# Capitol Dental Care, Inc.

## Oregon Health Plan Provider Handbook

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# Welcome

Welcome to Capitol Dental Care (CDC)!

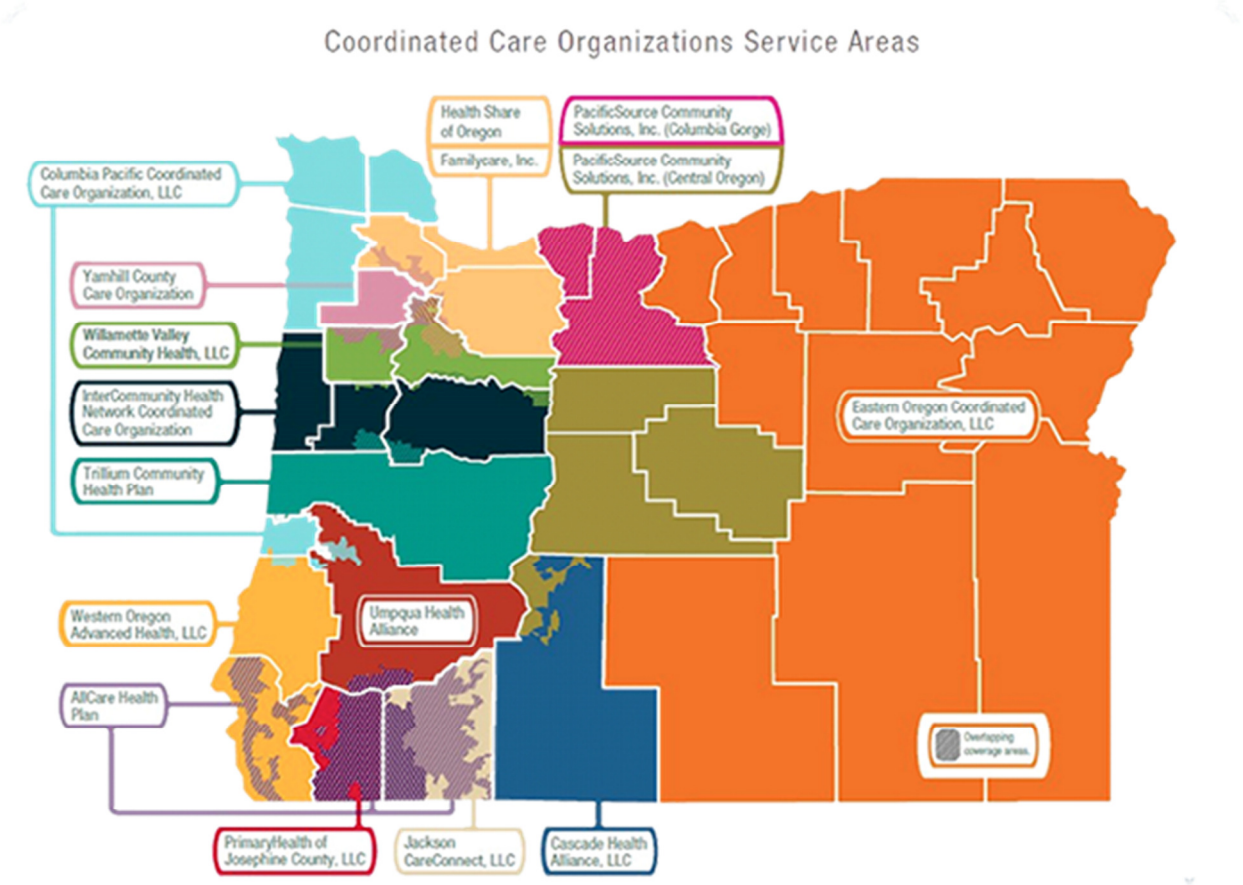
CDC is a dental care organization that contracts with the state and multiple coordinated care organizations to deliver dental care to members covered under the Oregon Health Plan. To our participating providers, thank you for being part of that collaboration. Together, we can help ensure our members are receiving high quality care and prevention education. Our staff is pleased to work with you to achieve these goals, and strives to maintain a successful partnership with our providers. This handbook is intended to assist you in providing services to our members.

# Coordinated Care Organizations

In addition to contracting directly with the state of Oregon, Capitol Dental Care also contracts with 14 coordinated care organizations (CCOs) statewide. A CCO is a network of health care providers who serve people who receive health care coverage under the Oregon Health Plan. CCOs integrate physical, mental and dental care with the goal of improving member health and quality of care at a lower cost. CCOs do this by focusing on prevention of illness and disease and effectively managing existing health conditions.

**CDC contracts with the following CCOs:**

- AllCare Health Plan (Jackson and Josephine Counties)
- Columbia Pacific (Clatsop, Columbia Counties)
- Eastern Oregon (Umatilla County)
- Health Share of Oregon (Clackamas, Multnomah, Washington Counties)
- Intercommunity Health Network (Benton, Lincoln, Linn Counties)
- Jackson Care Connect (Jackson County)
- Pacific Source Community Solutions - Central Oregon Region (Deschutes County) of Josephine County
- Trillium Community Health (Lane County)
- Willamette Valley Community Health (Marion, Polk Counties)
- Yamhill Community




**Map Source:** OHA Transformation Center

Although we contract with the above CCOs, our participating providers contract directly with us. We are a hands-on dental plan and pride ourselves in developing and maintaining strong provider-plan relationships. We look forward to working with you to improve the oral health needs of Oregonians and hope you will contact us should you have any questions or comments about this Provider Handbook.

# OHP Administrative Rules

Participating providers agree to abide by the following Oregon Administrative Rules (OARs) that govern OHP. You can locate these OAR rule online at:

**OREGON ADMINISTRATIVE RULES**
http://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx

**OHP DENTAL SERVICES**
http://www.oregon.gov/oha/HSD/OHP/Policies/123rb010117.pdf

**OHP GENERAL RULES**
http://www.oregon.gov/oha/hsd/ohp/pages/policies.aspx

These rules are periodically updated by the state. A provider can sign up to be notified by email of an update.
http://www.oregon.gov/oha/HSD/OHP/Pages/Rule-Notices.aspx

# Credentialing

Credentialing is the process of verifying a licensed provider's education, licensure, and experience. Credentialing and re-credentialing is required to become a participating provider with our plan. A provider must complete the credentialing process and be approved before treating our members. Credentialing is a health care industry standard and our credentialing requirements are based on OHP, state and national standards. A provider is credentialed when initially joining our plan. In addition, re-credentialing is a necessary requirement to remain an eligible participating provider. Re-credentialing occurs every three years.

At all times while participating with our plan a provider must have and maintain in good standing all licenses, registrations, certifications and accreditations required by law to provide dental care as applicable. Each participating provider must promptly notify us in writing of any formal action against any licenses or, if applicable, against any certifications by any boards or organizations. Participating providers also must notify us of any changes in practice ownership, business address, and any other information that may or will impact the participating provider's ability to provide services to our members.

**Providers must meet the applicable criteria to participate:**

1. Completion of applicable dental higher education degree.
2. Proof of minimum malpractice insurance coverage minimum of $1,000,000 per claim and $3,000,000 annual aggregate.
3. Current, active and in good standing applicable professional state license(s).
4. Never proven guilty of a federal crime within a court of law.
5. Not on any federal health care program Exclusion list.
6. Not have questionable work, complaint, or health history which could negatively affect the provision of dental care to our members.

We have the right to deny participation based on but not limited to, this criteria.
The provider is responsible for accuracy of information on the application and signing and dating the application, the attestation, and the authorization to release information form. Please attach legible, current and valid documents requested to the application. We do not accept an application and/or attached documents that have been altered, unsigned, incomplete, inaccurate, expired, and not legible or that have missing information.

**Discrepancy in credentialing information**

Information obtained during the verification process that varies substantially from the information submitted on the application will require a written explanation from the provider. We will notify you in writing of the discrepancy and request a written explanation. The response will be

reviewed by our dental director and Credentialing Committee. If no response is received, the application process is terminated.

**Application Approval or Denial**
Our Dental Director and Credentialing Committee will review the application information and decide to take one of the following actions:

- Approve the application.
- Approve the application conditionally. The provider is monitored until the conditional status is removed.
- Pend the application and request additional information to be reviewed at a future date.
- Deny the application. Only the Credentialing Committee may make this decision. We will notify the provider or appropriate credentialing contact person in writing within seven (7) calendar days of the Credentialing Committee's decision to deny. In the case of a denial, written information on the appeal process will be provided to the applicant. It is included under the Provider Appeal section of this Handbook.

**Provider Appeal**
The provider has 30 calendar days from the date of denial of participation to request an appeal with the Credentialing Committee. The request must be writing and mailed to us by certified mail. A provider who fails to request an appeal within the time and manner specified waives any right to an appeal of the decision in the future. There is no right to appeal granted to non-participating providers.

**Confidentiality**
All credentialing related information is considered confidential. In accordance with ORS 41.675, no disclosure of peer review information is released, except to those authorized to receive such information to conduct credentialing activities. The data utilized by the Credentialing Committee is strictly confidential and is available only to those authorized to receive it.

**Provider rights**
Providers have the right to:

- Not be discriminated against based on provider's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed, or patients in whom provider specializes.
- Review information obtained by us to evaluate the credentialing application, except that which is peer-protected by law and not shared with the provider.
- Correct erroneous information discovered during the verification process.
- Request a status via telephone, e-mail or correspondence of the application.
- Withdraw the application, in writing, at any time.
- Have the confidentiality of the application and supporting documents protected, and the information used for the sole purpose of application verification, peer review and panel participation decisions.

- Be notified of these rights.

## National Provider Identifier (NPI)

The NPI is a standard unique health identifier for healthcare providers. The NPI was mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Anyone who meets the criteria of a healthcare Provider will need an NPI. Apply through the National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov/NPPES/Welcome.do or by calling 800-465-3203 (NPI toll-free).

## DMAP Provider Number

In order for CDC to pay claims all providers must have a Division of Medical Assistance Programs (DMAP) provider number. You do not have to accept open card DMAP covered members if you obtain this number. The number can be restricted to your claims and encounter data submissions with CDC. Below is the link to sign up for a DMAP provider number.
http://www.oregon.gov/oha/healthplan/Pages/providerenroll.aspx

## OHP Plus Dental Services

On January 1, 2010, changes were made to the OHP Plus dental benefit. These changes separated the Plus benefit into the two different categories 1) Pregnant women and/or children under twenty-one and 2) Non Pregnant women and adults age twenty-one and over. Detailed information on what is covered under the OHP Plus dental benefit can be found in the OHP Dental Services rules: http://www.oregon.gov/oha/HSD/OHP/Tools/Covered%20and%20Non-Covered%20Dental%20Services,%20Effective%20January%201,%202017.pdf

We follow the OHP Dental Services rules closely when determining coverage - with a few exceptions. Example: If the rules require prior authorization of a service we almost always require the same. The easiest way to identify which services require prior authorize is to review the OHP Plus fee schedule. If a service requires prior authorization it is noted with a 'PA'.

## Pregnant Women and/or Children Under 21

- Routine new and/or existing patient evaluations covered twice a year.
- Prophylaxis covered twice a year.
- Fluoride Treatment is covered once in a twelve month period. It can be covered 2 to 4 times a year for high risk young children.
- Sealant care covered for un-restored occlusal surfaces of permanent molars. Benefit limited to one sealant, per tooth, during any five-year period for members ages 15 and younger.
- Amalgam and composite restorations. Posterior composite paid at amalgam rate.
- If filling cannot restore tooth (dentally appropriate) a stainless steel crown covered once in a five-year period.

- If filling cannot restore tooth (dentally appropriate) porcelain crown covered once in a seven-year period for members ages 17 and older and require clinical and X-ray information for review. Benefit is available for the following anterior teeth only: 6-11, 22 & 27. Permanent crowns are limited to a total of four crowns in a seven-year period.
- Periodontal scaling/root planning covered once per quadrant in any 24-month period.
- Full and/or Immediate Dentures (upper and/or lower) are covered once in a ten-year period, but only when dentally appropriate.
- Partial Dentures are covered once in a ten-year period and require X-ray and clinical information for review.
- Cast Partials are not covered.
- Adjustments to Complete and Partial Dentures have no frequency limitations.
- Denture Rebase and Reline Procedures are covered once in a three-year period.
- Replacement of a partial denture with a full denture is allowed ten years after the partial denture placement.
- Clinical symptoms required for complex surgical extraction of third molars.
- A separate, additional charge for alveoloplasty done in conjunction with removal of teeth is not covered.
- Orthodontics limited to members with a diagnosis of cleft palate with cleft lip

## Non-Pregnant Women and Adults 21 and Over

- Routine new and/or existing patient evaluations covered once a year.
- Prophylaxis (cleaning) covered once in a twelve-month period.
- Fluoride Treatment is covered once in a twelve month period.
- Sealants are not covered.
- Stainless Steel Crowns are not covered.
- Porcelain Crowns are not covered.
- Amalgam and composite fillings covered. Posterior composite paid at amalgam rate.
- Pulp capping is not covered.
- Retreatments (dentally appropriate) covered for anterior teeth by review only. Retreatments are not covered on posterior teeth.
- Root Canal for molars not covered.
- Root canal therapy only covered when final restoration on tooth covered.
- Periodontal maintenance allowed only as follow up to periodontal scaling/root planing once in any six-month period.
- Full mouth debridement is covered once in any two year period.
- Separate charge for post-operative care done within six months following periodontal surgery is not covered.
- Full and/or Immediate Dentures (upper and/or lower) covered once per lifetime, and only when placed within six months of the extraction (per arch).
- Partial Dentures covered once in a ten-year period and require X-ray and clinical information for review.
- Cast Partials are not covered.
- Adjustments to Complete and Partial Dentures have no frequency limitations

- Denture Rebase and Reline Procedures are covered once in a three-year period.
- Replacement of a partial denture with a full denture is allowed ten years after the partial denture placement.
- Clinical symptoms required for any complex surgical extraction of third molars.
- A separate, additional charge for alveoloplasty done in conjunction with removal of teeth is not covered
- Orthodontics not covered.

## Other Service Limitations and Exclusions

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employer's Liability Laws.
2. Procedures, appliances, restorations or other services that are primarily for cosmetic purposes are excluded.
3. Charges for missed or broken appointments are excluded.
4. Experimental procedures or supplies are excluded.
5. Dental Services started prior to the date the individual became eligible for such services under the OHP contract are excluded.
6. Any service related to the treatment of TMJ is excluded.
7. Services or supplies not specifically included in the OHP Plus dental benefit.
8. Dental services done of date member is not eligible are not covered.

## Services Not Covered by OHP

Providers must inform an OHP member of any charges for **non-covered** services **prior** to delivering a service. If a member chooses to receive a not covered service you are required to do the following:

1. Inform the member the service is not covered.
2. Provide an estimate of the cost of the service.
3. Explain to the member he/she is financial responsible for the service.
4. Have the member sign an OHP approved financial waiver **prior** to rendering the service which documents he/she has accepted financial responsibility for payment.

An OHP approved (waiver form) has been included in the back of this provider manual for your convenience.

**A member cannot be held financially responsible for a service that is covered by OHP. The difference between a provider's fee for a service and the payment we make to you is not covered. Services that have been denied due to provider error are not covered.**

## Prioritized List of Health Services

The Oregon Health Evidence and Review Commission (HERC) maintain a list of condition and treatment pairs known as the Prioritized List of Health Services. The list defines OHP benefits and

is organized by diagnosis and treatment pairs. Each pair is assigned a line number and is ranked by priority. HERC designates a particular coverage line as the funding level. A diagnosis and treatment pair that is above the line is covered and ones below are not covered. OHP covers dental services that are on funded lines.

You can access the list by visiting the website: http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritized-List.aspx

The list can be found by clicking on the link titled —Current Prioritized List. Due to legislative decisions, the funding line is subject to change.

## Eligibility

Eligibility for OHP Members is granted by the Department of Human Services. An OHP member will chose a CCO in their application process. Once enrolled, a CCO will place its member in a dental care organization. Some CCOs allow the member to select the dental care organization. Others assign the member to a dental care organization with the option to change if the member deems the assignment less than a good fit. All CCOs want their members to be in a dental care organization that is a good fit for them. If a member is not, have him/her contact the CCO for additional options.

It is the responsibility of the provider to verify a patient is eligible on the date of service and that CDC is the members assigned dental care organization. The provider assumes full financial risk of serving a patient not confirmed as eligible for the service provided on the date of service.

## CCO Enrollment

Assessing which CCO your patient is enrolled in is critical to the claims processing process. CDC's Third Party Administrator and claims payer is Performance Health Technology (PH Tech). CDC's member service staff can also help you determine a member's eligibility and identify which CCO they are enrolled in. You may call them from 7 AM to & 7 PM Monday through Friday at 1-800-525-6800.

## PH Tech CIM Access

CDC and Salem-based PH Tech work together ensuring your dental claims processing is simple and efficient. As CDC's Third Party Administrator, PH Tech specializes in processing claims for health plans. It offers a web-based software to all CDC providers to verify member eligibility. CDC providers can be granted access to PH Tech's secure web-based tool, **Clinical Integration Manager (CIM)**. All information regarding consultation referrals and others services are entered into CIM and allows providers to check eligibility and authorization status. Providers also have a direct communication line to confirm and authorization of services via email. For assistance with the Clinical Integration Manager (CIM) contact PH Tech CIM Support at 503-584-2169, option 2.

If you are a contracted provider with Capitol Dental Care and need CIM access, please contact PH Tech at 866-947-9443.

# Referrals

Sometimes it becomes necessary to refer a patient to a specialist or different provider. If a referral is needed, please review the following information and contact our Member Services Department.

**Services that require a referral:**

- Endodontics
- Oral surgery
- Some Pediatric dentistry
- Periodontics

Some services may require prior authorization by our dental consultant before a referral is approved. A referral does not guarantee payment for the referred service.

# Referral Process

The PCD Provider can call 1-800-525-6800 or fax a completed referral form to 503-581-0043. The referral form must be filled out in its entirety. Omitting information may delay processing of the referral. We will notify the PCD Provider if a referral is denied, approved or is pending further review. When a referral is approved the PCD provider will be given a referral number. If a referral is denied, we will fax or mail the referral request back to the PCD Provider and include the reason for the denial. A formal written denial is mailed to the member.

Specialists must receive a referral from the member's PCD Provider before seeing a member, unless the request occurs as a result of an emergency. If the latter is the case, the specialist must notify CDC as soon as possible after the visit. A verbal approval by a PCD provider to a specialist does not mean we have approved the referral. The specialist should receive a copy of the referral with the referral number indicating approval from us. The specialist must check eligibility before providing services regardless of whether or not he or she has an approved referral. The patient must be eligible on the date of a service for the referral to be valid.

**Referral Request Requirements:**

- All pertinent patient information (name, ID number, birth date, medical concerns etc.)
- Dental procedures, type of service provider being requested (i.e. oral surgery, children's dentistry).
- Any important details as to why the referral is needed (I.e. young child with abscess office treatment attempted but failed).
- Provider contact information including mailing address and a return fax number, when applicable.

# Prior Authorization (PA) of Benefits

A prior authorization of benefits lets the provider and member know if a benefit will be covered prior to the service being rendered. Some services are identified in the OHP Dental Services rules as requiring prior authorization as a condition of coverage. A prior authorization is based on a

member's history and eligibility at the time the prior authorization is processed, and subject to change.

A current American Dental Association (ADA) form should be submitted with the following information:

- The request for prior authorization (predetermination) box at the top of the form should be checked.
- Current ADA codes for all procedures proposed.
- Any written clinical (i.e. chart notes, periodontal charting applicable) and X-rays to determine benefits.

**Send a PA to:**
Capitol Dental Care
Attention: PA Request
3000 Market Street Plaza NE
Suite 228
Salem, Oregon 97301

# Denials, Appeals, Administrative Hearings

**Denials**

CDC will notify a PCD provider when a referral request is denied. We will also notify a PCD provider when a prior authorization or claims payment is denied. A written denial letter with appeal and hearing rights will be mailed to the member with a copy to the PCD provider and/or specialist (as applicable).

If the member speaks a language other than English, the denial letter will be translated into the member's primary language. Denial letters include the following information:
Service requested
Reason for denial
Member's appeal rights and instructions

**Appeals**

Letters denying a referral or a prior authorization inform the member he/she has a right to file an appeal. The member can contact their CCO or us to request an appeal. If an appeal is asked for verbally it must be followed up by a written request. Providers can also appeal on behalf of the member with the member's approval to do so.

**An appeal may be requested as follows:**
Write: Appeal
Capitol Dental Care
3000 Market Street Plaza NE
Suite 228
Salem, Oregon 97301

Fax: 503-581-0043
Telephone: CDC Member Services at 1-800-525-6800.

**Administrative Hearing**
The denial letter informs the member of the right to request an administrative hearing through the Division of Medical Assistance Programs (DMAP). The letter advises the member on how to request an administrative hearing.

# Member Complaints

A complaint is an expression of dissatisfaction a member has about any matter that does not involve a denial, limitation, reduction or termination of a requested covered service. Examples of complaints include, but are not limited to, access to providers, waiting times, demeanor of dental care personnel, quality of care and adequacy of facilities. Providers are encouraged to resolve complaints, problems and concerns brought to them by their patients. If a complaint cannot be resolved, inform the member that we have a formal complaint process. Members can contact our member service department to file a verbal complaint or request an OHP complaint form.

# Quality Review

Periodic chart audits and internal outcome measures obtained from administrative data will be used to track the quality of care provided by contracted providers. We also track providers' utilization and claims data over time.

The goals of the Quality Improvement (QI) program are to improve the quality of care and service delivery to our members and thereby improve the health status of our members. Selection of QI projects is based on a number of factors including acuity, high volume, high cost, high outcomes variance, and population-based care standards such as preventive services, patient safety, member satisfaction levels and available resources.

The issues reviewed by the QI Committee include, but may not be limited to:

- Access to care
- Compliance with government regulations
- Customer satisfaction
- Outcomes of care
- Patient safety
- Utilization of services

**Fraud and abuse:**
It is CDC's policy that its employees, agents and contractors — including contracted providers — comply with all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste and abuse in the provision of healthcare services to CDC members and payment for such services to healthcare providers. CDC has internal controls and procedures designed to prevent and detect potential fraud, waste and abuse activities by groups, members, providers and employees. This plan includes operational policies and controls in areas

such as claims, prior authorization, utilization management and quality review, member complaint and grievance resolution, practitioner credentialing and contracting, practitioner and CDC employee education, human resource policies and procedures, and corrective action plans to address fraud, waste and abuse activities. Verified cases of fraud, waste or abuse are reported to the appropriate regulatory agency. CDC reviews and revises this policy as necessary and on an annual basis.

## Tobacco Cessation

Tobacco cessation is a covered service OHP service. Basic treatment includes the following services: Ask — systematically identify all tobacco users — usually done at each visit. Advise — strongly urge all tobacco users to quit. Assess — measure willingness to attempt to quit using tobacco within 30 days. Assist — help with brief behavioral counseling, treatment materials and the recommendation/prescription of tobacco cessation therapy products (e.g., nicotine patches and gum, oral medications intended for tobacco cessation treatment). Arrange — schedule follow-up support and/or referral to more intensive treatments, if needed. When providing basic treatment, include a brief discussion to address a patient's concerns and provide the support and encouragement needed to assist with tobacco cessation efforts. These brief interventions, less than six minutes, generally are provided during a visit for other conditions.

## Oregon Tobacco Quit Line

The Oregon Tobacco Quit Line is a free telephone service available to all Oregon residents who want to stop using tobacco. The Quit Line offers free quitting information, one-on-one telephone counseling, and referrals for members. For more information regarding the Oregon Tobacco Quit line, you can visit its website at https://www.quitnow.net/oregon.

Phone: 800-QUIT-NOW
Spanish: 877-2NO-FUME
TTY: 877-777-6534

## Interpreter Services

Interpreter services for a member's appointment can be provided for a covered dental service. To arrange for interpretation services, call our member services department.

## Privacy and Security Standards

The following privacy and security standards are required:
Give each new patient a copy of the Notice of Privacy Practices. (Provide prospective and existing patients with a copy, upon request. Have a copy posted in the reception area.)

Restrict the use and/or disclosure of the patient's dental records to only those authorized by the patient or persons involved with the patient's direct care and/or payment of care.

Ensure that people in the reception area cannot overhear discussions of confidential patient matters or see confidential papers or computer screens.

If using electronic records, comply with the provisions of HIPAA's Security Rule. This includes, but is not limited to:

- Have a process to track the release of information.
- Have screen savers with password protection.
- Review any request by a patient to see his/her medical records.
- Ensure staff change passwords on a regular basis (< 90 day cycle).
- Develop effective policies and procedures that help guide the development of an effective compliance program.
- Ensure that electronic PHI, whether stored, created or placed in transit is safe and secure.

## Physical Access

All participating provider sites must comply with the requirements of the Americans with Disabilities Act (ADA) of 1990, including but not limited to, street-level access or an accessible ramp into the facility and wheelchair access to the lavatory.

## Timely Access

To ensure members have access to quality care in a timely manner, we follow OHP access standards, New and established members who are asymptomatic at the time of scheduling are scheduled within 4-8 weeks of the initial request. Members with non-urgent symptomatic care, including walk-ins and telephone, are seen within seven calendar days of request. Urgent-needs are seen within 24 hours of the request.
Emergency needs are to be immediately assessed/referred/treated.

## Confidentiality

Confidentiality of member information is extremely important. Healthcare providers who transmit or receive health information in one of the Health Insurance Portability and Accountability Act's (HIPAA) transactions must adhere to the HIPAA privacy and security regulations. There may be state and federal laws that provide additional protection of member information.

Providers must offer privacy and security training to any staff that have contact with individually identifiable health information. All individually identifiable health information contained in the medical record, billing records or any computer database is confidential, regardless of how and where it is stored. Examples of stored information include clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disc, compact disk or optical media formats.

Health information contained in medical or financial records is to be disclosed only to the patient or personal representative unless the patient or personal representative authorizes the disclosure

to some other individual or organization, or a court order has been sent to the provider. Health information may only be disclosed to those immediate family members (and to friends participating in the patient's care) with the verbal or written permission of the patient or the patient's personal representative. Health information may be disclosed to other providers involved in caring for the member without the member's or the legal representative's written or verbal permission.

Patients must have access to, and be able to obtain copies of, their medical and financial records from the provider as required by federal law. Information may be disclosed to insurance companies or their representatives for the purposes of quality and utilization review, payment or medical management. Providers may release legally mandated health information to the state and county health divisions and to disaster relief agencies when proper documentation is in place.

All healthcare personnel who generate, use or otherwise deal with individually identifiable health information must uphold the patient's right to privacy. Extra care shall be taken not to discuss patient information (financial as well as clinical) with anyone who is not directly involved in the care of the patient or involved in payment or determination of the financial arrangements for care.

# Submitting Claims

**Filing a claim**

Participating providers agree to bill CDC for covered services provided to OHP members with coverage through CDC. Once the coverage through CDC has been verified members should not be asked for payment at the time of services.

**Use your provider number**

In order for claims to be processed correctly, each claim must include the correct Tax Identification Number (TIN), correct NPI(s) and correct DMAP number. If you operate within a clinic with multiple providers, the name of the individual who provided the service must also be noted. If this information is not provided, the claim may be returned for resubmission with the missing information.

**Acceptable claim forms**

ADA Claim form.

If you would like information on billing claims electronically, please contact (503) 584-2169 opt.1

**Timely filing guidelines**

CDC requires that all eligible claims for covered services be received within 120 days of the date of service. If a claim meets one of the following criteria, we may waive the 120-day timely filing rule:

- Billing was delayed due to eligibility issues, such as retroactive deletions or retroactive enrollments
- Third-party resources are involved, such as Workers Compensation.

- Other reasonable circumstances for delay

When submitting a claim electronically using an electronic claims service or clearinghouse, it is important to check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing.

All information required to process a claim must be submitted in a timely manner (e.g., date of onset, accident information, medical records as requested). Any adjustments needed must be identified and the adjustment request received within 12 months of the date of service in order for the request to be considered.

**Corrected billings**
All claims submitted as corrected billings to previously submitted claims need to be clearly marked as —corrected billing. All claims for corrected billings must be received within 12 months of the date of service. Claims received greater than 12 months from the date of service shall be invalid and not payable.

**Additional information request/denial**
If a claim was previously denied and/or additional information is requested, the provider has 95 days to submit the requested information or appeal the denied charges in order for the claim to be reconsidered. This time period starts with the original denial and ends when the necessary information is received.

**Coordination of benefits**
OHP coverage is always secondary to other insurance carriers. If there is a primary carrier, such as private insurance, that carrier's Explanation of Benefits should be submitted with the claim as soon as the EOB is received. The 4-month (120-day) timely filing rule is waived when CDC is the secondary payer. However, claims must be submitted within 12 months of the date of service for the claim to be considered.

**Calculating coordination of benefits**
As secondary payer, CDC issues benefits only when the primary carrier paid less than the CDC allowed amount. Payment is the difference between our allowed amount and the primary carrier's payment or the patient responsibility, whichever is less.
If the primary plan pays more than the CDC allowed amount, no additional benefit is issued.

# Over Payment, Fraud and Abuse Prevention

CDC's program for prevention of overpayments, fraud and abuse includes:
Clinical editing
Prepayment audits and reviews
Post-payment audits
Audit and review vendors
Participation in multi-agency Fraud and Abuse Task Force

**Audits**
During the normal course of our claims processing, claims will be selected for audit and review to ensure correct coding, completeness of documentation, billing practices, contractual compliance, and any benefit or coverage issues that may apply. Services are expected to be billed with correct coding and billing.
Audit reviews are performed to identify overpayments as well as uncover and identify unacceptable misleading billing practices or actions that otherwise interfere with timely and accurate claims adjudication, including but not limited to:

- Falsifying documentation or claims.
- Allowing another individual or entity to bill using provider's name.
- Billing for services not actually rendered.
- Billing for services that cannot be substantiated from written medical records.
- Failing to supply information requested for claims adjudication.
- Using incorrect billing codes, unlisted codes or multiple codes for a single charge or up-coding.
- Unbundling charges (for the purpose of this agreement, unbundling means separating charges for services that are normally covered together under one procedure code or included in other services).

**Providing records for review**
All information required to support the codes and services submitted on the claim is expected to be in the member's dental record and available for review. The provider submitting the claim is responsible for providing upon request all pertinent information and records needed to support the services billed. When the billing provider receives a letter or fax requesting information needed for an audit or review, if the requested documents and information are not received by CDC within the required timeframe, the record is deemed not to exist, and the services not documented. If the documentation is incomplete or insufficient to support the services, then the service or item will be considered as not documented.

Any records, documentation or information not received in response to the original records request or discovered after the review is complete will be included for possible reconsideration in the audit review at CDC's sole discretion. Please ensure that your response to records requests is both prompt and complete.

When services (procedure codes) are not documented, the record does not support that the services were performed and so they are not billable. Therefore, services that are determined to be not documented are denied to provider responsibility and the member should not be balance-billed for the items denied. A refund will be requested if necessary (e.g., claim already released, post-payment audit).

When submitting claims procedure codes are to be selected based upon the services documented in the patient's dental record at the time of code selection.
Legally amended corrections to the medical record made within 30 days of the date of service and prior to claims submission and/or medical review will be considered in determining the validity of services billed.

Any changes that appear in the record more than 30 days after the date of service or after a records request or payment determination will not be considered. In those cases, only the original record will be reviewed in determining payment of services billed to CDC.

All providers are to have in effect Document Retention Policies that are consistent with state and/or Federal HIPAA requirements. From time to time, CDC may request that the provider produces such policy(s) to confirm practices are consistent with requirements.

**Falsified documentation**
Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or adding to existing documentation (except as described in late entries, addendums and corrections)

**Coordination with external agencies**
The CDC Compliance Team coordinates all information requests and reporting, whether initiated internally or externally. CDC promptly refers all suspected cases of fraud, waste and abuse by groups, members, practitioner and employees of the organization to the appropriate regulatory agencies for further investigation. In addition, CDC assists various governmental agencies as practical in providing information and other resources during the course of investigations of potential practitioner or member fraud or abuse. These agencies include, but are not limited to city, county, state and federal agencies; the DHS Audit Unit, the Medicaid Fraud Control Unit of the Oregon Attorney Generals' Office, and the United States Office of the Inspector General.

**Suspended, debarred and excluded practitioners**
Participating provider contracts stipulate provider responsibilities to comply with all applicable federal, state and local laws, rules and regulations, to maintain and furnish records and documents as required by law. Providers who are found to have violated a state or federal law regarding fraud, waste and abuse are often suspended, debarred or excluded from participation in federal programs and thus such practitioner's participating provider agreement with CDC will terminate.

# Dismissal of a Member

Dismissal is when a member is removed from the care of his or her assigned PCD Provider. Disenrollment is when a member is removed from his or her CCO.

CDC follows Department of Human Services (DHS) rules regarding member dismissal. We encourage a member and his/her provider to resolve complaints, problems and concerns at the clinic level.

**Key points when considering dismissing a member**

In general, the key requisites when considering dismissing a member include the following:

- Timely early communication.
- Thorough documentation of events, problems and behaviors.
- A plan generated by the PCD provider to attempt to address the problem or concern.
- Consideration should be given to the use of contracts and case conferences with the member and his/her CCO.
- Mental health conditions should be taken into account whenever dismissing or requesting disenrollment of a member.

**When can a member be dismissed?**

A member may be dismissed from a PCD provider with just cause subject to Americans with Disabilities Act (ADA) requirements. The list of just causes, identified by DHS includes, but is not limited, to the following:

- Missed appointments, except prenatal care patients
- Disruptive, unruly or abusive behavior.
- Drug-seeking behavior.
- The member commits or threatens an act of physical violence directed at a medical provider or property, clinic or office staff, other patients.
- Dismissal from PCD provider by mutual agreement between the member and the provider.
- Provider and CDC agree that adequate, safe and effective care can no longer be provided.
- The member commits a fraudulent or illegal act, such as permitting someone else to use his or her medical ID card, altering a prescription, or committing theft or any other criminal act on any provider's premises.

**If PCD provider decides to dismiss a member**

When the clinic management moves to dismiss a member, a letter is sent to the member informing him or her of the dismissal with a copy sent to CDC. PCD providers are asked to provide urgent care for the dismissed member for 30 days following notification of the member.

CDC member services will work with the member to establish a new PCD provider.

**When a member cannot be dismissed**

Oregon Administrative Rules state that members shall not be dismissed solely because:

- The member has a physical or mental disability.
- There is an adverse change in the member's health.
- The PCD provider or CDC believes the member's utilization of services is either excessive or lacking, or the member's use of plan resources is excessive.
- The member requests a hearing.
- The member exercises his or her option to make decisions regarding his or her medical care with which the provider or the plan disagrees.
- The member's behavior resulting from the DMAP member's special needs.

**Missed appointment policy**
Providers should individually establish an office policy for the number of missed appointments they allow before dismissing a member from their practice. This policy must be administered the same way for all patients. The provider's office must inform all members of their office policy on missed appointments at the member's first visit. The provider should have members sign an acknowledgement of the office policy. DMAP rules do not allow providers to bill members or charge them a fee for missed appointments.

If the member continues to miss appointments and the provider decides to dismiss the member, the provider must send a letter to the member informing him or her of the dismissal. A copy of the dismissal letter should be sent to CDC along with a copy of the office policy on missed appointments and any other relevant documentation, including chart notes, correspondence sent to the member, signed contracts and/or documentation of case conferences.

**Second Opinion Policy**
Providers recognize that a member has a right to request a second opinion from a qualified participating provider. The provider shall work with CDC to assist the member in obtaining a second opinion at no cost to the member. This assistance may take the form of a referral request to CDC on behalf of the member or a discussion regarding benefits/outcomes with the member. Whenever possible, the member shall be referred to a participating provider in the same office.

# Member Transportation

Transportation to medical appointments is paid by DMAP directly.
Members should contact their Department of Human Services (DHS) caseworker or local Adult and Family Services (AFS) branch if they do not have a caseworker for information about transportation options.

**MEMBER RIGHTS AND RESPONSIBILITIES**
A copy of these rights and responsibilities are also available to the Member in the Dental Member Handbook that they receive from FDC upon enrollment.

**MEMBERS HAVE THE RIGHT TO:**

1. Be treated with dignity and respect and consideration for their privacy.
2. Be treated by participating Providers the same as other people seeking dental care benefits to which they are entitled.
3. Select or change primary care dentists (PCD).
4. Have a friend, family member or advocate present during appointments and at other times as needed within clinical guidelines.
5. Be actively involved in creating treatment plans.
6. Be given information about conditions, covered and non-covered services in order to make an informed decision about proposed treatment(s).
7. Consent to treatment or refuse services and be told the consequences of the decision, except for court-ordered services.
8. Receive written materials describing rights, responsibilities, benefits available, how to access services and what to do in an emergency.
9. To have written materials explained in a manner that is understandable.
10. To receive necessary and reasonable services to diagnose the presenting condition.
11. Receive a referral to specialty Providers for dentally appropriate covered services.
12. Have a clinical record maintained that documents conditions, services received and referrals made.
13. Have access to one's own clinical record, unless restricted by law and request and receive a copy of their records and request that they be amended or corrected.
14. Transfer a copy of his/her clinical record to another Provider.
15. Execute a statement of wishes for treatment (Advanced Directive), including the right to accept or refuse dental treatment and the right to obtain a power of attorney for healthcare.
16. Receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations.
17. Know how to make a complaint or appeal about any aspect of care or the plan.
18. Request an Administrative Hearing with the Department of Human Services.
19. Receive interpreter services.
20. Receive a notice of an appointment cancellation in a timely manner.
21. Receive covered services under OHP, which meet generally accepted standards of practice as is dentally appropriate.
22. Obtain covered preventive services.
23. Have access to urgent and emergency services 24 hours a day, seven days a week.
24. Be free from any form of restraint or seclusion used as a means of coercion, discipline convenience or retaliation and to report any violations to FDC or to the Oregon Health Plan.
25. Post stabilization services after an emergency department visit.
26. A second dental opinion.

**MEMBERS HAVE THE RESPONSIBILITY TO:**

1. Choose, or help with assignment to a Provider or clinic, once enrolled.
2. Treat all Providers and their staff with respect.
3. Be on time for appointments made with Providers and call in advance either to cancel if unable to keep the appointment or if he/she expects to be late.

4. Seek periodic dental exams, check-ups and preventive care from his/her dentist.
5. Use his/her dentist or clinic for diagnostic and other care except in an emergency.
6. Obtain a referral to a specialist from the general dentist before seeking care from a specialist.
7. Use urgent and emergency services appropriately and notify CDC within 72 hours of an emergency.
8. Give accurate information for the clinical record.
9. Help the Provider obtain clinical records from other Providers. This may include signing a release of information form.
10. Ask questions about conditions, treatments and other issues related to their care that they do not understand.
11. Use information to decide about treatment before it is given.
12. Help in the creation of a treatment plan with the Provider.
13. Follow prescribed, agreed-upon treatment plans.
14. Tell Providers that his/her dental care is covered under the Oregon Health Plan before services are received and, if requested, show the provider the DMAP Medical Care ID card.
15. Tell the DHS case worker of a change of address or phone number.
16. Tell the DHS case worker if she becomes pregnant and notify the DHS case worker of the birth of the child.
17. Tell the DHS case worker if any family members move in or out of the household.
18. Tell the DHS case worker if there is any other insurance available.
19. Pay for non-covered services received under the provisions described is OAR 410-120-1200 and 410-120-1280.
20. Pay the monthly OHP premium on time if so required.
21. Assist in pursuing any third party resources available and to pay CDC the amount of benefits paid from an injury from any recovery received from that injury.
22. Bring issues, complaints or grievances to the attention of CDC and DHS.
23. Sign an authorization for release of dental information so that CDC can get information pertinent and needed to respond to an administrative hearing request in an effective and efficient manner.

**SECLUSION AND RESTRAINT POLICY**

In accordance with Federal law, we recognize that each patient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

A ***restraint*** is (a) any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or (b) a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

***Seclusion*** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members or others from harm. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm. In addition, the nature of the restraint or seclusion must take into consideration the age, medical and emotional state of the patient. Under no circumstances may an individual be secluded for more than one (1) hour.

The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by this policy and in accordance with applicable state law. In addition, the use of restraint or seclusion must be in accordance with the order of a physician or other licensed health care professional who is responsible for the care of the patient.

**CDC requires their participating OHP dentists to have a policy and procedure regarding the use of seclusion and restraint as required under the Code of Federal Regulations and also requires the provider to provide CDC a copy of their policy upon request.** *(42 CFR, 438.100, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation)*

# Contact Information

**Send Dental Claims to:**
3000 Market Street Plaza NE
Suite 228
Salem, Oregon 97301
Attention: Billing
Ph: (505) 585-5205

**Send Complaints and Appeals to:**
3000 Market Street Plaza NE
Suite 228
Salem, Oregon 97301
Attention: Member Services Manager
Ph: (505) 585-5205 ext. 90230

**OHP Customer Service:**
Ph: (800) 699-9075 (TTY 711)

**PH Tech Support**
Ph: (503) 584-2169, option 2.