score the points when:
 - a. Open spacing. One or both interproximal tooth surfaces and adjacent papillae are visible in an anterior tooth; both interproximal surfaces and papillae are visible in a posterior tooth.
 - b. Closed spacing. Space is not sufficient to permit eruption of a tooth that is partially erupted.
5. Overjet. Score the points when the mandibular incisors occlude on or over the maxillary mucosa in back of the maxillary incisors, and the mandibular incisor crowns show labial axial inclination.
6. Overbite. Score the points when the maxillary incisors occlude on or opposite labial gingival mucosa of the mandibular incisor teeth.
7. Cross-bite. Score the points when the maxillary incisors occlude lingual to mandibular incisors, and the posterior teeth occlude entirely out of occlusal contact.
8. Open-bite. Score the points when the teeth occlude above the opposing incisal edges and above the opposing occlusal surfaces of posterior teeth.
9. Mesiodistal deviations. Relate mandibular to opposing maxillary teeth by full cusp for molars; buccal cusps of premolars and canines occlude mesial or distal to accepted normal interdental area of maxillary premolars.

Instruction for using the "Handicapping Malocclusion Assessment Record"

Introduction

This assessment record (not an examination) is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health,

function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment. Assessments can be made from casts or directly in the mouth. An additional assessment record form is provided for direct mouth assessment of mandibular function, facial asymmetry, and lower lip position.

A. INTRA-ARCH DEVIATIONS

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record." The scoring can be entered later.

1. Anterior segment: A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.
 - a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
 - b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
 - c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.
 - d. Spacing
 - 1) Open spacing refers to tooth separation that exposes to view the interdental papilla on the alveolar crest. Score the number of papillae visible (not teeth).
 - 2) Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.
2. Posterior segment: A value of 1 point is scored of each tooth affected.
 - a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
 - b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

- c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.
- d. Spacing
 - 1) Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).
 - 2) Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

B. INTER-ARCH DEVIATIONS

When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

- 1. Anterior segment: A value of 2 points is scored for each affected maxillary tooth only.
 - a. Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.
 - b. Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.
 - c. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.
 - d. Open-bite refers to vertical interarch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion. Edge-to-edge occlusion is not assessed as open-bite.

- 2.** Posterior segment: A value of 1 point is scored for each affected tooth.
- a.** Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.
 - b.** Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.

Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

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, Ste. 400
Smyrna, GA 30080
Attn: Utilization Management

ADDENDUM
UPMCHP GUIDELINES AND PROCEDURES FOR
MEMBER COMPLAINTS, APPEALS AND GRIEVANCES

Complaints, Grievances and Appeals

Avesis is not delegated to resolve Member Complaints, Grievances or Appeals. If a UPMCHP Member wants to file a Complaint, Grievance or Appeal, the Member should contact the Member Services number listed on their UPMCHP ID Card. If a Member contacts the Avesis Member Services department, Avesis will transfer the call to the appropriate UPMCHP Member Services department for assistance. While Avesis is not delegated this responsibility, Avesis will cooperate and assist UPMCHP in resolving member concerns. All Complaint, Grievance and Appeal procedures comply with Federal and State regulations and meet appropriate accreditation standards.

Members receive instructions on how to file a Complaint, Grievance or Appeal in their Plan documents. Members may contact the Member Services number on their UPMCHP ID Card for assistance on filing a Complaint, Grievance or Appeal.

Member or Providers may access the Complaint, Grievance or Appeal procedures on the UPMCHP website at www.upmchealthplan.com.

DPW Fair Hearing Appeal

A UPMC *for You* member may ask for a DPW Fair Hearing Appeal. A member requests this appeal by sending a letter to DPW within 30 days from the date of the notice by UPMC *for You* 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 DPW within 10 days from the date of the notice from UPMC *for You*. The DPW Fair Hearing Appeal should be sent to:

Pennsylvania Department of Public Welfare
Office of Medical Assistance Programs
HealthChoices Program
P.O. Box 2675
Harrisburg, PA 17105-2675

DPW Expedited Fair Hearing

If a provider believes the usual timeframes for deciding a UPMC *for You's* complaint or grievance will harm his or her health, the provider or the member can call the Department of Public Welfare at (800) 798-2339 and ask for an expedited fair hearing. Providers need to send a fax to (717) 772-6328 explaining why the member's health will be jeopardized by the typical timeframe.

ADDENDUM ADDITIONAL UPMCHP GUIDELINES AND INFORMATION

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 PCP of its existence, provide a copy of the document to be included in personal medical records, and discuss this decision with the PCP.

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:

The Pennsylvania Medical Society
Division of Communication and Public Affairs
77 East Park Drive
Harrisburg, PA 17105-8820
(717) 558-7750

UPMCHP 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 1-(800) 425-7800.

Special Needs Coordination

UPMC *for You* Special Needs Department can assist providers in locating language interpreters, and those who can provide American Sign Language. Providers may contact UPMCHP Special Needs Department at (888) 876-2756. Avesis will work in coordination with the Special Needs Unit at UPMCHP 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 (888) 876-2756. 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 Language Line interpreter for any language that the member speaks and understands.

Medical Assistance Clinical Sentinel Hotline

The Clinical Sentinel Hotline (CSH) was set up by the Medical Director for the Office of Medical Assistance Programs at the Department of Public Welfare (DPW). The CSH was developed to ensure that the HealthChoices managed care organizations (MCOs) and behavioral health plans honor the Member's right to have requests for

medically necessary care and services responded to in a timely manner. The CSH helps all Medical Assistance recipients who are enrolled in the HealthChoices Program.

The CSH is answered by nurses who work for DPW. If a Member or a medical Provider has requested medical care or services and the MCO or behavioral health UPMC Health Plan has not responded in time to meet the Member or Provider's needs, the Member or Provider is to call the CSH. The CSH will make sure that the MCO or behavioral health UPMC Health Plan responds to the request soon enough to meet the Member or Provider's needs. Members or Providers can also call the CSH if the MCO or behavioral health UPMC Health Plan has denied medically necessary care or services and won't accept a request to file a grievance.

The CSH operates Monday through Friday between 8:00 AM and 6:00 PM EST. Members or Providers can call the CSH at (866) 542-3015.

The CSH cannot provide or approve urgent or emergency medical care. Members or Providers who believe they have an urgent emergency medical situation should seek the care they need through their PCP or local hospital.