Oregon Health Plan Provider Handbook

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Welcome

Welcome to Capitol Dental Care! Thank you for being part of our network of offices. This handbook is a reference to provide you with information regarding processes and procedures.

Capitol Dental Care

Capitol Dental Care (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. CDC has served members of the Oregon Health Plan since its inception in 1994. CDC has a track record of being "user friendly" to dentists and their offices. We have built a solid reputation for fast service, fair treatment, and being readily available. CDC's commitment to those values remains firm.

Mission Statement

Capitol Dental Care is committed to preventing dental disease and improving the oral and systemic health of children and low income patients. We create access to quality care, use evidence-based methods and provide dental leadership within the communities we serve.

Contact Information

Capitol Dental Care, Inc.
3000 Market St. NE Suite 228
Salem, OR 97301
Phone: (800) 525-6800
Fax: 503-581-0043
Office Hours: Monday–Friday from 7:00 a.m. to 6:00 p.m.

Email:
Member Services – members@capitoldentalcare.com
Provider Services – providers@capitoldentalcare.com
Compliance – compliance@capitoldentalcare.com
Other – admin@capitoldentalcare.com

IMPORTANT: Please do not submit any personal information such as social security number, Oregon Health Plan member number or any personal health information through email. Email is not secure and has the potential to be seen by others. Please call, fax or ensure you are using secure email before sending confidential or protected data.

Our Members

Our members select or are assigned to Capitol Dental Care upon enrolling in the Oregon Health Plan (OHP), the Oregon Medicaid program. The enrollment process is handled by the State or the Coordinated Care Organizations. Questions regarding members should be directed to CDC's member services group.

Coordinated Care Organizations

Coordinated Care Organizations (CCOs) were developed by the state to manage the members' physical, mental and oral healthcare needs. A CCO develops a network of health care providers with the goal of improving member health and quality of care at a lower cost. The CDC network of dental providers is a critical component of the dental delivery system for many of the CCOs. CDC encourages oral health professionals to be aware of manifestation of systemic health that are present in the mouth. We can help improve overall health in partnership with the CCOs through awareness, coordination, early identification of disease and preventive services.

Learn more about CCOs and how they are helping improve the care and health of Oregonians at http://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx

Providers

Joining the CDC Network

The first step in becoming a CDC provider is to complete a Prospective Provider Form. The form can be found on the CDC website at the link below. Completion of this form allows CDC to determine if the services you provide and your practice location meet existing needs within the network. You will be informed either that your office does not meet an existing need or you will receive information to initiate the credentialing process.

http://capitoldentalcare.com/wpcontent/uploads/2012/05/Prospective_Provider_Form_ver05.23.2018.pdf

Credentialing

Provider credentialing is a process of assessing, re-assessing and validating the qualifications and practice history of a dental provider for the purpose of obtaining approval from a health plan to join their network. CDC credentialing requirements are based on OHP, state and other regulatory agencies national standards of accrediting. Dental Specialists, General Dentists, Denturists, and Expanded Practice Dental Hygienists (working outside a dental office) are required to credential with CDC. The credentialing process must be completed and approved prior to a provider treating members. CDC is only able to pay credentialed providers and credentialing cannot be backdated to cover a service provided before the process is complete.

The following are some of the criteria that must be met to be credentialed.

1. Completion of applicable dental degree.
2. Proof of minimum malpractice insurance coverage minimum of $2,000,000 per claim and $4,000,000 annual aggregate.
3. Current, active and in good standing with the applicable professional state license(s).
4. Never proven guilty of a federal crime.
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.

CDC reserves 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. CDC verifies information in the application and checks the National Practitioner Data Bank, Dental Licensing Boards and other sources. A provider is entitled to provide a written explanation for any negative findings or for information obtained during the verification process that varies substantially from the information submitted on the application. CDC will notify you and request a written explanation if this is necessary. If no response is received, the application process is terminated.

Please attach legible, current and valid documents requested in the application. We do not accept an application and/or attached documents that have been altered, unsigned, incomplete, inaccurate, expired, and illegible or that have missing information.

CDC's credentialing team will review the information submitted in the packet for final review and participation decision. All information provided during the credentialing and re-credentialing process is kept confidential. The credentialing application, source data verification and all other pertinent information will be reviewed and presented to CDC's clinical director and the CDC Quality Improvement Committee for final approval in determining 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.

In the case of a denial, written information on the appeal process will be provided to the applicant. The provider has 30 calendar days from the date of denial of participation to request an appeal. The request must be in 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.

Recredentialing

Recredentialing is a necessary requirement to remain an eligible participating provider. Re-credentialing occurs every three years. The recredentialing process is similar to the initial credentialing.

Notifications

At all times while participating with CDC, dentists 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 CDC of any changes, formal action against any licenses or, if applicable, against any certifications by any certifying boards or organizations. Additionally, providers must notify CDC credentialing in writing of any changes in practice ownership or business address.

Provider Directory

CDC's provider directory identifies participating providers, their availability to new patients and information about their practices to assist members understand options available to them. CDC attempts to keep the directory accurate and up-to-date. Your assistance in notifying CDC of any changes and or corrections needed is appreciated.

Case Management

CDC's member services group is available to help with member case management as needed for difficult clinical situations and or for coordinating efforts with physical or mental health providers.

Quality Review

CDC has a Quality Improvement (QI) Committee charged with ensuring members receive care that is both high in quality and appropriate to improve their health. 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.

Areas of concern are access to care, outcomes of care, over and underutilization of services, patient safety, member satisfaction, and compliance with rules and regulations. Providers are expected to cooperate with quality review efforts, which may include responding to questions that arise during CDC's quality review audit process.

Termination of Participation

Termination of participation with CDC is determined by the Provider Agreement. In general a provider can be terminated for cause when failing to meet the terms of the agreement. Either the provider or CDC is allowed to terminate participation with notice as specified in the agreement. Termination with CDC does not relieve a provider of any obligation they may have to a member who is a patient of record.

Training

CDC's provider services group will provide training on the OHP program upon request. The CDC website has links to resources to assist you in working with CDC and complying with the OHP program requirements.

Record Retention and Review

Participating providers must keep and maintain necessary financial, dental and other records pertaining to services rendered to members of CDC. All records must be kept in accordance with federal and/or state laws governing record retention. Termination of participation with CDC does not terminate a provider's obligation to retain records.

CDC will have the right to conduct on site visits and to request and inspect all records of the provider related to a member as permitted by law, and as may be necessary for CDC to perform its contract obligations. These records will be provided at no cost.

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 to be 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. 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.
- Be notified of their rights as a provider.

Provider Responsibilities

CDC Providers are responsible for providing services to the member that they are entitled to receive in a manner that ensures member rights are maintained. To ensure members have access to quality care in a timely manner, emergency needs should be addressed immediately, urgent needs within 24 hours and routine care within 4-8 weeks.

Claims Processing

A claim must be submitted to CDC for each service provided to a CDC member.

Third Party Administrator

CDC's, third party administrator, PH TECH processes and pays claims on behalf of CDC. PH TECH can be reached for assistance at 866-947-9443. Web site help is found at https://help.phtech.com/hc/en-us.

PH Tech's Clinical Integration Manager (CIM)

PH Tech offers a web based system, CIM, to CDC providers as a tool to find information on member's eligibility, referrals, predeterminations and claims. Certain operational tasks such as referral requests and communications regarding claims can also be initiated in CIM.

To obtain CIM access contact PH Tech at 866-947-9443; for assistance with using CIM contact PH Tech CIM Support at 503-584-2169, option 2.

Verifying Eligibility

It is the responsibility of the provider to verify a patient's CDC eligibility on the date of service. A member's eligibility may be confirmed in the CIM system. CDC's member service staff can also help you determine a member's eligibility. A member service representative is available 7 AM to 7 PM Monday through Friday, other than Federal holidays, at 1-800-525-6800. The provider assumes full financial risk for serving a patient whose eligibility was not confirmed on the date of service.

Submitting Claims

Participating providers agree to bill CDC for covered services provided to CDC members. CDC requires that all claims be received within 120 days of the date of service. Corrected billings to previously submitted claims need to be clearly marked as —corrected billing. If a claim is previously denied and/or additional information is requested, the provider has 95 days to submit the requested information or appeal the denial. All claims, including corrections, adjustments, and requested information must be received within 12 months after the date of service to be valid.

Electronic Claims: It is preferable to have claims submitted electronically. When submitting claims electronically, it is important to check the error report from your electronic claims service or clearinghouse to verify that all claims have been successfully sent.

Paper Claims: Claims can be submitted on paper using a current ADA form.

For information or assistance with billing electronically, please contact PH Tech.

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. As secondary payer, CDC pays for benefits only when the primary carrier paid less than the CDC allowed amount. Payment is based upon the difference of either the primary carrier's allowed charge or our allowed amount and the primary carrier's payment, whichever is less. If the primary plan pays more than the CDC allowed amount, it constitutes the total allowable payment and CDC will not make any payment.

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, these numbers must accurately align with the identified billing entity and treating dentist. The treating dentist must be the individual who provided the service.

Taxpayer Identification Number: A Taxpayer Identification Number (TIN) is an identifying number used for tax purposes in the United States. A TIN may be assigned by the Social Security Administration or by the Internal Revenue Service (IRS). You can apply online at https://www.irs.gov/businesses/small-businesses-self-employed/apply-for-an-employer-identification-number-ein-online.

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). 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. The link to sign up for a DMAP provider number is http://www.oregon.gov/oha/healthplan/Pages/providerenroll.aspx. Obtaining a DMAP provider number does not require you to accept all Medicaid patients or to do business directly with the state. You can restrict the use of your DMAP number to your claims and encounter data submissions with CDC.

Claims Inquiries

Questions regarding claims may be answered by using the CIM system. You can also contact PH TECH or CDC provider services group.

Claims Appeals

Claims denied for information that is incorrect or lacking should be resubmitted to PH Tech to be adjudicated. To appeal coverage decisions include comprehensive documentation to include, a detailed description of the issue or dispute, the basis for your disagreement, as well as all evidence and documentation supporting your position.

Referrals

Sometimes it becomes necessary to refer a patient to a specialist or different provider. If a referral is needed call 1-800-525-6800 or fax a completed referral form to 503-581-0043. The referral form (found on CDC's website) must be filled out in its entirety. Omitting information may delay processing of the referral. We will notify you if a referral is denied, approved or pending further review. When a referral is approved the Primary Care Dentist (PCD) will be given a referral number. If a referral is denied, we will fax or mail the referral request back to the PCD and include the reason for the denial. A formal written denial is mailed to the member.

Specialists must receive an approved referral from CDC before seeing a member. In an emergency, the specialist must notify CDC as soon as possible to obtain approval for the visit. Eligibility must be checked before providing services regardless of whether or not there is 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 of Benefits

CDC will allow you to confirm in advance during normal business hours whether the dental services to be provided are dentally necessary and covered benefits; and to determine CDC's requirements that apply to you in providing the service.

CDC has also identified certain services for which you must submit for prior authorization (PA). In the event you fail to submit a required prior authorization, CDC may deny, in whole or in part, any claims for those services. A prior authorization is based on a member's history and

eligibility at the time the prior authorization is processed is not a guarantee of payment should changes occur after the date of the prior authorization.

A current American Dental Association (ADA) form should be submitted, separate from your claims, with the following information:

- The request for prior authorization (predetermination) box at the top of the ADA 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.

Mail PAs to:
Capitol Dental Care
Attention: PA Request
3000 Market Street Plaza NE
Suite 228
Salem, Oregon 97301

Or via email to: providers@capitoldentalcare.com

Hospital Dentistry

Hospital dentistry or in office dentistry under general anesthesia requires coordination with the member's physical health providers. A form to facilitate the process was jointly developed and is available on the CDC web site.

Members

Enrollment

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.

Second Opinions

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.

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 the 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, prior to dismissing a member consider the following:

- A plan generated by the PCD provider to attempt to address the problem or concern.
- The use of contracts and case conferences with the member and his/her CCO.
- Mental health conditions.
- Thorough documentation of events, problems and behaviors.

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.
- 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 special needs.

Missed appointments

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.

Member Rights

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.
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.

Member Responsibilities:

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.

Member Grievances and Appeals

Complaints and Grievances

A complaint or grievance 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 include, but are not limited to, access to providers, waiting times, demeanor of dental care personnel, quality of care and adequacy of facilities.

Members have the right to file complaints. CDC follows OHP guidelines to report and resolve all expressed complaints. CDC encourages both the provider and member to resolve complaints, problems and concerns directly with those involved. For complaints that cannot be resolved, providers should inform the member of the formal complaint process as outlined in the member handbook. ALL complaints should be reported to CDC.

Members (or providers) can contact our member service department to file a verbal complaint or request an OHP complaint form.

Denials, Appeals, Administrative Hearings

If a referral or prior authorization 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.

Letters sent denying a referral or a prior authorization inform the member he/she has a right to file an appeal. The member can contact CDC or their CCO to request an appeal. Oral requests

must be followed up with a written request. Providers can also appeal on behalf of the member with the member's approval to do so.

Appeals
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.
members@capitoldentalcare.com

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 make the request.

Member Benefits

The OHP Plus benefit group is broken into three categories with slightly different benefits: Under 21, pregnant age 21 and older and non-pregnant age 21 and older.

Covered Services

The member benefits include urgent treatment to relieve pain and basic services such as cleaning, fluoride varnish, fillings, extractions, and dentures. Pregnant women and children under 21 are eligible for root canals on back teeth and crowns that are not available to adults 21 and older. A complete listing by ADA Code of what is covered 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

Service Limitations and Exclusions

Services that are excluded from or have limited coverage include treatment for: injuries or conditions compensable under Worker's Compensation or Employer's Liability Laws, cosmetic purposes, experimental, TMJ and orthodontics. Charges for missed appointments are not allowed.

Charging for Services Not Covered

Providers must do the following prior to treatment in order to bill an OHP member for any **non-covered** services: Inform the member the service is not covered, provide an estimate of the cost of the service, and explain to the member they are financial responsible for the service. The member must also sign an OHP approved financial waiver.

An OHP Client Agreement to Pay for Health Services (financial waiver) is available in multiple languages at:
https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx?wp2131=se:%22client+agreement%22

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 cannot be charged to the patient. Services that have been denied due to provider error cannot be charged to the patient.

Other Benefits

Transportation: Transportation to dental appointments is the responsibility of the state and the CCOs. Members may contact their Department of Human Services (DHS) caseworker, local Adult and Family Services (AFS) branch or their CCO to arrange transportation or for information about transportation options.

Interpreter Services: Interpreter services for a member's appointment to provide covered benefits can be provided. To arrange for interpretation services, call the CDC member services department.

Tobacco Cessation:
Tobacco cessation is a covered OHP service. Basic treatment includes the following services: Ask systematically identify all tobacco users. Advise strongly urge all tobacco users to quit. Assess measure willingness to attempt to quit using tobacco within the next 30 days. Assist help with brief behavioral counseling and including prescription of nicotine patches and medications. Arrange schedule follow-up support or referral to more intensive treatments. Oral Health Providers are expected to participate with Ask, Advise, and Assess. Referrals should be made to the appropriate healthcare provider to Assist and Arrange.

A brief discussion regarding tobacco can help address a patient's concerns and provide support and encouragement to facilitate tobacco cessation efforts. The Oregon Tobacco Quit Line is a free telephone service available to all Oregon residents and offers free information and counseling. 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

Rules and Guidelines

OHP Rules

The rules governing the OHP program and dental services with OHP are located 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

CDC Clinical Practice Guidelines

CDC Providers are expected to follow practice guidelines established by their regulatory board and professional associations. CDC has adopted the following evidence based practice guidelines:

- Association of State and Territorial Dental Directors Best Practices
- American Dental Hygienists Association Standards in Practice
- FDA Guidelines for Prescribing Dental Radiographs
- American Dental Association Center for Evidence-Based Dentistry Practice Guidelines
- American Association of Pediatric Dentistry Clinical Practice Guidelines and Recommendations
- Oregon Opioid Prescribing Guidelines for Dentists
- American Heart Association Guideline for the Prevention of Infective Endocarditis
- CDC Seclusion and Restraint and Advance Directive Policies outline guidelines for these areas.

These guidelines can be reached via links at CapitolDentalCare.com.

Fraud, Waste & Abuse

CDC providers must 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 and billing of healthcare services to CDC members.

CDC has internal controls and procedures designed to prevent and detect potential fraud, waste and abuse activities by groups, members, providers and employees as outlined in our Fraud, Waste and Abuse Detection and Prevention policy that is available on our web site.

CDC has an obligation to report cases of fraud, waste or abuse to the appropriate regulatory agency.

Privacy and Security Standards

Healthcare providers must adhere to the Health Insurance Portability and Accountability Act (HIPAA) and ensure their staff is adequately trained in privacy and security.

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, physically or electronically. 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.

Providers' employees (including physicians) must not have unapproved access to their own records or records of anyone known to them who is not under their care.

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.

Seclusion and Restraint

Capitol Dental Care (CDC) recognizes that there are circumstances where pediatric and special needs patients may need to be restrained in order to safely deliver quality dental treatment and care. It is the policy of CDC that use of physical restraint is only to be used as a last resort after other methods have failed. In those circumstances where it is the only option, it is critical to build a trusting relationship between the dentist, dental staff, the patient and the parent or guardian.

The term "seclusion" means the involuntary confinement of a patient alone in a room where the patient is physically prevented from leaving.

The term "restraint" means any method of physically restricting or reducing a patient's freedom of movement, physical activity, or normal access to his or her body. Within this policy the terms immobilization and restraint are used interchangeably and when used strictly by the parent or guardian is not considered restraint.

The term "time out" refers to requiring the patient to abstain from social interaction with others and all activities. While CDC understands that a "time out" may be necessary in certain instances for the patient to gain control of emotions, seclusion is never acceptable behavior management in the dental office environment.

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

Please refer to Capitol Dental Care Seclusion and Restraint Policy for more details.

Advance Directives and Declarations for Mental Health Treatment

An advance directive is a written instruction, such as a living will or durable power of attorney for health care, relating to the provision of health care when the individual is incapacitated.

Declarations for Mental Health Treatment are instructions regarding the kind of care a patient wants if they become unable to make decisions.

Dental providers should be aware that their patients may have these instructions in place or they may inquire regarding how to put them in place. Information can be found on the State and most CCO websites, or from their medical or mental health providers.