PREMIER ACCESS

PROVIDER MANUAL FOR HEALTHY FAMILIES AND HEALTHY KIDS SANTA BARBARA PROGRAMS

Please visit our website at www.premierppo.com **to obtain patient eligibility, patient benefit schedule, and patient certificate of insurance for any of the government programs. You may also submit on-line requests for additional forms, such as: Grievance and Specialty Referral forms.**

P.O. Box 659010
Sacramento, CA 95865-9010
Phone (916) 922-2500 • Fax (916) 646-9000

Revised: 060111

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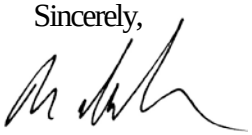
A Word from the President

Dear Provider:

This Provider Manual is to help you and your staff understand ***Premier*** Access Insurance Company's dental benefit programs and the responsibilities of both ***Premier*** Access Insurance Company and the provider as it relates to services provided to members. One of our primary goals in preparing this Provider Manual was to keep the information brief and simple.

I would like to thank you for participating in ***Premier*** Access Insurance Company's provider network and encourage you to use this Provider Manual as part of your office operations when treating ***Premier*** Access Insurance Company's members.

Sincerely,



Reza Abbaszadeh, DDS
President and Chief Executive Officer

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Provider Manual

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Introduction

Why the Provider Manual is an important tool for you and how to use it.

Use the information in this manual to ensure you are providing quality services to **Premier** Access Insurance Company (**Premier**) members, the services you provide are covered benefits, and you are paid promptly for your services.

This manual is for you! We have created this manual for the sole purpose of assisting **Premier** Providers. If information in this manual is unclear, or you would like additional information included in the future, please let us know. When any changes in criteria and/or policies occur, revised pages will be issued for the purpose of updating the information in this handbook. Please carefully insert them in this provider manual as soon as possible, according to the instructions provided with each revision.

Understanding Icon Keys

✓ Key information

Important phone number

The "icon keys" at left are used throughout the manual to highlight areas of particular importance. If the "Key information" icon appears in the margin of the manual, the information is critical to providers for ensuring prompt and appropriate payment or approval of services. If the "Important phone number" icon appears in the margin of the manual, the Premier Access Insurance Company phone number related to the particular topic is included in the discussion.

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Health Insurance Portability and Accountability Act

Premier Access Insurance Company (**Premier**) takes pride in the fact that we administer our dental plan in an effective and innovative manner while safeguarding our members' protected health information. We are committed to complying with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our commitment is demonstrated through our actions.

Premier has appointed a Privacy Officer to develop, implement, maintain and provide oversight of our HIPAA compliance program as well as assist with the education and training of our employees on the requirements and implications of HIPAA.

Premier has created and implemented internal corporate wide policies and procedures to comply with the provisions of HIPAA. **Premier** has and will continue to conduct employee training and education in relation to HIPAA requirements.

Premier has disseminated its Notice of Privacy Practices. Existing members were mailed a copy of the notice and all new enrollees are provided with a copy with their member materials. Should you have any questions regarding **Premier** Access Insurance Company's HIPAA compliance efforts please contact the Privacy Officer via via email at PrivacyOfficer@premierlife.com or via telephone at (916) 920-2500.

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Abbreviations Used in This Manual

Abbreviations used in this manual are shown below with their full text.

ADA.....American Dental Association
CADP ..... California Association of Dental Plans
CCS ..... California Children Services
CHDP .....Child Health and Disability Prevention Program
EPA ..... Environmental Protection Agency
HEDIS.....Health Employers Data Information Set
HFP..... Healthy Families Program
HIPAA ..... Health Insurance Portability and Accountability Act
HKSB ..... Healthy Kids Santa Barbara
LAP .....Language Assistance Program
LEP..... Limited English Proficient
NPDB ..... National Practitioner Data Bank
OSHA.....Occupational Safety and Health Administration
PCD.....Primary Care Dentist
QM.....Quality Management

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Program Forms Used by Providers

The following forms used by providers are discussed in detail in this manual in the chapters indicated.

FORM	CHAPTER
Grievance Form	Appeal and Grievances
Orthodontic Pre-Screening Form	California Children's Services
Specialist Referral Form	Referrals

Important Phone Numbers

Important phone numbers for quick reference when contacting **Premier** Access Insurance Company for services:

Member Services

Government Programs:

1-888-584-5830
CustomerService@premierlife.com

Our customer service representatives are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m.

Grievances

916-563-6013
800-270-6743, ext. 6013
Grievancedept@premierlife.com

Emergency/Regular Specialty Referrals

888-584-5830
Fax: 916-679-9197
PremierReferral@premierlife.com

Claims

888-584-5830
Fax: 916-679-9197
PremierReferral@premierlife.com

Plan's 24 Hour Emergency

800-870-4290

Provider Relations / Provider Dispute

800-640-4466
ProviderRelations@premierlife.com

Ordering Forms

800-640-4466
Info@premierlife.com

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Benefit Plans

A description of the Healthy Families Program and Healthy Kids Santa Barbara.

Premier Access Insurance Company (**Premier**) provides dental coverage under government programs who are enrolled under the Healthy Families Program and Healthy Kids Santa Barbara.

◆ Healthy Families Program

Premier participates in California's Healthy Families Program. The Healthy Families Program provides health, dental and vision coverage for children one through eighteen years of age who are uninsured and have family income below the income thresholds of the program.

The program uses Federal, State and County funds to provide health care coverage to approximately 900,000 uninsured children of lower income working Californians who are ineligible for Medi-Cal.

◆ Healthy Kids Santa Barbara

Premier participates in Healthy Kids Santa Barbara (HKSB). The HKSB program provides comprehensive health insurance for uninsured low-income children (age 0 to 19) and incomes below 300 percent of the Federal poverty level and do not qualify for any government programs such as Medi-Cal or Healthy Families.

◆ Copayment

HFP and HKSB members have some minimal copayments to meet for certain services. The PCD must collect these copayments when delivering services.

American Indians and Alaskan Native children are exempt from all Healthy Families Program copayments.

In order to receive reimbursement for copayment amounts for services to American Indians and Alaskan Native children, providers are encouraged to use ADA claim forms to report these services and request payment for these copayment amounts.

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Accessibility Standards

Premier complies with standards of accessibility of dental services for members, as established by California State Law and Regulations.

Appointment Scheduling

Appointments for an initial assessment, non-emergency routine services, and/or preventive care must be made available to members within three weeks of the date a member requests an appointment.

Appointments for acute/urgent care from a PCD shall not exceed one day from the date of the request for an appointment.

Waiting Time for Scheduled Appointments

Member waiting time for scheduled appointments with their PCD or a specialty provider must not exceed thirty (30) minutes. Provider offices must maintain records indicating when a member arrives for an appointment and when the provider sees the member.

After Hours and Emergency Services Availability

The provider's after-hours response system must enable members to reach an on-call dentist 24 hours a day, seven days a week.

Members may first attempt to contact their Primary Care Dentist (PCD) during regular office hours. Urgent appointments should be scheduled within 24 hours and patient should be informed that only the emergency would be treated at that time. After-hours calls should be forwarded to an answering service or directly to the PCD. If the PCD is not on duty, an on-call provider should be available to act on his behalf.

Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one hour of the time the member contacts the provider's after hours telephone service.

If the PCD or on-call dentist does not respond, the member may contact **Premier's** 24 hour answering service at 800-870-4290.

If the member requires emergency care when outside the service area (greater than 50 miles from the PCD), the member may seek treatment from the nearest available dentist or emergency room as circumstances dictate.

Cultural and Linguistic Services

Premier understands that many of the applicants and subscribers who seek dental services may be limited English proficient (LEP) and/or may be members of cultural or ethnic groups who have minimal exposure to routine dental care.

To support the Cultural and Linguistic (C& L) needs of our members, **Premier** has translated Member-oriented documents into multiple, non English languages. **Premier** has availability of free language assistance services for all your enrollees with interpreting services 24 hours a day, 7 days a week. Member can access the interpreting services at no charge by calling the Plan's Member Services Representatives at 1-888-584-5830.

Under no circumstances do we require friends or family members to serve as interpreters on dental matters, instead, we encourage members to use the qualified interpreters we provide. The Provider will document the language needs of subscribers in their medical record, and shall ensure that the request or refusal of the services is documented in the dental record.

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Healthy Families Program and Healthy Kids Santa Barbara

A description of Premier's Healthy Families Program and Healthy Kids Santa Barbara, including procedures and copayments.

The Healthy Families (HFP) Program provides health, dental and vision coverage for uninsured low-income children (under 19 years of age) up to 250 percent of the Federal poverty level. The program uses Federal, State and County funds to provide health care coverage to approximately 900,000 uninsured children of lower income working Californians who are ineligible for Medi-Cal.

The Healthy Families Program (HFP) has made changes to the program. Based on the HFP income categories, there will be copayments and $1500 annual maximum amounts for applicable covered benefit services.

The Healthy Kids Santa Barbara (HKSB) program provides comprehensive health insurance for uninsured low-income children (age 0 to 19) and incomes below 300 percent of the Federal poverty level and do not qualify for any government programs such as Medi-Cal or Healthy Families.

Scope of Dental Benefits

This chapter contains a current list of procedure codes and description for the Healthy Families Program and Healthy Kids Santa Barbara.

Except for emergency, preventive, and diagnostic services, please submit a prior authorization for other services to the Plan. The HFP or HKSB member identified on the card MAY NOT BE BALANCE BILLED. All claim forms and Prior Authorization forms should be sent to:

Premier Access Insurance Company
P.O. Box 659010
Sacramento, CA 95865-9010

Determination of authorization is based on submitted documentation and the benefits outlined in the programs benefit schedule.

Review criteria for prior authorization has been adopted from Medi-Cal Dental Program.

The HFP Scope of Dental Benefits is available by request, or can be reviewed online at www.mrmib.ca.gov.

The HKSB Scope of Dental Benefits is available by request, or can be reviewed online at www.cencalhealth.org.

Reimbursement for Copayments

The HFP/HKSB members have some minimal copayments to meet for certain services. The PCD must collect these copayments when delivering services. Following are the benefits and copayments for the Healthy Families Program and Healthy Kids Santa Barbara.

The HFP has increased copayments for applicable covered services for members who are in Income Categories B & C. Members in income category A shall pay no more than $5.00 copayment for applicable covered services as described in this benefit description section. If you have any questions regarding the new copay increase, please call the Premier's Member Services Department at 888-584-5830, Monday through Friday from 8:00AM to 6:00PM.

American Indians and Alaskan Native children are exempt from all HFP copayments.

In order to receive reimbursement for copayment amounts for services to American Indians and Alaskan Native children, providers are encouraged to use ADA claim forms to report these services and request payment for these copayment amounts.

Dental Plan Covered Benefits Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.

The HFP has increased copayments for applicable covered services for members who are in Income Categories B & C. This copayment increase does not apply to members in Income Category A.

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
Diagnostic and Preventive Care Services	Initial and periodic oral examinations, Consultations, including specialist consultations, Topical fluoride treatment, Preventive dental education and oral hygiene instruction, Roentgenology (x-rays), Prophylaxis services (cleanings), Space Maintainers, Dental sealant treatments.	No copayment	No copayment
Restorative Dentistry (Fillings)	Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries, Micro filled resin restorations which are noncosmetic, Replacement of a restoration, Use of pins and pin build-up in conjunction with a restoration, Sedative base and sedative fillings.	No copayment	No copayment
Oral Surgery	Extractions, including surgical extractions, Removal of impacted teeth , Biopsy of oral tissues, Alveolectomies, Excision of cysts and neoplasms, Treatment of palatal torus, Treatment of mandibular torus, Frenectomy, Incision and drainage of abscesses, Post-operative services, including exams, suture removal and treatment of complications, Root recovery (separate procedure).	No copayment, except • $5 copayment for the removal of impacted teeth for a bony impaction • $5 copayment per root recovery	No copayment, except • $10 copayment for the removal of impacted teeth for a bony impaction • $10 copayment per root recovery
Endodontic	Direct pulp capping, Pulpotomy and vital pulpotomy, Apexification filling with calcium hydroxide, Root amputation, Root canal therapy, including culture canal, Retreatment of previous root canal therapy, Apicoectomy, Vitality tests.	No copayment, except • $5 copayment per canal for root canal therapy or retreatment of previous root canal therapy • $5 copayment per root for an apicoectomy	No copayment, except • $10 copayment per canal for root canal therapy or retreatment of previous root canal therapy • $10 copayment per root for an apicoectomy
Periodontics	Emergency treatment, including treatment for periodontal abscess and acute periodontitis, Periodontal scaling and root planing, and subgingival curettage, Gingivectomy, Osseous or muco-gingival surgery.	No copayment, except • $5 copayment per quadrant for osseous or muco-gingival surgery	No copayment, except • $10 copayment per quadrant for osseous or muco-gingival surgery
Crown and Fixed Bridge	Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel, Related dowel pins and pin build-up, Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, Recementation of crowns, bridges, inlays and onlays, Cast post and core, including cast retention under crowns, Repair or replacement of crowns, abutments or pontics.	No copayment, except • $5 copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. • $5 copayment per pontic. • The copayment for any precious (noble) metals used in any crown or bridge will	No copayment, except • $10 copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. • $10 copayment per pontic. • The copayment for any precious (noble) metals used in any crown or bridge will

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
		be the full cost of the actual precious metal used.	be the full cost of the actual precious metal used.
Removable Prosthetics	Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, Office or laboratory relines or rebases, Denture repair, Denture adjustment, Tissue conditioning, Denture duplication, Stayplates.	No copayment, except: ▪ $5 copayment for a complete maxillary or mandibular denture ▪ $5 copayment for partial acrylic upper or lower denture with clasps ▪ $5 copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles ▪ $5 copayment for removable unilateral partial denture ▪ $5 copayment for reline of upper, lower or partial denture when performed by a Laboratory ▪ $5 copayment for denture duplication	No copayment, except: ▪ $10 copayment for a complete maxillary or mandibular denture ▪ $10 copayment for partial acrylic upper or lower denture with clasps ▪ $10 copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles ▪ $10 copayment for removable unilateral partial denture ▪ $10 copayment for reline of upper, lower or partial denture when performed by a Laboratory ▪ $10 copayment for denture duplication
Other Benefits	Local anesthetics, Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure, Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of licensure, Emergency treatment, palliative treatment, Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.	No Charge	No Charge
Orthodontia Services	Not a Healthy Families Program covered benefit. Services are provided to members under the age of 19 through the California Children's Services Program (CCS) if the Member meets the eligibility requirements for medically necessary orthodontia coverage.	Not applicable	Not applicable
Deductibles	**No deductibles will be charged for covered benefits.**		
Annual Maximums	**No annual maximum.**		
Lifetime Maximums	**No lifetime maximum limits on benefits apply under this plan.**		

*Benefits are provided if the plan determines the services to be medically necessary.

BENEFITS AND COPAYMENTS
HFP / HKSB

ALL FREQUENCY LIMIT DATES ARE CALCULATED TO THE EXACT DATE

DIAGNOSTIC AND PREVENTATIVE				
120	Periodic oral evaluation	Once every 6 months	$0	$0
140	Limited oral evaluation	Problem focused evaluation, for a specific problem and or a dental emergency, trauma, acute infection, etc.	$0	$0
150	Comprehensive oral evaluation		$0	$0
210	Intraoral-complete series including bitewings	Once every 24 consecutive months	$0	$0
220	Intraoral-periapical-first film		$0	$0
230	Intraoral periapical-each additional film		$0	$0
240	Intraoral-occlusal film		$0	$0
270	Bitewing-single film		$0	$0
272	Bitewings-two films	Once every 6 months	$0	$0
274	Bitewings-four films			
330	Panoramic film	Once every 24 consecutive months	$0	$0
350	Photograph 1st		$0	$0
350	Photograph each additional (up to 7)		$0	$0
460	Pulp vitality tests		$0	$0
473	Histopathologic examinations		$0	$0
1110*	Prophylaxis - includes scaling of unattached tooth surfaces & polishing - adult (13 yrs and up)	Once every 6 months	$0	$0
1120*	Prophylaxis - children through age 12			
1201*	Topical application of flouride including prophylaxis-through age 5			
1203	Topical application fl excluding prophy-child			
1204	Topical application fl excluding prophy-adult			
1205*	Topical application of flouride including prophylaxis-adult(6-17)			
1206	Topical fluoride varnish			
1330	Oral hygiene instruction			
1351	Sealant - per tooth	Permanent 1st and 2nd molars only/once every 36 months	$0	$0
1510	Space maintainer - fixed unilateral	Must have adequate space to allow normal eruption of permanent tooth not a benefit for congentially missing teeth	$0	$0
1515	Space maintainer-fixed bialateral			
1525	Space maintainer-removeable-bilateral			
RESTORATIVE DENTISTRY				
2110	Amalgam - one surface primary	amalgam, composite resin, acrylic, synthetic or plastic restorations are covered for the treatment of caries lesions only. posterior resins will be down graded to an amalgam filling.	$0	$0
2120	Amalgam - two surfaces primary			
2130	Amalgam - three surfaces primary			

*NOTE AGE RESTRICTIONS

CDT CODE	PROCEDURE DESCRIPTION		HFP CO-PAY	HKSB CO-PAY
2131	AMALGAM - 4 OR MORE SURFACES PRIMARY	AMALGAM, COMPOSITE RESIN, ACRYLIC, SYNTHETIC OR PLASTIC RESTORATIONS ARE COVERED FOR THE TREATMENT OF CARIES LESIONS ONLY. POSTERIOR RESINS WILL BE DOWN GRADED TO AN AMALGAM FILLING.	$0	$0
2140	AMALGAM - ONE SURFACE PERMANENT			
2150	AMALGAM - TWO SURFACES PERMANENT			
2160	AMALGAM - THREE SURFACES PERMANENT			
2161	AMALGAM - 4 OR MORE SURFACES PERMANENT			
2330	ANTERIOR RESIN RESTORATION. ANY COMPOSITES, WHICH DO NOT MEET 2335 CRITERIA, ARE TO BE BILLED AS 2330. EXAMPLE: F, B, I, ETC.			
2331	ANTERIOR RESIN RESTORATION. ANY COMPOSITES WHICH, DO NOT MEET 2335 CRITERIA, ARE TO BE BILLED AS 2330. EXAMPLE: ML, F, B, DF, DL, MF, I, ETC.			
2332	ANTERIOR RESIN RESTORATION. ANY COMPOSITES WHICH, DO NOT MEET 2335 CRITERIA, ARE TO BE BILLED AS 2330. EXAMPLE : DFL, MFL, ETC.			
2335	COMPOSITE FILLING MUST MEET THE FOLLOWING CRITERIA TO BE BILLED AS 2335: A)INCLUDE INCISAL AND ONE OR MORE OTHER SURFACES B)INCLUDE BOTH MESIAL AND DISTAL, WITH OR WITHOUT OTHER SURFACE			
CROWNS				
THE COST OF PRECIOUS METALS USED IN ANY FORM OF DENTAL BENEFITS IS THE RESPONSIBILITY OF THE MEMBER				
2544*	ONLAY – METALLIC FOUR OR MORE SURFACES	FOR CHILDREN 12 YEARS AND OLDER (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) □ ONCE EVERY 36 MONTHS. ONLY IF A FILLING CAN NOT BE PLACED, AND NO MORE THAN 5 UNITS PER ARCH	$5.00	$0
2710*	CROWN - RESIN - LABORATORY	FOR CHILDREN UNDER 12 YEARS OLD ONCE EVERY 36 MONTHS	$0	$0
2740*	CROWN - PORCELAIN/CERAMIC SUBSTRATE	FOR CHILDREN 12 YEARS AND OLDER (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) ONCE EVERY 36 MONTHS. ONLY IF A FILLING CAN NOT BE PLACED, AND NO MORE THAN 5 UNITS PER ARCH	$5.00	$0
2750*	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL			
2751*	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL			
2752*	CROWN - PORCELAIN FUSED TO NOBLE METAL			
2781*	CROWN - 3/4 PREDOMINANTLY BASE METAL			
2790*	CROWN - FULL CAST HIGH NOBLE METAL			
2791*	CROWN - FULL CAST PREDOMINANTLY BASE METAL			
2792*	CROWN - FULL CAST NOBLE METAL			
2920	RECEMENT CROWN		$0	$0
2930	PREFAB STAINLESS STEEL CROWN PRIMARY TOOTH		$0	$0
2931	PREFAB STAINLESS STEEL CROWN PERMANENT TOOTH	FOR CHILDREN UNDER 12 YEARS OLD	$0	$0
2940	SEDATIVE FILLINGS	PAID AS 9110	$0	$0
2951	PIN RETENTION PER TOOTH IN ADDITION TO RESTORATION		$0	$0
2952	CAST POST AND CORE IN ADDITION TO CROWN		$0	$0
2954	PREFAB POST AND CORE IN ADDITION TO CROWN		$0	$0

CDT CODE	PROCEDURE DESCRIPTION		HFP CO-PAY	HKSB CO-PAY
2980	CROWN REPAIR - BY REPORT		$0	$0
	ENDODONTICS			
3110	PULP CAP, DIRECT, EXCLUDING FINAL RESTORATION		$0	$0
3220	THERAPEUTIC PULPOTOMY, EXCLUDING FINAL RESTORATION		$0	$0
3310	ROOT CANAL, ANTERIOR, EXCLUDING FINAL RESTORATION	RETREATMENT. ONLY IF SIGNS OF ABSCESS FORMATION PRESENT. NOT FOR REMOVAL OF SILVER POINTS, OVERFILLS, UNDERFILLS, OR BROKEN INSTRUMENTS WITHOUT PATHOLOGY.	$5.00 PER CANAL	$0
3320	ROOT CANAL, BICUSPID, EXCLUDING FINAL RESTORATION			
3330	ROOT CANAL, MOLAR, EXCLUDING FINAL RESTORATION			
3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY, ANTERIOR			$0
3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY, BICUSPID			
3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY, MOLAR			
3351	APEXIFICATION/RECALCIFICATION - INITIAL VISIT	THE APEXIFICATION PROCEDURE MAY BE REPEATED AT SIX-MONTH INTERVALS, AFTER THE INITIAL APEXIFICATION SESSION WITH PAYMENT ALLOWED FOR EACH TREATMENT.	$0	$0
3352	APEXIFICATION/RECALCIFICATION - INTERIM			
3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT			
3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR		$5.00 PER CANAL	$0
3421	APICOECTOMY/PERIRADICULAR SURGERY - BICUS FIRST ROOT			
3425	APICOECTOMY/PERIRADICULAR SURGERY - MOLAR SECOND ROOT			
3430	RETROGRADE FILLING - PER ROOT	INCLUDED IN THE GLOBAL FEE OF APICOECTOMY	$0	$0
3450	ROOT AMPUTATION - INCLUDING ANY ROOT REMOVAL		$0	$0
	PERIODONTICS			
4210	GINGIVECTOMY/GINGIVOPLASTY - PER QUADRANT	CO-PAYMENT, MUST INCLUDE POST SURGICAL VISITS	$0	$0
4211	GINGIVECTOMY/GINGIVOLPLASTY - PER TOOTH	NOT IN CONJUNCTION WITH CROWN PREPARATION	$0	$0
4260	OSSEOUS - MUCO - GINGIVAL SURGERY PER QUADRANT		$5.00	$0
4341	PERIODONTAL SCALING AND ROOT PLANING FOUR OR MORE TEETH PER QUADRANT	UP TO 5 QUADRANTS IN 12 MONTH PERIOD. A BENEFIT TO TREAT ABSCESS OR ACUTE PERIODONTITIS	$0	$0
4342	PERIODONTAL SCALING AND ROOT PLANING ONE TO THREE TEETH PER QUADRANT		$0	$0
4930	EMERGENCY PERIODONTAL TREATMENT		$0	$0
	PROSTHETICS			
5110	COMPLETE DENTURE - UPPER	ONCE EVERY 36 MONTHS	$5.00	$0
5120	COMPLETE DENTURE - LOWER			
5130	IMMEDIATE DENTURE - UPPER			
5140	IMMEDIATE DENTURE - LOWER			
5211	UPPER PARTIAL-RESIN BASED WITH CONVENTIONAL CLASPS, RESTS & TEETH			$0

CDT CODE	PROCEDURE DESCRIPTION		HFP CO-PAY	HKSB CO-PAY
5212	LOWER PARTIAL-RESIN BASED WITH CONVENTIONAL CLASPS, RESTS & TEETH			$0
5213	UPPER PARTIAL-CAST METAL RESIN BASED WITH CONVENTIONAL CLASPS, RESTS & TEETH	ONCE EVERY 36 MONTHS	$5.00	$0
5214	LOWER PARTIAL-CAST METAL RESIN BASED WITH CONVENTIONAL CLASPS, RESTS & TEETH			$0
5410	ADJUST COMPLETE DENTURE - UPPER		$0	$0
5411	ADJUST COMPLETE DENTURE - LOWER		$0	$0
5421	ADJUST PARTIAL DENTURE - UPPER		$0	$0
5422	ADJUST PARTIAL DENTURE - LOWER		$0	$0
5510	REPAIR BROKEN COMPLETE DENTURE BASE		$0	$0
5520	REPLACE MISSING/BROKEN T-COMPL. DENT- EACH T.		$0	$0
5610	REPAIR RESIN DENTURE BASE		$0	$0
5620	REPAIR CAST FRAMEWORK		$0	$0
5630	REPAIR OR REPLACE BROKEN CLASP		$0	$0
5640	REPLACE BROKEN TEETH - PER TOOTH		$0	$0
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE		$0	$0
5660	ADD CLASP TO EXISTING PARTIAL DENTURE		$0	$0
5730	RELINE COMPLETE UPPER DENTURE - CHAIRSIDE	ONE PER ARCH IN ANY 12 CONSECUTIVE MONTHS	$0	$0
5731	RELINE COMPLETE LOWER DENTURE - CHAIRSIDE			
5740	RELINE UPPER PARTIAL DENTURE - CHAIRSIDE			
5741	RELINE LOWER PART DENTURE - CHAIRSIDE			
5750	RELINE COMPLETE UPPER DENTURE - LABORATORY	ONE PER ARCH IN ANY 12 CONSECUTIVE MONTHS	$5.00	$0
5751	RELINE COMPLETE LOWER DENTURE - LABORATORY			
5760	RELINE UPPER PARTIAL DENTURE - LABORATORY			
5761	RELINE LOWER PARTIAL DENTURE - LABORATORY			
5820	INTERIM PARTIAL DENTURE (UPPER)	A BENEFIT ONLY IF USED AS ANTERIOR SPACE MAINTAINER IN CHILDREN	$0	$0
5821	INTERIM PARTIAL DENTURE - (LOWER)			
5850	TISSUE CONDITIONING, MAXILLARY	LIMITED TO TWO PER DENTURE	$0	$0
5851	TISSUE CONDITIONING, MANDIBULAR			
BRIDGES				
PONTIC				
6210*	PONTIC - CAST HIGH NOBLE METAL	CO-PAYMENT PER UNIT WHEN NECESSARY FOR PATIENTS (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY)	$5.00	$0
6211*	PONTIC - CAST PREDOMINANTLY BASE METAL			
6212*	PONTIC - CAST NOBLE METAL			
6240*	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	16 YEARS OLD OR OLDER AND WHOSE ORAL HEALTH PERMITS, FOR ANTERIOR TEETH ONLY. UP TO 5 UNITS ALLOWED PER ARCH. OPTIONAL WHEN PROVIDED WITH A PARTIAL DENTURE ON SAME ARCH OR WHEN ABUTMENT TEETH ARE DENTALLY SOUND.		
6241*	PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL			
6242*	PONTIC - PORCELAIN FUSED TO NOBLE METAL			
6251*	PONTIC - PONTIC RESIN PREDOMINANTLY BASE METAL			

CDT CODE	PROCEDURE DESCRIPTION		HFP CO-PAY	HKSB CO-PAY
RETAINER				
6545*	RETAINER - CAST METAL RESIN BOND FIX PROSTH.	CO-PAYMENT PER UNIT WHEN NECESSARY FOR PATIENTS (COST OF NOBLE METAL IS MEMBER RESPONSIBILITY) 16 YEARS OLD OR OLDER AND WHOSE ORAL HEALTH PERMITS, FOR ANTERIOR TEETH ONLY. UP TO 5 UNITS ALLOWED PER ARCH. OPTIONAL WHEN PROVIDED WITH A PARTIAL DENTURE ON SAME ARCH OR WHEN ABUTMENT TEETH ARE DENTALLY SOUND.	$5.00	$0
6740*	CROWN - PORCELAIN / CERAMIC			
6750*	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL			
6751*	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL			
6752*	CROWN - PORCELAIN FUSED TO NOBLE METAL			
6780*	CROWN - ¾ CAST HIGH NOBLE METAL			
6790*	CROWN FULL CAST HIGH NOBLE METAL			
6791*	CROWN - FULL CAST PREDOMINANTLY BASE METAL			
9792*	CROWN - FULL CAST NOBLE METAL			
6930	RECEMENT BRIDGE		$0	$0
6970	CAST POST AND CORE, IN ADDITION TO RETAINER		$0	$0
6980	BRIDGE REPAIR, BY REPORT		$0	$0
ORAL SURGERY				
7111	CORONAL REMNANTS - DECIDUOUS TOOTH		$0	$0
7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT		$0	$0
7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF FLAP AND REMOVAL OF BONE AND/OR SECTIONING OF TOOTH		$0	$0
7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE		$0	$0
7230	REMOVAL OF IMPACTED TOOTH PART BONY		$5.00	$0
7240	REMOVAL OF IMPACTED TOOTH - COMPLETE BONY		$5.00	$0
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS REQUIRING CUTTING OF SOFT TISSUE AND BONE AND CLOSURE		$5.00	$0
7270	TOOTH REIMPLANTATION/STABILIZATION		$0	$0
7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)		$0	$0
7286	BIOPSY OF ORAL TISSUE - SOFT		$0	$0
7310	ALVEOPLASTY IN CONJUNCTION WITH EXTRATIONS - PER QUADRANT		$0	$0
7311	ALVEOPLASTY IN CONJUNCTION WITH EXTRATIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT		$0	$0
7320	ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRATIONS - PER QUADRANT		$0	$0
7321	ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRATIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT		$0	$0
7410	EXCISION OF BENIGN LESION UP TO 1.25 CM		$0	$0
7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM		$0	$0
7450	REMOVAL OF BENIGN-ODONTOGENIC. CYST OR TUMOR LESION DIAMETER UP TO 1.25CM		$0	$0

CDT CODE	PROCEDURE DESCRIPTION		HFP CO-PAY	HKSB CO-PAY
7451	REMOVAL OF BENIGN-ODONTOGENIC. CYST OR TUMOR LESION DIAMETER GREATER THAN 1.25CM		$0	$0
7460	REMOVAL OF BENIGN NONODONTOGENIC. CYST OR TUMOR LESION DIAMETER UP TO 1.25CM		$0	$0
7461	REMOVAL OF BENIGN NONODONTOGENIC. CYST OR TUMOR LESION DIAMETER GREATER THAN 1.25CM		$0	$0
7472	REMOVAL OF PALATAL TORUS		$0	$0
7473	REMOVAL OF MANDIBULAR TORUS		$0	$0
7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE		$0	$0
7520	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL		$0	$0
7960	FRENECTOMY - SEPARATE PROCEDURE		$0	$0
	OTHERS			
9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR		$0	$0
9215	LOCAL ANESTHESIA		$0	$0
9220	GENERAL ANESTHESIA - FIRST 30 MINUTES	A BENEFIT ONLY WITH AUTHORIZED SURGICAL PROCEDURE	$0	$0
9221	GENERAL ANESTHESIA - EACH ADDITIONAL 15 MINUTES		$0	$0
9230	ANALGESIA, NITROUS OXIDE		$0	$0
9248	NON-INTRAVENOUS CONSCIOUS SEDATION	INCLUDES NON-INTRAVENOUS ADMINISTRATION OF SEDATIVEAND/OR ANALGESIC AGENT(S) AND APPROPRIATE MONITORING	$0	$0
9310	CONSULT DIAG. SVC BY NONTREAT PRACTITIONER		$0	$0
9430	OFFICE VISIT DURING REGULAR HOURS-NO OTHER SERVICES		$0	$0
9440	OFFICE VISIT – AFTER REGULAR SCHEDULED HOURS		$0	$0
9630	OTHER DRUGS AND OR MEDICATIONS BY REPORT		$0	$0
9920	BEHAVIOR MANAGEMENT		$0	$0
9930	COMPLICATIONS, POST SURGICAL, UNUSUAL, BY REPORT		$0	$0
9999	UNSPECIFIED ADJUNCTIVE PROCEDURE BY REPORT		$0	$0

Please use the following code to report missed or broken appointments.
Statement for broken appointment.

777	BROKEN APPOINTMENT	WITHOUT 24 HOUR NOTIFICATION	$5.00	$0

PREMIER ACCESS

2

Provider Responsibilities

A discussion of the responsibilities of each provider.

Each member who joins Premier may select any network Primary Care Dentist who is approved for HKSB/HFP under Premier. A Primary Care Dentist (PCD) is responsible for providing or coordinating all dental care for that member. This includes but is not limited to specialty referrals and coordination of services. Both Primary Care Dentists and Participating Specialists have certain responsibilities to ensure care provided to **Premier** members is provided under the appropriate requirements including covered benefits and referrals.

PCD Responsibilities

Primary Care Dentists are responsible to:

- Provide or coordinate all dental care for the member.
- Perform an initial dental assessment.
- Work closely with specialists to enhance continuity of patient care.
- Obtain prior authorization, when required, for any specialty referral or supplemental payment.
- Participate in **Premier's** Quality Management Program and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements.
- Arrange for coverage by another provider when necessary (vacation, illness, etc.)
- Provide for availability of after-hours for emergency services.
- Provide dental services to members during normal working hours, and during such other hours as may be necessary in order to keep patient appointment schedules on a current basis. (Dentist shall not differentiate by days or time of day when professional services are rendered to members.)
- Provider compliance with accessibility parameters shall be routinely monitored by **Premier** through member surveys, and review of complaints
- Corrective actions shall be implemented as needed, and monitored for effectiveness.
- Provide 24-hour emergency service, seven days a week.

- Refer patients who have California Children's Services eligible conditions to **Premier**. (Refer to the California Childrens's Services Chapter for more details.)
- Maintain dental records for five years from the date of service and make dental records available during regular business hours.
- Provide updated credential information upon request by the **Premier** Provider Relations Department. Credentialing is a recurring process, repeated every four years to verify that licenses and certification remain current for each dentist. An automated system generates reminder reports and letters when credentialing documents expire.
- Provide a complete copy of dental records including x-rays upon member request.
- Ensure that dental records are protected and confidential in accordance with all Federal and State laws and the California Dental Practice Act.
- Provide documentation within 5 days of receiving an acknowledgment letter from **Premier** regarding a patient complaint.
- Provider should not use aggressive sales techniques to sell optional (non-covered) services or inadequately document the consent of the member for accepting optional services.
- All covered dental services shall be provided in accordance with generally accepted dental practices and standards prevailing in the professional community at the time of treatment.
- As a participating network dentist, you will integrate specialty care into the member's course of dental treatment by referring to a specialist when necessary. The referrals need to be mailed to **Premier** in a timely manner.
- Inform the members of availability of free language assistance services for any linguistic need by calling the Plan's Member Services Representative at 1-888-584-5830.
- Provider shall comply with the **Premier's** Language Assistance Program (LAP) it has developed pursuant to Title 28, California Code of Regulations, Section 1300.67.04.

Updating Provider Information

Providers are required to inform Premier of changes in their practice in writing. Providers must report changes in practice, such as name and address changes, the addition of rendering associates, registered dental hygienists, tax identification information or the sale of your practice.

Specialist Responsibilities

All specialty care must be authorized by Premier and documented through a referral form that is initiated by the Primary Care Dentist (PCD). If a member requires

additional specialty care beyond the scope of the services authorized, the member must be referred back to the PCD for a new referral. Specialists are responsible to:

- Provide specialty care to members.
- Ensure prior authorization has been obtained.
- Work closely with primary care dentists to enhance continuity of patient care.
- Send a notification to PCD upon completion of treatment.
- Collect any applicable patient copayment.
- Participate in **Premier's** Quality Management Program and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements.
- Maintain dental records for five years from the date of service and make dental records available during regular business hours.
- Ensure that dental records are protected and confidential in accordance with all Federal and State laws and the California Dental Practice Act.
- Provide updated credential information upon request by the **Premier** Provider Relations Department. Credentialing is a recurring process, repeated every four years to verify that licenses and certification remain current for each dentist. An automated system generates reminder reports and letters when credentialing documents expire.
- Inform the members of availability of free language assistance services for any linguistic need by calling the Plan's Member Services Representative at 1-888-584-5830.
- The provider shall comply with the Premier's Language Assistance Program (LAP) it has developed pursuant to Section 1367.04 of the Knox-Keene Health Care Service Plan Act of 1975, as amended, and Title 28, California Code of Regulations, Section 1300.67.04.

PREMIER ACCESS

3

Referrals

When a referral is required, how to complete a referral and ensure it can be acted on promptly.

Referrals are required for services considered to be specialty treatments. The following is a brief explanation of specialty guidelines of **Premier**.

The Primary Care Dentist requesting the referral must submit a **Premier** specialty referral form. Providers are given a supply of Specialty Referral forms to keep in their offices. To obtain additional information regarding referrals you may contact **Premier** at:

1-888-584-5830, or
Providerrelations@**Premier**life.com

Information provided by dental offices is key to authorizations. Decisions authorizing referrals for specialty services are based on information provided by your office to **Premier**. **Premier's** Dental Consultants make the final decisions regarding authorization for specialty services.

The Dental Consultant, who is a California licensed dentist, reviews all referral decisions requiring professional judgment, including all potential denials.

Referrals are valid for 90 days from the date of approval by Premier.

Regular Specialty Referrals

A regular (non-emergency) referral is obtained by completing a referral form and mailing the form to Premier. Documentation supporting the reasons for the referral must be included with the referral form**.** **Premier** will respond to a referral request within five (5) business days from the date the request is received in our offices. The form should be mailed to:

Premier Access Insurance Company
P.O. Box 659010
Sacramento, CA 95865-9010
Attn: Specialty Referral

Regular referrals must be mailed as soon as possible.

Determinations of referrals are based on submitted documentation and the benefit as outlined in Title 22, Title 10 and the Department of Health Care Services Medi-Cal Dental Program Manual of Criteria for Dental Services. A copy of the approved Specialty Referral form is sent to the specialist, the member and the PCD. In addition, the PCD and member receive a letter notifying them of the approval and advising them, when appropriate, that follow-up treatment needs to be performed by the PCD.

Specialty referrals may be denied for any of the following reasons:

- Lack of eligibility.
- Procedure not a benefit.
- Insufficient documentation.
- Dental necessity for procedure not evident.
- Poor prognosis or longevity questionable.
- Procedure requested is within the scope of the PCD.

Decisions resulting in denial, delay or modification of all or part of the requested dental services shall be communicated to the member in writing within two business days and to the member's treating provider within 24 hours of the decision.

Denial notification includes the rationale for the denial as well as the member's right to appeal the decision and the appeal process, including timeframes for submitting an appeal. Members are also advised of their right to seek a second or third opinion at no charge. The Referral/Case Management Coordinator assists the member in obtaining a second or third opinion.

When a referral is denied because the services fall within the scope of the PCD, the member is instructed to return to their PCD for treatment.

Emergency Specialty Referrals

An emergency referral is available for patients requiring immediate treatment. An emergency referral may be requested by telephone with a fax confirmation to **Premier**'s Referral Department.

Telephone number: 888-584-5830 or
Faxed to: 916-679-7197

Premier will respond to an emergency referral request within seventy-two (72) hours from the time the request is received in our offices. If the request for emergency referral is approved,

Premier will contact the specialty provider to inform him/her of the patient's urgent need for treatment and authorization by **Premier**.

While emergency specialty referrals do not require prior authorization, specialty providers are requested to notify **Premier** prior to treating the member whenever possible. This is done to ensure that the provider understands **Premier**'s program and does not provide routine non-emergent dental services for which he or she may not be reimbursed.

Dental emergency (emergent) services are defined as follows:

Those services required for alleviation of severe pain, severe swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions, which, if not immediately diagnosed and treated, would lead to disability or harm to the member.

Specialty Referrals by Category

Premier authorizes referrals to specialists only for treatment of conditions that are beyond the scope of the general practitioner so as long the services are covered benefits under the Healthy Families Program or Healthy Kids Santa Barbara.

Prior to referring a patient to a specialist, the Primary Care Dentist must send a "specialty referral request" to Premier with information indicating the need for the specialty referral.

Premier reserves the right to select the specialist for the required services.

General Guidelines: Complete Member information must be submitted with the referral request, i.e., Member ID#, Date of Birth and supporting documentation, as to why the general dentist is unable to perform the requested services.

Diagnostic, mounted and dated pre-op x-rays must be submitted with the referral request. Please indicate the reason, if x-rays are not available.

Endodontics: All routine endodontic procedures are the responsibility of the General Dentist. This includes treatment of root canal fillings for a single and multi-canal teeth. The Dentist must also provide emergency pulpal treatment such as, pulpal debridement and/or open and medicate.

Referrals may be made for complicated "tried and failed" cases such as calcified canals, curved roots, apicoectomies, and retro fillings.

Pedodontics: The General Dentist is responsible for the routine care of children of all ages. Routine care includes but not limited to extractions, fillings, stainless steel crowns, pulpotomies, space maintainers, sealants, prophylaxis, and fluoride treatment.

Young children with complicated behavior management may qualify for a referral to a specialist, if at least one documented

attempt has been made by the Dentist in treating the patient. Special needs individuals may be considered as exceptions to this policy.

Periodontics: The General Dentist is responsible for the diagnosis and maintenance of their patient's periodontal care including, but not limited to prophylaxis root planning and oral hygiene instruction.

Specialty referral procedures may include: gingival surgery and osseous surgery. All periodontal referrals must indicate that the following procedures have been performed by the General Dentist, prior to the referral:

- Complete exam, full mouth x-rays, full periodontal examination, full mouth root planning and recall periodontic exam within 3 to 6 months from the date of the initial root planning.
- Periodontal referrals may be authorized for treatment of periodontal disease.

Oral Surgery: The General Dentist is responsible for providing Oral Surgery for erupted dentition, including simple and surgical extractions, root sectioning and retrieval, soft tissue impaction, intra-oral incision and drain, and/or routine minor surgical procedures.

Please note that removal of impacted teeth (including wisdom teeth) with no pathology is not a benefit under the plan. Extractions will be considered only with evidence of existing pathology. Removal of immature third molars, which are currently impacted, is not a covered benefit.

Treatment of developmental or malformation conditions, such as mesiodent and supernumerary teeth, is not a benefit under the Healthy Families Program or Health Kids Santa Barbara.

Referral to an Oral Surgeon may be considered for the following conditions:

- Full and/or Partial bony impactions when evidence of pathology exists.
- Biopsies, cysts and tumor removal.
- Children with special needs requiring dentistry in a hospital setting.

Oral surgery procedures related to orthodontic treatments are not covered benefits under the Healthy Families Program or Health Kids Santa Barbara.

Anesthesia: The use of General Anesthesia or I.V. Sedation is only a benefit when provided by an Oral Surgeon with a valid permit in cases of severe or prolonged surgical procedures.

Orthodontics: Orthodontics and orthodontic related procedures are not a benefit under the Healthy Families Program or Health Kids Santa Barbara. Members may be eligible to receive orthodontic treatment from California Children's Services (CCS) Program. More information can be obtained by contacting our Member Services Department or contacting the CCS office in your County. (Refer to the California Children's Services Chapter for more details.)

Other: An authorization for a second opinion.

Denial of Referral Due to Inadequate Information

If **Premier** receives a referral form that lacks required information, the referral form is returned to the PCD with a listing of the missing information. The missing information must be included when the referral form is resubmitted to **Premier**. If the missing information is not submitted, **Premier** cannot process the referral.

Second Opinion

Premier members are entitled to a second opinion for their treatments. A request for a second opinion may also be submitted to **Premier** by a participating PCD or any other participating provider such as a specialist, who is treating a member.

If a member requests a second opinion, your office should contact **Premier** and request a referral to another provider. **Premier** will then provide the member with an authorization to obtain a second opinion.

If a member is requesting a second opinion about care from his or her PCD, the second opinion shall be provided by an appropriately qualified dental provider of the member's choice within **Premier**'s network. An appropriately qualified health care professional means a primary care dentist, specialist, or other licensed health care provider who meets these requirements.

If a member is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the member's choice within **Premier**'s network of the same or comparable specialty. If the specialist is not within **Premier**'s network, **Premier** shall incur the cost or negotiate the fee arrangements of that second opinion, beyond the applicable copayments paid by the member. If there is no participating **Premier** provider within the network who is an appropriately qualified dentist, **Premier** shall authorize a second opinion by an appropriately qualified dentist outside of **Premier**'s provider network. **Premier** shall take into account the ability of the member to travel to the provider. The cost of obtaining the second opinion will be borne by **Premier**. Providers who are treating members also can request second opinions.

The reasons for a second opinion shall include, but are not limited to the following reasons:

- Member questions the reasonableness or necessity of the recommended procedures.
- Member questions the diagnosis or plan of care for a condition that threatens loss of life, substantial impairment, including a serious chronic condition.
- The clinical indications are not clear, the provider is unable to diagnose the condition or the diagnosis is unclear due to conflicting test results and the member requests additional diagnosis.
- The treatment plan in progress is not improving the dental condition of the member within an appropriate period of time given the diagnosis and the member requests a second opinion regarding the diagnosis or continuance of treatment.
- Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Premier shall review the reasons for the request for a second opinion and provide an authorization or a denial in an expeditious manner. The second opinion will be rendered within 72-hours from receipt of request by **Premier** where the member's condition poses imminent and serious threat to the member's life.

Premier shall require the provider who is rendering the second opinion to provide the member and the initial provider with a consultation report, including any recommended procedures or tests that this second provider deems appropriate.

In the event that **Premier** denies a request by a member or a treating provider for a second opinion, **Premier** shall notify the member and the provider in writing of the reasons for the denial and shall inform the member and the provider of the right to file a grievance with **Premier** .

Members, providers, or public interested in obtaining the timeline for authorizing second dental opinions can contact **Premier** at:

Premier Access Insurance Company
P. O. Box 659010
Sacramento, CA 95865-9010
Attn: Specialty Referrals

Completion of the Referral Form

The date of authorization of a specialty referral is the date from which the 90-day authorization period is calculated. An authorization will expire 90 days after this date. Services must be provided prior to expiration of the authorization. Additional documentation of the referral request may be required.

Premier's Specialty Referral Form must be completed for all referral authorizations, including emergency referrals. Instructions for completing the form are shown below. A

sample form that corresponds to the numbers on these instructions is included on the next page.

1. Check the box for the type of referral (routine or emergency) and the program coverage of the patient.
2. Complete patient information must be provided.
3. The requesting PCD must complete the provider information, including the provider license number.
4. The specific specialty referral must be indicated.
5. The inclusion of required documentation and x-rays (if any) must be noted.
6. The requesting PCD must complete the information, including procedure code and description of the service to be provided by the specialist and a statement regarding the need for a specialist.
7. The requesting PCD must sign and date the referral form.

PREMIER ACCESS

SPECIALIST REFERRAL FORM

☐ HFP ☐ HKSB

Mail to: Premier Access Insurance Company – Referral Department
PO Box 659010 • Sacramento, CA • 95865-9010
Telephone: 888-584-5830 • Fax: 877-679-7197 or (916) 679- 7197

PLEASE CHECK APPROPRIATE BOXES:

❶ ☐ **Routine Referral** ☐ **Emergency Referral**

PATIENT INFORMATION	**REFERRING DENTIST INFORMATION**
Patient Name: ❷	Provider Name: ❸
Parent's Name (if minor):	License Number:
Member ID#:	Provider Phone Number:
Phone: DOB:	Provider Fax Number:
Address:	Address:
City, State, Zip:	City, State, Zip:
Social Security Number (optional):	License Number:

REQUEST FOR REFERRAL: ❹

☐ **Endodontist** ☐ **Pedodontist** ☐ **Periodontist**
☐ **Oral Surgeon** ☐ **Orthodontist** ☐ **Other**

ATTACHMENTS: ❺ ☐ **X-rays included:** ☐ **YES** ☐ **NO** **If yes, how many?**_____ **(PLEASE ATTACH FILMS TO THIS FORM)**

DESCRIBE THE PROCEDURE AND REASON FOR SPECIALTY REFERRAL

❻

PATIENT MUST BE ELIGIBLE FOR COVERAGE AT TIME OF SERVICE

IN MY PROFESSIONAL JUDGMENT THE TREATMENT LISTED REQUIRES A SPECIALIST: ☐ YES ☐ NO

REFERRING DENTIST SIGNATURE: ❼ _____ **DATE:** _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF APPROVAL.

FOR PREMIER ACCESS USE ONLY

Eligibility: ☐ Yes ☐ No Date: Initial:

PLEASE SEE ATTACHED RESPONSE TO SPECIALTY REFERRAL REQUEST FOR THE FOLLOWING

☐ Approved	Date:	Initial:
☐ Modified	Date:	Initial:
☐ Insufficient Information	Date:	Initial:
☐ Denied	Date:	Initial:

Premier Access – HFP / HKSB Specialty Referral Guidelines

Premier Access authorizes referrals to specialists only for treatment of conditions that are beyond the scope of the general practitioner so as long the services are covered benefits under Healthy Families Program.

Prior to referring a patient to a specialist, the Primary Care Dentist must send a "specialty referral request" to Premier Access with information indicating the needs for the specialty referral.

Premier Access reserves the right to select the specialist for the required services.

General Guidelines: Complete Member information must be submitted with the referral request, i.e., Member CIN #, Date of Birth and supporting documentation as to why the general dentist is unable to perform the requested services.

Diagnostic, mounted and dated pre-op x-rays must be submitted with the referral request. Please indicate the reason, if x-rays are not available.

Endodontics:

All routine endodontic procedures are the responsibility of the General Dentist. This includes treatment of root canal fillings for single and multi-canal teeth. The Dentist must also provide emergency pulpal treatment such as, pulpal debridement and/ or open and medicate.

Referrals may be made for complicated "tried and failed" cases such as calcified canals, curved roots, apicoectomies, and retro fillings.

Pedodontics:

The general Dentist is responsible for the routine care of children of all ages. Routine care includes extractions, fillings, stainless steel crowns, pulpotomy, space maintainers, sealants, prophylaxis, and fluoride treatment. Young children with complicated management problems may constitute an appropriate referral to a specialist if at least two documented attempts with date of attempts, have been made by the Dentist in treating the patient. Some Patients with special health care needs may be considered as exceptions to this policy.

Approvals of pedodontic referrals will not be authorized for children ages 6 years and older.

Periodontics:

The General Dentist is responsible for the diagnosis and maintenance of their patient's periodontal care including, but not limited to prophylaxis, root planning and oral hygiene instruction.

Specialty referral procedures may include: gingival surgery and osseous surgery. All periodontal referrals must indicate that the following procedures have been performed by the General Dentist, prior to the referral:

Complete exam, full mouth x-rays, full periodontal examination, full mouth root planning and recall periodontic exam within
3-6 months from the date of the initial root planning

Periodontal referrals may be authorized for treatment of periodontal disease.

Oral Surgery:

The General Dentist is responsible for providing Oral Surgery for erupted dentition, including simple and surgical extractions, root sectioning and retrieval, soft tissue impaction, intra-oral incision and drain, and/or routine minor surgical procedures.

Please note that removal of impacted teeth, including wisdom teeth, with no pathology is not a benefit under the plan. Extractions will be considered only with evidence of existing pathology. Removal of immature third molars, which are currently impacted, is not a covered benefit.

Treatment of developmental or malformation conditions such as mesiodent and supernumerary teeth is not a benefit under the Healthy Families Program.

- Referral to an Oral Surgeon may be considered for the following conditions:
- Full and/ or Partial bony impactions when evidence of pathology exists.
- Biopsies, cysts and tumor removal
- Children with special needs requiring dentistry in a hospital setting.

Oral surgery procedures related to orthodontic treatments are not covered benefits under the Healthy Families Program.

Anesthesia:

The use of General Anesthesia or I.V. Sedation is only a benefit when provided by an Oral Surgeon with a valid permit in cases of severe or prolonged surgical procedures.

Orthodontics:

Orthodontics and orthodontic related procedures are not a benefit of the Premier Access Healthy Families Program. Members may be eligible to receive orthodontic treatment from California Children's Services (CCS) Program. More information can be obtained by contacting our Member Services Department or contacting the CCS office in your county.

PREMIER ACCESS

4

Claims Processing and Provider Dispute Resolution Mechanism

How to submit a claim and challenge, appeal or request reconsideration of a denied or contested claim.

After a provider delivers treatment to a **Premier** member, the provider must complete a claim form and submit it to**Premier**. The claim form must include the name of the program under which the member is covered (HFP or HKSB).

Review criteria for claims processing has been adopted from the Medi-Cal dental program provider manual. This criteria is applied with covered benefits, limitations, and exclusions of **Premier's** Programs. Claims without valid authorization may be denied.

Claims Processing

To ensure claims are processed accurately and timely, Premier **providers must adhere to the following guidelines:**

Claim Submission Instructions

The following sections describe **Premier's** claims submission process.

Notice and Proof of Claim

Written notice of a claim must be given to Premier within 30 days after the occurrence or commencement of any covered service or supply, or as soon thereafter as reasonably possible, but no later than 180 days from the date of service. Any appeals related to the adjudication of claims by Premier must be submitted no later than 180 days from the date of the original / first Explanation of Payments related to that claim. Claims submitted more than 180 days after the date of service will not be considered for payment. Appeals submitted 180 days after the date of the original / first Explanation of Payments will not be considered by Premier.

All claims and appeals must be sent to the Plan at:

Premier Access Insurance Company
Claims Department
P. O. Box 659010
Sacramento, CA 95865-9010

Acknowledgment of Claims

Premier will acknowledge the receipt of each claim by mail. You may also verify **Premier's** receipt of your claim by contacting **Premier's** Member Services at 1-888-584-5830.

Claim Submission Requirements

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by Premier:

- All claims must be submitted to **Premier** for payment for services no later than 180 days after the date of service.
- All claims must include the name of the program under which the member is covered (HFP or HKSB) and all the information and documentation necessary to adjudicate the claim.
- For emergency services, please submit a standard claim form which must include all the appropriate information, including pre-operative x-rays and a detailed explanation of the emergency circumstances.

Fee Schedules

Contracted providers may request the complete fee schedule by contacting **Premier**'s Provider Relations Department at 800-640-4466.

Claims Overpayment

The following sections describe the process that will be followed if **Premier** determines that it has overpaid a claim.

Notice of Overpayment of a Claim

If **Premier** determines that it has overpaid a claim, **Premier** will notify the provider in writing through a separate notice clearly identifying the claim; the name of the patient, the date of service and a clear explanation of the basis upon which **Premier** believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Contested Notice

If the provider contests **Premier's** notice of overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, must send written notice to **Premier** stating the basis upon which the provider believes that the claim was not overpaid. **Premier** will process the contested notice in accordance with **Premier's** contracted provider dispute resolution process described in the section titled Provider Dispute Resolution Process.

No Contest

If the provider does not contest **Premier's** notice of overpayment of a claim, the provider must reimburse **Premier** within 30 working days of the provider's receipt of the notice of overpayment of a claim. In the event that the provider fails to reimburse **Premier** within 30 working days of the receipt of overpayment of the claim, **Premier** is authorized to offset the uncontested notice of overpayment of a claim from the provider's current claim submissions.

Offsets to Payments

Premier may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when; (1) the provider fails to reimburse **Premier** within the timeframe set forth above, and (2) **Premier's** contract with the provider specifically authorizes **Premier** to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, **Premier** will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

Provider Dispute Resolution Process

Definition: A contracted or non-contracted provider dispute is a provider's written notice to **Premier** challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

Dispute Resolution Process for Contracted Providers

Each contracted provider dispute must contain, at a minimum, the following information: provider's name; provider's license number, provider's contact information, and:

- If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from **Premier** to a contracted provider: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.
- If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on the issue.

Premier will resolve any provider dispute submitted on behalf of an enrollee through **Premier's** Consumer Grievance Process. A provider dispute submitted on behalf of an enrollee **will not be resolved through Premier's Provider Dispute Resolution Process.**

Sending a Contracted Provider Dispute to Premier

Contracted provider disputes submitted to **Premier** must include the information listed above for each contracted provider dispute. All contracted provider disputes must be sent to the attention of the Provider Dispute Resolution Mechanism Department at the following address:

Premier Access Insurance Company
ATTN: Provider Dispute Resolution Mechanism Department
8890 Cal Center Drive
Sacramento, CA 95826

Time Period for Submission of Provider Disputes

- Contracted provider disputes must be received by **Premier** within 365 days from **Premier's** action that led to the dispute (or the most recent action if there are multiple actions).
- In the case of **Premier's** inaction, contracted provider disputes must be received by **Premier** within 365 days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
- Contracted provider disputes that do not include all required information may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to **Premier** within thirty (30) working days of your receipt of a returned contracted provider dispute.

Acknowledgment of Contracted Provider Disputes

Contracted provider disputes will be acknowledged by **Premier** within fifteen (15) working days of the date of receipt by **Premier**.

Contracted Provider Dispute Inquiries

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to the Provider Dispute Resolution Mechanism Department at: 1-800-270-6743 ext. 6008.

Instructions for Filing Substantially Similar Contracted Provider Disputes

Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted with a cover sheet for each batch describing each provider dispute.

Time Period for Resolution and Written Determination of Contracted Provider Disputes

Premier will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments

If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, **Premier** will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

Dispute Resolution Process for Non-Contracted Providers

Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

- If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from **Premier** to the provider the following must be provided: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect.
- If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

The dispute resolution process for non-contracted providers is the same as the process for contracted providers.

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Quality Management Program

Premier Access expects providers to provide the highest quality dental care to all members with an emphasis on dental disease prevention and the provision of exceptional customer service to members.

Monitoring of Provider Performance

Ongoing monitoring of provider performance occurs most often as a result of investigations conducted when potential quality of care issues (PQI) are identified and confirmed on individual case, from information obtained during grievances/appeals investigations, or other daily functions such as clinical review of referrals, treatment authorizations and claims.

Premier Access uses the criteria set by California Association of Dental Plans (CADP) for reviewing the process of care and the facility of the provider.

Premier's dental providers are expected to cooperate with the recommendations and corrective actions of the Dental Director.

CADP Structural Review Evaluation Measures, and CADP Process of Care Evaluation Criteria are provided on the following pages.

CADP
STRUCTURAL REVIEW EVALUATION MEASURES

Review Criteria	Reviewer Evaluation Measures
I. Accessibility	
A. 24 Hour Emergency Contact System?	Active after hours mechanism (Answering machine, answering service, cell phone, or pager) available for 24hour / 7 day a week contact or instructions. 1. Patients informed of emergency system for 24/7 access. 2. Inability to provide 24-hour access for dental emergencies is a departure from accepted standard of care.
B. Reasonable appointment scheduling for plan members?	The patients wait time to schedule an appointment should be reasonable and appropriate according to filed access standards (Individual to each Plan). 1. Urgent Appointments - Within 72 Hours 2. Non-urgent Appointments- Within 36 Business Days 3. Preventive Dental Care Appointments- Within 40 Business Days
C. Language Assistance Program and Documents?	Patients requiring Language Assistance can receive it. Confirm languages spoken in office- indicate in check box or via manual entry those languages spoken. Provider knows how to contact plan to obtain language assistance for patients needing translation and/or interpretation services. Provider knows to document a patient's refusal of assistance in the patient's treatment record.
II. Facility and Equipment	
A. Clean, safe neat and well-maintained	Verification made that facility and equipment are clean, safe and in good repair 1. There are no visible stains or significant scarring of furniture or floors. 2. There is no debris on floors or other areas, especially patient care, reception, infection control areas and laboratories. 3. Décor should be in good taste, easily cleaned and well maintained 4. For protection of everyone, employees and patients, lighting should be sufficient to allow safe ingress/egress and to maintain good vision without fatigue. 5. Dental equipment should be appropriate and in good working condition: a. No equipment with obviously broken parts, visible damage, temporary repairs or grossly torn upholstery. b. Current certification results for equipment requiring local, state or federal certification on file at the facility. (radiographic equip/ medical waste)

CADP
STRUCTURAL REVIEW EVALUATION MEASURES

Review Criteria	Reviewer Evaluation Measures
B. Compliance with mercury hygiene, safety regulations?	Compliance with mercury hygiene, safety regulations. 1. Amalgamators covered. 2. Bulk mercury and scrap amalgam stored in sealed, unbreakable containers. 3. Mercury spill kit.
C. Nitrous Oxide Recovery System?	Verification that nitrous oxide equipment is clean, safe and in good repair. 1. No visible cracking or destruction to hoses or nose piece. 2. Recovery System with connection to exhaust or suction system. Usually requires a minimum of four hoses for this to be accomplished. 3. Fail Safe mechanism present for correct delivery of gasses.
D. Lead Apron (with thyroid collar for patient)	There should be a lead apron present with a thyroid collar. The collar does not have to be attached to the apron, but must be used on all patients when exposing radiographs. Separate thyroid collar is acceptable.
III. Emergency Procedures and Equipment	
A. Written emergency protocols?	For fire and/or natural disasters: 1. A plan indicating escape routes and staff member's responsibilities, including calling for help. 2. Exits clearly marked with exit signs. 3. Emergency numbers posted (911, Fire, Ambulance and local 7-digit numbers in both front office and back office or lab). Written protocol for calling for help. Note: If office protocol entails only calling 911, this section does not apply and evaluation should be marked "N/A".
B. Medical emergency kit on-site?	Medical emergency kit should be easily accessible and labeled with an inventory of contents. All required drugs (per JADA 3/2002 article) are current. Staff should be aware of location of kit. Recommend staff in-service training for general use of contents.
C. Portable oxygen supply available?	Portable oxygen supply tank / ambu- bag for medical emergencies should be available. 1. Recommend tanks be maintained full and a positive pressure bag or ambu bag be available. 2. Recommend staff in-service training for use of emergency oxygen source. 3. Staff should be aware of and have access to location.

CADP
STRUCTURAL REVIEW EVALUATION MEASURES

Review Criteria	Reviewer Evaluation Measures
IV. Sterilization and Infection Control	
A. Sterilization and infection control protocols followed?	Verify sterilization and infection control procedures are in place. Verify staff trained in sterilization and infection control procedures and protocols. Sterilization and infection control procedures shall conform to the Dental Board of California. (DPA Section 1680dd, January 1993)
B. Protocols posted for sterilization procedures?	Protocols conspicuously posted. Dental Board of California. (DPA Section 1005b23, January 2001)
C. Weekly biological (spore) monitoring of sterilizer?	Sterilization procedures shall be monitored weekly and recorded, by appropriate methods, as required by the Dental Board of California. (DPA Section 1005b14, January 2001)
D. All instruments and hand-pieces properly cleaned, sterilized, and stored?	1. Contaminated instruments are properly cleaned. a. Utility gloves used. b. Ultrasonic cleaning recommended. Solutions changed per manufacture's specifications. 2. Acceptable procedures for sterilization are: a. Storage of instruments shall be in sterile bags or packs that are sealed. There should be no evidence of moisture or torn bags. Instruments must remain in sealed, sterile bags or packs until ready for use. Once opened, all instruments must be rebagged and resterilized, regardless of whether they were used or not. b. Hand-pieces must be properly sterilized between patients and bagged until use. c. Instruments, which cannot be cold-sterilized, or autoclaved, must be disposable and must be disposed of immediately after use. d. High level disinfectant should be utilized only on instruments that cannot be subjected to other methods of sterilization
E. Log kept monitoring changing of Sterilization solution?	Maintain a written log indicating: 1. Acceptable EPA registered brand name of the cold sterilant (high-level disinfectant) tuberculocidal hospital disinfectant, utilized according to the manufacturer's recommendations for sterilization. 2. Indicate dates solution changed, and dates of expiration of fresh solution. 3. Indicate name of staff member making the change. (Dental Practice Act)

CADP
STRUCTURAL REVIEW EVALUATION MEASURES

Review Criteria	Reviewer Evaluation Measures
F. Staff wears appropriate personal protective equipment?	1. Personnel shall always use protective gloves, masks, eyewear, coats or gowns during patient care. 2. Splattered masks and garments should be replaced as necessary. 3. Gloves must be changed between patients and before leaving the operatory.
G. Proper and adequate use of barrier techniques?	1. Verification made that hard surfaces in all operatories are disinfected between patients and at the end of each day. A Cal OSHA/EPA approved solution should be used. 2. Verification made that surfaces not capable of being disinfected by routine methods should be covered with impervious materials.
H. Hand-pieces and waterlines flushed appropriately?	Operatory unit water lines shall be flushed between each patient and in the morning before use, for an appropriate amount of time (per manuf. guidelines).
I. Infection control and cross contamination prevention procedures followed in the office and laboratory?	1. The pumice pan should be changed after each use and rag wheels should be sterilized after each use or discarded. 2. Impressions, dentures and other appliances going to and coming from the laboratory should be properly rinsed and disinfected.

CADP
PROCESS OF CARE EVALUATION CRITERIA

Review Criteria	Reviewer Evaluation Measures
I. DOCUMENTATION	
A. Medical History	
1. Comprehensive information collection	General medical history with information pertaining to general health and appearance, systemic disease, allergies and reactions to anesthetics. Should include a list of any current medications and/or treatment. Proactive format is recommended. Name & telephone number of physician and person to contact in an emergency. Patient must sign and date all baseline medical histories. Must Questions: 1) Bisphosphonate Use and 2) Latex Sensitivity
2. Medical follow-up	Patient comments, DDS/DMD notes, or consultation with a physician should be documented in the chart.
3. Appropriate medical alert	Should be uniform and conspicuously located on the portion of the chart used during treatment and should reflect current medical history.
4. Doctor signature and date	Dentist must sign and date all baseline medical histories after review with patient.
5. Periodic update	Documentation of medical history updates at appropriate intervals. Must be signed by the patient and the provider. Acceptable on medical history form or in the progress notes. Should reflect changes or no changes. Recommend update be done at least annually.
B. Dental History/Chief Complaint	Documentation of chief complaint and pertinent information relative to patient's dental history.
C. Documentation of Baseline Intra/Extra Oral Examination	
1. Status of teeth/existing conditions	Grid or narrative of existing restorations and conditions.
2. TMJ/Occlusal evaluation	Evidence of TMJ exam or evaluation of occlusion (classification) should be determined.
3. Prosthetics	Evaluation of existing appliance(s)(age, condition etc.), teeth replaced, clasps,etc.
4. Status of periodontal condition	a. Condition of gingival tissue, calculus, plaque, bleeding on probing, etc. b. Evidence of baseline probing should be documented (if indicated). c. Case type of perio conditions (Type I-IV) or (Normal, Gingivitis, or Slight, Moderate or Severe Periodontitis). Should be verified with radiographs/ pocket documentation.
5. Soft tissue/oral cancer exam	a. Evidence that soft tissue /oral cancer exam was performed initially and periodically (at least annually) b. Notation of any anatomical abnormalities
D. Progress Notes	
1. Legible and in ink	Provider should be reminded that progress notes are a legal document, all should be in ink, legible and should be in sufficient detail. Corrections should be made by lining-out. Documentation of any follow-up instructions to the patient or recommendations for future care. Documentation of patient leaving the practice and reasons, if known. Documentation if any records forwarded, etc.
2. Signed and dated by provider	All entries must be signed or initialed and dated by the treating provider. (Per CA. Dental Practice Act, Section 1683)

3. Anesthetics	Notation in progress notes as to the type and amount of anesthetic used; or notation "no anesthesia used" for applicable situations. (Including info on vaso-constrictors used, if any)
4. Prescriptions	Medications prescribed for the patient are documented and Sig., Rx, and Disp. in the progress notes or copies of all prescriptions are kept in the chart. Notation of an Rx given on phone. Recommended that dental lab prescriptions be documented in the progress notes or a copy kept in the chart.
II. QUALITY OF CARE	
A. Radiographs	
1. Quantity/Frequency	a. Adequate number of radiographs to make an appropriate diagnosis and treatment plan, per current FDA guidelines. b. Recall x-rays should be based on current FDA guidelines. Depends on complexity of previous & proposed care, caries susceptibility, amount and type of treatment and time since last radiographic exposure. c. Whenever possible, radiographs should not be taken if recent acceptable films are available from another source (previous Dentist). d. Any refusal of radiographs should be documented.
2. Technical Quality	a. No overlapping contacts, or cone cuts that affect diagnostic value; periapical films should show apices. b. Good contrast, not over or underdeveloped; no chemical stains.
3. Mounted, labeled and dated	Recent radiographs must be mounted, labeled and dated for reviewing and comparison with past radiographs.
B. Treatment Plan	
1. Present and in ink	a. Comprehensive documentation of patient needs and treatment recommendations, all documentation in ink. b. Consistent with diagnosis and clinical exam findings. c. Alternative treatment plans and options should be documented with clear concise indication of what the patient has elected to have performed. d. Consultations and referrals should be noted when necessary.
2. Sequenced	Case should be sequenced in order of need and consistent with diagnostic and examination findings, and in compliance with recognized accepted professional standards. (Dental Practice Act, Section 1685) A possible sequence follows: a. Relief of pain, discomfort and infection. b. Prophylaxis and instructions in preventive care. c. Treatment of extensive caries and pulpal inflammation. Endodontic therapy. d. Periodontal treatment e. Replacement of missing teeth, or restorative treatment f. Placement of patient on recall schedule with documentation of progress notes.

3. Informed Consent	a. Documentation that treatment plan has been reviewed with the patient and that the patient understands the risks, benefits and alternatives to care. Patient should also understand the financial component of the treatment proposed. b. An appropriate form signed by the patient is recommended. Documentation that all patient's questions were answered. Evidence of a 'meeting of the minds'. c. Documentation of any refusal of recommended care, including referrals.
III. TREATMENT OUTCOMES OF CARE	
A. Preventive Services	
1. Diagnosis	Documentation that prophylaxis was performed in a timely manner. Documentation of fluoride treatments planned or rendered, as appropriate to age of patient and caries incidence.
2. Oral Hygiene Instructions	Documentation of Home Care/ Oral Hygiene instructions given to patient.
3. Recall	Documentation of timely, case appropriate recall of patient.
B. Operative Service	
1. Diagnosis	Recall and past radiographs used to evaluate proper diagnosis of caries and the need for treatment. Treatment performed in a timely manner.
2. Restorative Outcome and Follow-Up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
C. Crown and Bridge Services	
1. Diagnosis	Recall and past radiographs used to evaluate the need for treatment. Treatment performed in a timely manner.
2. Restorative Outcome and Follow-Up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
D. Endodontic Services	
1. Diagnosis	Signs and symptoms documented (if need not evident on radiographs).
2. Rubber Dam Use	Evidence of rubber dam use on working images and/or documentation of use in progress notes.
3. Endodontic Outcome and Follow-Up	a. Radiographic evaluation of treatment to determine that canal(s) is/are properly filled and well condensed. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment, no eivdence of extraction of recently completed endo. c. Documentation of final restoration. d. Recall follow-up recommend with PA image.
4. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.

E. Periodontal Services	
1. Diagnosis	Evidence that clinical examination including pocket charting and radiographs is available to determine proper type of treatment needed.
2. Treatment per visit	Rationale for more than 2 quadrants of scaling/root planing per visit should be documented.
3. Periodontal Follow-Up/Outcome	Recall follow-up recommended with radiographs or probing.
4. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
F. Prosthetic Services	
1. Diagnosis	Evaluation of form, fit, and function of existing prosthesis. Evaluation of need where no previous prosthesis exists.
2. Prosthetic Outcome and Follow-Up	a. Treatment was done in a timely manner, including necessary adjustments. b. Prognosis good for appropriate longevity.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
G. Surgical Services	
1. Diagnosis	Radiographic and/or soft tissue / clinical exam supports treatment rendered
2. Surgical Outcome and Follow-Up	a. Comprehensive documentation of treatment done, materials used, and any noteworthy occurrences during the procedure. b. Documentation of post-operative instructions to patient. c. Documentation of any needed post-operative care, including suture removal.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
IV. OVERALL PATIENT CARE	Overall care is clinically acceptable (to the extent that it is possible to determine by x-rays and available information.)

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Continuation of Services with Terminated or Nonparticipating Provider

Upon request of a current or newly covered member, **Premier** is required to provide for the completion of covered services for treatment of certain specified conditions if (a)the services were being provided by a terminated provider at the time of termination of the provider's contract, or (b)the covered services were being provided by a nonparticipating provider to a newly covered member at the time his or her coverage became effective. Members are entitled to continuation of services from such providers for the following circumstances and timeframes:

- **Acute Conditions:** The duration of an acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration).
- **Newborn Children between Birth and Age 36 Months:** Premier shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the provider's contract or 12 months from the effective date of coverage for a newly covered member.
- **Surgery or Other Procedures:** Performance of surgery or other procedure authorized by Premier as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current members or 180 days from the effective date of coverage for newly covered members.

Premier is not required to provide benefits that are not otherwise covered under the terms and conditions of the subscriber contract. This policy does not apply to a new member covered under an individual subscriber agreement.

Premier is not required to provide for completion of covered services by a provider whose contract has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in Section 805(a)(6) of the Business and Profession Code, fraud or other criminal activity.

Members may request continuation of care by calling **Premier's** Customer Service Department at 1-888-584-5830 during normal business hours or by sending a written request to **Premier. Premier** may obtain copies of the member's dental records from the member's provider to evaluate the request.

The Dental Director (or his/her designee) will determine if the member is eligible for continuation of care under **Premier's** *Enrollee Block Transfers and Continuity of Care from Terminated or Non-Participating Providers* policy and the California Knox-Keene Act. The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

- Whether one of the circumstances described above, exists;
- Whether the requested services are covered by **Premier**; and
- The potential clinical effect that a change of providers would have on the member's treatment.

Premier shall provide the member with the Dental Director's decision in writing within 5 business days of the receipt of the request and a copy of the member's dental record. The written notice shall inform the member how to file a grievance in the event the enrollee is dissatisfied with the decision.

Premier requires the terminated or nonparticipating provider to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracted providers, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. **Premier** is not required to continue the services with a provider if the provider does not accept the payment rates provided for in this paragraph.

The amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the member if receiving care from a provider currently contracted with or employed by **Premier**.

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California Children's Services (CCS)

A description of the California Children's Services (CCS) applicable to dental patients.

California Children's Services (CCS) is a Program which treats children under 21 years of age with certain physical limitations and diseases. The program is paid for by California taxpayers and offers medical care to children whose families cannot afford all or part of the needed care. Patients must apply to CCS to become eligible for services under the CCS Program.

CCS Eligibility for Dental Services

Orthodontic services are not a benefit through the Healthy Families Program or Healthy Kids Santa Barbara. However if a patient meets eligibility requirements, orthodontic services may be provided by California Children Services.

CCS clients eligible for dental services through the CCS program include those who have been accepted for and are authorized to receive orthodontic services by a CCS-paneled orthodontist, as well as other clients with CCS-eligible conditions, such as:

- Medically handicapping malocclusion (one or more of the following conditions)
  - deep impinging overbite
  - crossbite of individual anterior teeth when destruction of soft tissue is present
  - severe traumatic deviations (for example, loss of premaxilla segment by burns or accident, the result of osteomyelitis; or other gross pathology
  - overjet of greater than 9 mm
  - mandibular protrusion of 3 mm or more
  - suspected need for orthognatic surgery

- combinations of the following conditions that appear to be medically handicapping:
  a) overjet
  b) overbite
  c) mandibular protrusion
  d) openbite
  e) ectopic eruption (excluding 3rd molars)
  f) anterior crowding
  g) posterior crossbite

- Cleft lip and/or palate (hard or soft)
- Congenital and/or acquired oral and craniofacial anomalies
- Complex congenital heart disease
- Seizure disorders
- Immune deficiencies
- Cerebral palsy
- Hemophilia and other blood dyscrasia
- Malignant neoplasms, including leukemia
- Rheumatoid arthritis
- Nephrosis
- Cystic fibrosis
- Organ transplants

Referrals for CCS Patients

If a dentist suspects a child has medically handicapping malocclusion or one of the other CCS eligible medical conditions listed above, the dentist must complete a CCS Orthodontic Screening Form. Only those cases meeting the requirements will be considered for referral. In addition, the dentist must specify the suspected CCS medical condition. It is very important that the dentist ensure the patient's information is complete.

The CCS Orthodontic Screening Form needs to be mailed to Premier, and not forwarded directly to your local CCS office, at the following address:

Premier Access Insurance Company
Referral Department - CCS
P. O. Box 659010
Sacramento, CA 95865-9010

Upon receiving the form from the provider, **Premier** will then refer the child to the local CCS program for determination of eligibility. For additional information, the provider may contact Premier Member Services at the following number:

Premier Member Services..... 888-584-5830

In addition to the referral, the provider should refer the child back to their health plan for preliminary diagnosis of the medical condition, if applicable. The health plan will then refer the child to CCS, if appropriate.

CCS-Approved Dental Providers

Dentists from every field of dentistry provide services for CCS clients. Prior to treating a CCS client, orthodontists and oral and maxillofacial surgeons must become CCS-paneled by the Children's Medical Services (CMS) Branch of the State Department of Health Services. Other dental providers (pediatric dentists, general dentists, endodontists, periodontists, and prosthodontists) are not required to be paneled. These non-paneled dental providers are listed as "approved providers" by the local CCS programs.

Providers may become an approved provider by contacting the local CCS administrator and offering to provide CCS dental services. Providers must complete a State Department of Health Services CCS *Panel Application* form. In addition, both CCS-paneled providers and approved providers must fill out a State Department of Health Services *Provider CGP Number Application* form to be compensated for the services they provide. **Premier** encourages its providers to become "CCS-approved providers." This will ensure continuity of care for these children.

For further information on becoming a CCS-approved provider, or to receive the State Department of Health Services forms, contact the Children's Medical Services Branch at: (916) 322-8702.

Services unrelated to the CCS eligible condition continue to be benefits under the Healthy Families Program and Healthy Kids Santa Barbara and are not covered by CCS. The Primary Care Dentist provides these benefits.

Premier HFP/HKSB Orthodontic Pre-screening Form

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Patient | **Primary Care Provider**

Name:_____ **Name:**_____

CIN #:_____ **Date:**_____

- **Member must be in permanent dentition unless age 13 and older**
- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF THE CONDITION IS ABSENT.

CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS — **HLD Score**

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation) Indicate an 'X' if present and score no further _____

2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist) Indicate an 'X' if present and score no further _____

3. Deep impinging overbite WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE. TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT. Indicate an 'X' if present and score no further _____

4. Crossbite of individual anterior teeth WHEN **CLINICAL ATTACHMENT LOSS AND RECESSION OF THE GINGIVAL MARGIN ARE PRESENT .** Indicate an 'X' if present and score no further..... _____

5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.) Indicate an 'X' if present and score no further ..... _____

6A. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm. Indicate an 'X' if present and score no further _____

THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

6B. Overjet equal to or less than 9 mm..... ..... _____

7. Overbite in mm..... _____

8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm..... _____ **x 5** = _____

9. Open bite in mm..... _____ **x 4** = _____

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.

10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars) _____ (tooth numbers) _____ (total) **x 3 =** _____

11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE) _____ (maxilla) _____ (mandible) _____ (total) **x 5** = _____

12. Labio-Lingual spread in mm ..... _____

13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bi-lateral posterior crossbite).....Score 4 _____

TOTAL SCORE: _____

IF A PATIENT DOES NOT SCORE 26 OR ABOVE NOR MEETS ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS, HE/SHE MAY BE ELIGIBLE UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – SUPPLEMENTAL SERVICES (EPSDT–SS) EXCEPTION IF MEDICAL NECESSITY IS DOCUMENTED.

☐ EPSDT–SS EXCEPTION: (Indicate with an 'X' and attach medical evidence and appropriate documentation for each of the following eight areas on a separate piece of paper IN ADDITION TO COMPLETING THE HLD SCORE SHEET ABOVE.)

a) Principal diagnosis and significant associated diagnosis; and DO NOT WRITE IN THIS AREA.
b) Prognosis; and
c) Date of onset of the illness or condition and etiology if known; and
d) Clinical significance or functional impairment caused by the illness or condition; and
e) Specific types of services to be rendered by each discipline associated with the total treatment plan; and
f) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals; and
g) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care; and
h) Any other documentation which may assist the Department in making the required determinations.

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

6A **Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm:** Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and it's corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

6B **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.

7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)

8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).

9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.

13. **Posterior Unilateral Crossbite**: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERIAL CROSSBITE.**

PREMIER ACCESS

8

Member Identification

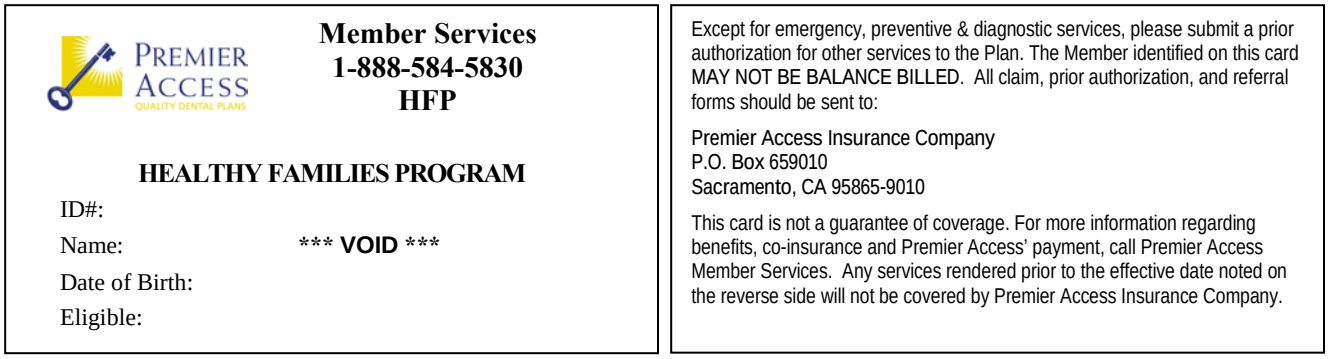
A description of how member identification is documented.

Identification of Premier Plan members is accomplished through member identification cards issued by **Premier**. Except for children, members must also show a photo identification card.

Possession of a **Premier** identification card does not guarantee eligibility. Your office must contact **Premier** Member Services to verify patient eligibility at the following number:

Premier Member Services..... 888-584-5830

A copy of the **Premier** identification card is shown below. Identification cards specify the program under which the individual is eligible. This sample is for the Healthy Families Program.



PREMIER ACCESS

9

Member Appeals and Grievances

A description of provider and member appeals and grievance processes.

Members may appeal specialist referral denials, or providers may appeal on behalf of the member.

Member Appeals

Member appeals are submitted in writing to the **Premier** office at 8890 Cal Center Drive, Sacramento, CA 95826. Appeals are forwarded to the Grievance/Appeals Coordinator who compiles all the information used in the initial review and any additional information received, and presents the case to **Premier**'s Dental Director. **Premier**'s Dental Director reviews all available information and makes a determination.

The determination is communicated to the Grievance/Appeals Coordinator who notifies the member and provider of the outcome, including their right to appeal to the Department of Insurance.

Provider/ Member Complaints/Grievances

The main objective of the provider and member grievance process is to ensure an effective system for addressing and resolving complaints and grievances in a timely manner. In addition, the grievance process provides a mechanism for identifying systemic or provider trends that may be deleterious to patient care.

Complaints and grievances can be registered by phone, in writing or in person at the following address, phone number and email address:

Premier Access Insurance Company
Attn: Grievance Coordinator
P. O. Box 255039
Sacramento, CA 95865-5039

8890 Cal Center Drive
Sacramento, CA 95826

(916) 563-6013, or
1-800-270-6743, ext. 6013
Grievancedept@premierlife.com

All complaints will be handled expeditiously. Inquiries/complaints that concern quality of care are reviewed by the Dental Consultant.

Provider Follow-Up Documentation

In order for the Plan to investigate and resolve the member complaint, we require your office to submit the following information within 10 business days:

1. Copy of all the patient's treatment records.
2. Copy of the patient's signed consent.
3. Copy of all x-rays.
4. Copy of the patient's financial records.
5. Any comments your office my have regarding the patient's complaint.

A sample Grievance Form is provided on the following page.

PREMIER ACCESS

Grievance Form

☐ **Healthy Families Program**
1-888-584-5830

☐ **Healthy Kids Santa Barbara**
1-866-682-9904

Premier Access Insurance Company ("Premier") takes very seriously the problems raised by its enrollees and endeavors to reach solutions acceptable to all concerned. To facilitate these efforts, please provide us with the following information. If you need assistance in completing this form, please contact any Premier Member Services Representative at the numbers above.

Name: _____
Address: _____
City: _____ **State:** _____ **ZIP Code:** _____
Telephone: (_____) _____

Nature of Complaint -- Please be as specific as possible and include the date(s) of service and name(s) of provider of service. Please use additional sheets if more space is needed.

Please mail this form to:

Premier Access Insurance Company
Attention: Grievance Department
P. O. BOX 255039
Sacramento, CA 95865-5039

DO NOT WRITE BELOW THIS LINE
FOR COMPANY USE ONLY

COMPLAINT RECEIVED BY: _____

DATE RECEIVED: _____

TIME RECEIVED: _____

COMPLAINT LOG COMPLETED BY: _____

PREMIER ACCESS

Formulario de Queja o Reclamación por Agravio

La Compañía de Seguros Access Dental **(el plan "*Premier*") toma muy en serio los problemas que tienen sus Personas Afiliadas, y se esfuerza para lograr soluciones aceptables para todas las partes involucradas. A fin de facilitar estos esfuerzos, por favor, proporciónenos la siguiente información. Si necesita ayuda para completar este formulario, por favor, comuníquese con cualquier Representante del Servicio de Atención a las Personas Afiliadas al plan *Premier*,al 1-888-715-0760, ó con un(a) representante de cualquier Proveedor del plan *Premier*.**

Nombre: _____
Domicilio: _____
Ciudad: _____ **Estado:** _____ **Código Postal:** _____
Teléfono: (_____)_____

Índole de la Queja – Por favor sea lo más específico(a) posible e incluya la(s) fecha(s) de servicio y el/los nombre(s) del/de los proveedor(es) del servicio. Por favor, use hojas adicionales, si necesita más espacio.

Por favor envíe este formulario por correo a:

Premier Access **Insurance Company**
Attention: Grievance Department
P. O. BOX 255039
Sacramento, CA 95865-5039

NO ESCRIBA DEBAJO DE ESTA LÍNEA
SOLAMENTE PARA USO DE LA COMPAÑÍA

COMPLAINT RECEIVED BY: _____

DATE RECEIVED: _____

TIME RECEIVED: _____

COMPLAINT LOG COMPLETED BY: _____

PREMIER ACCESS

10

Emergency and Out-of-Area Care

Definition of emergency and out-of-area care and how to receive payment.

EMERGENCY CARE IS DEFINED AS those services required for alleviation of severe pain, severe swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions, which, if not immediately diagnosed and treated, would lead to disability or harm to the member.

Emergency services are exempt from prior authorization, but must be justified according to the following criteria:

> Any service classified as an emergency which would have been subject to prior authorization had it not been so classified, must be supported by a physician's or dentist's statement that describes the nature of the emergency; including relevant clinical information about the patient's condition and states why the emergency services rendered were considered to be immediately necessary. It must be comprehensive enough to support a finding that an emergency existed.

Emergency Care After Hours

During regular office hours, members may obtain care by contacting their PCD for emergency treatment. After business hours, members should contact their PCD through the after-hours emergency care phone number of their PCD.

Dentist shall provide directions to their patients on how to obtain emergency services 24 hours per day, seven days per week, including vacations and holidays. Urgent appointments should be scheduled within 24 hours and the patient should be informed that only the emergency would be treated at that time. This after-hours number must provide for a return call to the member within one hour.

Out of Area Emergency Care

Providers may be requested to provide emergency services to out-of-area members if contacted by the Plan. Such treatment provided to the member must be directly related to treatment of the emergency condition, as defined above. Providers who provide emergency treatment to members will submit a claim **Premier** for the treatment, with accompanying documentation that verifies the emergency. **Premier** will be responsible for the cost of the emergency treatment only.

PREMIER ACCESS

11

Prior Authorization Requirements

To ensure all non-emergency dental procedures are consistently evaluated for dental necessity and appropriateness.

With the exception of preventive dental care, all non-emergency dental procedures require prior authorization from **Premier Access Insurance Company.** Providers may initiate authorization requests via fax, however, since hard copy supporting documentation is usually required to make a determination, **Premier** encourages providers to submit requests via mail. To be approved, dental services must meet criteria for dental necessity/appropriateness and be a covered benefit of the Healthy Families Program and Healthy Kids Santa Barbara.

Dental Necessity: The underlying principle of whether a service is reasonable and necessary is whether or not the requested service or item, which is a program benefit, is fully documented to be immediately necessary, is in accord with generally accepted standards of dental practice and is indispensable to the oral health of the beneficiary. Authorization shall be granted only for the lowest cost covered service appropriate to the presenting adverse condition.

Prior Authorization Requirements

1. Prior Authorizations should be sent to:
   Premier Access Insurance Company
   P. O. Box 659010
   Sacramento, CA 95865-9010
2. The PCD or specialist submits a request for authorization to **Premier** via mail and must include diagnostic properly mounted and labeled x-rays.

3. **Premier** evaluates the request to determine the necessary documentation is complete and the requested procedure is a covered benefit as outlined in the program benefit schedule and determine dental necessity/appropriateness.
4. Determination of authorization is based on submitted documentation and the benefits outlined in the program's benefit schedule.
5. If no prior authorization is obtained from **Premier** the provider may not pursue the member for payment of denied services, as it is the responsibility of the provider to obtain prior authorization for the services prior to rendering them.
6. Please refer to the following for the documents that are required by **Premier** for determination of authorization.

- ♦ Appliances
  - Space maintainers (acrylic and fixed bond type) – pre-operative periapical and bitewing x-rays are required
- ♦ Restorative Dentistry (Fillings)
  - Anterior composite restorations – pre-operative periapical x-rays
  - Posterior amalgam restorations primary or permanent teeth – pre-operative periapical and bitewing x-rays
- ♦ Endodontics
  - Pulpotomy and Vital Pulpotomy– pre-operative periapical and bitewing x-rays
  - Root Canals – pre-operative periapical x-rays
  - Apicoectomy – pre-operative periapical x-rays
- ♦ Periodontics
  - Root planing – dated periodontal chart and pre-operative mounted x-rays
- ♦ Crown & Fixed Bridges
  - Pre-operative periapical x-rays
- ♦ Oral Surgery
  - Pre-operative x-rays or Pano are required for all oral surgery treatments except for incision and drainage of abscesses
  - Biopsy of oral tissue – clinical narrative of pathology is required

PREMIER ACCESS

12

Language Assistance Program

Premier maintains a comprehensive language assistance program, providing language assistance services for Limited English Proficient (LEP) members. This chapter describes the services **Premier** provides and the Dentist responsibilities related to the language assistance program.

Points of Contact

- Language assistance services are available to members at no charge.
- Interpreter services are available 24 hours a day, 7 days a week for seeking dental services within **Premier's** provider network.
- Members shall receive timely access to language assistance services.
- Language assistance services are available to members at the following points of contact:

Plan Member Service Line

- Members in all service areas contact the Member Service Line by calling the toll-free Member Service Line phone number provided on each member identification card (phone numbers differ based on dental program).
- Member Service Line is available between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday (holidays excluded).
- Members may request to speak with a Member Services representative in a specific language.
  - If a bilingual **Premier** representative is available who speaks the requested language, the member is connected as soon as the representative is available.
  - If a bilingual **Premier** representative is not available to speak with the member, a call is initiated to **Premier's** Interpreting Service and the interpreter facilitates the call between the **Premier** representative and the member.

- When a member is identified to be a LEP member from the language code on the member record, the **Premier** representative will offer interpreter services to the member. When a **Premier** representative notices a member is having difficulty communicating, interpreter services are offered, regardless of the language code on the member record.

Plan Complaints/Grievances Department

- Members in all service areas contact the Complaints/Grievance Department by telephone, mail, or in person between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday (holidays excluded), at the Plan's headquarters located at:

  Premier Access Insurance Company
  Complaints/Grievances Department
  8890 Cal Center Drive
  Sacramento, CA 95826
  800-270-6743, ext. 6013

- Members calling into the Complaints/Grievances Department may request to speak with a representative in a specific language.
  - If a bilingual **Premier** representative is available who speaks the requested language, the member is connected as soon as the representative is available.
  - If a bilingual **Premier** representative is not available to speak with the member, a call is initiated to **Premier's** Interpreting Service and the interpreter facilitates the call between the **Premier** representative and the member.
- Members contacting the Complaints/Grievances Department by mail to report a grievance submit a letter or Grievance Form.
  - Grievance forms are translated into Spanish, **Premier**'s threshold language.
  - Translated grievance forms are available on **Premier**'s website, www.premierppo.com.
  - Translated grievance forms are included at the end of this chapter for providers/office staff to provide for members upon request.
- Members contacting the Complaints/Grievances Department in person at **Premier's** headquarters may request to speak with a representative in a specific language.

- If a bilingual **Premier** representative is available who speaks the requested language, the member is assisted in person by the representative.
- If a bilingual representative is not available to speak with the member, a call is initiated to **Premier**'s Interpreting Service. The interpreter facilitates the conversation between the **Premier** representative and the member.

- Members have the right to file a grievance if their linguistic needs are not met by **Premier** and/or provider office.

Provider Offices

- Member demographic profile data will be disclosed to contracting providers upon request for lawful purposes, including language assistance and health care quality improvement purposes.
- Members can utilize interpreting service available through bilingual provider office staff.
- Member demographic profile data will be disclosed to contracting providers upon request. The members may request face-to-face interpreting service for appointments.
  - Members may request face-to-face interpreting service for an appointment by contacting the Premier Member Service Line.
  - The **Premier** representative will schedule the appointment with the Interpreting Service.
  - **Premier** will retain financial responsibilities to provide language assistance services to the members.

Member Notice

- The Member Notice notifies members of the availability of free language assistance services and how to access the services.
- The Member Notice will be in English and **Premier**'s threshold language (Spanish).
- The Member Notice will be sent with all vital documents, enrollment materials for new and renewing members, and other periodic member correspondences, such as brochures, newsletters, outreach, or marketing materials.

Translation Services

- Standardized vital documents will be translated into **Premier**'s threshold languages at no charge to enrollees.

- For vital documents that are not standardized, but which contain enrollee-specific information, **Premier** will provide the English version together with the Department-approved written notice of the availability of interpretation and translation services.
  - If a translation is requested, **Premier** shall provide the requested translation within 21 days of the receipt of the request for translation.
- The threshold language identified by **Premier** is Spanish.
- Members can call the Plan Member Services Line to request translated documents.
- The following vital documents will be translated into **Premier**'s threshold languages and are available to members upon request:

Standardized Vital Documents

- Benefit and Copay Schedule
- Exclusions and Limitations
- Grievance Form
- Privacy Notice
- HIPAA-related forms

Enrollee-specific Vital Documents

- Explanation of Benefits
- Grievance Acknowledgment Letter
- Grievance Resolution Letter
- Referral
- Notice of Authorization

- Subscriber contracts, Evidence of Coverage booklets and other large disclosure forms and enrollee handbooks will not be translated in their entirety. A summary matrix, translated into the threshold languages, is available for LEP members. This matrix includes the following information:
  - Major categories of benefits covered under the plan;
  - Corresponding copayments and coinsurance;
  - Exclusions and limitations; and
  - Any applicable deductible and lifetime maximums.

Interpreting Services

- Interpreting services available at all points of contact, free of charge to members, are offered through the following:
  - Bilingual **Premier's** staff members;
  - Bilingual contracted providers and office staff; and
  - Interpreting Service.
- Members can call **Premier**'s Member Services Line at 1-888-584-5830 to request interpreter services. Interpreter services can be provided over the phone or arranged for a member's appointment, based on the member's request. If a member goes in for an appointment without first arranging for interpreter services, the provider may contact **Premier** at the time of the appointment to arrange for phone interpreter services or face-to-face interpreter services (which would require the member to reschedule the appointment for a later time).
- Provider office staff shall offer interpreting services to LEP members, including when a member is accompanied by a family member or friend who has the ability to provide interpretation services. The offer of interpreting service, and the acceptance or denial by the member, shall be documented in the member record or file, as applicable.
- Provider directories identify contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff.
- **Premier** shall require the following criteria for individuals providing interpretation services:
  - Fluency in the language for which the individual is performing interpretive services.
  - Knowledge and understanding of dental terminology.
  - Knowledge and understanding of **Premier's** policies and procedures.
  - Understanding and acceptance of interpreter standards – accuracy, confidentiality, impartiality, professionalism and cultural sensitivity.

Provider Responsibilities

- Contracting providers must provide and perform the language assistance services included in the provider contract, which are as follows:
  - Provider office staff shall offer interpreting services to LEP members, including when a member is accompanied by a family member or friend who has the ability to provide interpretation services. The offer of

interpreting service, and the acceptance or denial by the member, shall be documented in the member record or file, as applicable.

- Provider office will contact **Premier** to obtain information regarding a member's language preference, as necessary.
- Provider office will record member's language preference in the patient record.

♦ During the initial contracting process, and periodically thereafter, the provider office is required to certify the provider(s) and/or office staff who are bilingual and capable of providing interpreting services. **Premier** will confirm the availability of the bilingual provider(s) and/or staff during provider office quality assurance audits.

♦ The provider office will provide translated grievance forms to members upon request. Grievance forms are available translated into **Premier's** threshold language(s) by contacting the Member Services.

PREMIER ACCESS

13

Member Responsibilities

A description of members' responsibilities.

MEMBERS OF PREMIER HAVE CERTAIN RESPONSIBILITIES. These responsibilities ensure that all members participate in their own dental care and hygiene. Dental offices should be familiar with member responsibilities.

Premier members have the following responsibilities:

- Knowing and understanding the rules and regulations of **Premier** and abiding by them in the interest of quality dental care.
- Learning about their dental condition(s) and following prescribed treatment plans.
- Contacting his or her primary care dentist to make a dental appointment.
- Arriving at the office five to ten minutes before the scheduled appointment to allow time for filling out any necessary paper work.
- Calling the dentist and rescheduling an appointment at least 24 hours in advance if they cannot keep a scheduled appointment.
- Requesting individual counseling by the PCD to establish a healthy dental routine.
- Adopting positive lifestyle choices, such as brushing, flossing, checkups, good diet, avoiding tobacco, not biting hard foods, not opening containers with teeth and using fluoride.
- Attending classes held throughout the community addressing health education and promotion.
- Reading health education materials available at the dentist's office.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- File a complaint if your linguistic needs are not met.
- Always present your Member Identification Card when getting services.
- Treat all **Premier** personnel and providers respectfully and courteously.

PREMIER ACCESS

14

Infection Control

To ensure standard precautions are set in place to minimize the transmission of pathogens in the dental office.

Premier shall require all providers to comply with the standard precautions and infection control measures as outlined and mandated by the Dental Board of California under California Code of Regulations (CCR) Title 16, Section 1005 and the California Division of Occupational Safety and Health (Cal-OSHA) under Title 8, Section 5193. ***Premier*** shall verify providers' compliance with the regulation during the routine on-site audits

Definitions:

- **Standard precautions** - is a set of combined precautions that include the major components of universal precautions (designed to reduce the risk of transmission of blood borne pathogens) and body substance isolation (designed to reduce the risk of transmission of pathogens from moist body substances). Similar to universal precautions, standard precautions are used for care of all patients regardless of their diagnoses of personal infectious status.
- **Critical instruments** – are surgical and other instruments used to penetrate soft tissue or bone.
- **Semi-critical instruments and devices** – are surgical and other instruments that are not used to penetrate soft tissue or bone, but contact oral tissue.
- **Non-critical instruments and devices** – are instruments and devices that contact intact skin.

- **Low-level disinfection** – is the least effective disinfection process, kills some bacteria, viruses and fungi, but does not kill bacterial spores or mycobacterium tuberculosis var bovis, a laboratory test organism used to classify the strength of disinfectant chemicals.
- **Intermediate-level disinfection** – kills mycobacterium tuberculosis var bovis indication that many human pathogens are also killed, but does not necessarily kill spores.
- **High-level disinfection** – kills some, but not necessarily all bacterial spores. This process kills mycobacterium tuberculosis var bovis, bacteria, fungi, and viruses.
- All germicides must be used in accordance with intended use and label instructions.
- **Sterilization** – kills all forms of microbial life.
- **Personal Protective Equipment** - includes items such as gloves, masks, protective eyewear and protective attire (gowns/lab coats) which are intended to prevent exposure to blood and body fluids.
- **Other Potentially Infectious Materials (OPIM)** - means any one of the following: (A) human body fluids such as saliva in dental procedures and any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (B) any unfixed tissue or organ (other than intact skin) from a human (living or dead); (C) HIV-containing cell or tissue cultures, organ culture and blood, or other tissues from experimental animals.

Licensees shall comply with infection control precautions mandated by the California Division of Occupational Safety and Health (Cal-OSH).

All licensees shall comply with and enforce the following minimum precautions to minimize the transmission of pathogens in health care setting:

- Standard precautions shall be practice in the care of all patients.
- A written protocol shall be developed by the licensee for proper instrument processing, operatory cleanliness, and management of injuries.
- A copy of Title 16 section 1005 regulation shall be conspicuously posted in each dental office.

Personal Protective Equipment

- Health care workers shall wear surgical facemasks in combination with either chin length plastic face shields or protective eyewear when treating patients whenever there is potential for splashing or spattering of blood or OPIM. After each patient and during patient treatment if applicable, masks shall be changed if moist or contaminated. After each patient, face shields and protective eyewear shall be cleaned and disinfected, if contaminated.
- Health care workers shall wear reusable or disposable protective attire when their clothing or skin is likely to be soiled with blood or OPIM. Gowns must be changed daily or between patients if it should become moist or visibly soiled. Protective attire must be removed when leaving laboratories or areas of patient care activities. Reusable gowns shall be laundered in accordance with Cal-OSHA Bloodborne Pathogens Standards. (Title 8, Cal. Code Regs., section 5193)

Hand Hygiene

- Health care workers shall wash contaminated or visibly soiled hands with soap and water and put on new gloves before treating each patient. If hands are not visibly soiled or contaminated an alcohol based hand rub may be used as an alternative to soap and water.
- Health care workers who have exudative lesions or weeping dermatitis of the hand shall refrain from all direct patient care and from handling patient care equipment until the condition resolves.

Gloves

- Medical exam gloves shall be worn whenever there is a potential for contact with mucous membranes, blood or OPIM. Gloves must be discarded upon completion of treatment and before leaving laboratories or areas of patient care activities. Healthcare workers shall perform hand hygiene procedures after removing and discarding gloves. Gloves shall not be washed before or after use.

Sterilization and Disinfection

- Reusable dental instruments used for invasive procedures, those procedures that penetrate the mucous membrane or skin, are cleaned of all visible debris and then sterilized by an autoclave device. FDA cleared chemical sterilants/disinfectants shall be used for sterilization of heat-sensitive critical items and for high-level disinfection of heat-sensitive semi-critical items.
- Dental Instruments sterilized by a heat or vapor method shall be packaged or wrapped before sterilization if they are not to be used immediately after being sterilized. These packages or containers shall remain sealed unless the instruments within them are placed onto a setup tray and covered with a moisture impervious barrier on the day the instruments will be used and shall be stored in a manner so as to prevent contamination.
- All high-speed dental hand pieces, low-speed hand piece components used intraorally, and other dental unit attachments such as reusable air/water syringe tips and ultrasonic scaler tips, shall be heat-sterilized between patients.
- Single use disposable instruments (e.g. prophylaxis angles, prophylaxis cups and brushes, tips for high-speed evacuators, saliva ejectors, air/water syringe tips) shall be used for one patient only and discarded.
- Needles shall be recapped only by using the scoop technique or a protective device. Needles shall not be bent or broken for the purpose of disposal. Disposable needles, syringes, scalpel blades or other sharp items and instruments shall be placed into sharps containers for disposal according to all applicable regulations.
- All biohazardous and sharp waste shall be handled and processed according to the California Medical Waste Guide.
- Proper functioning of the sterilization cycle shall be verified at least weekly through the use of a biological indicator (such as a spore test). Test results must be maintained for 12 months as required by the Dental Board of California.

Irrigation

- Sterile coolants/irrigants shall be used for surgical procedures involving soft tissue or bone. Sterile coolants/irrigants must be delivered using a sterile delivery system.

Facilities

- If items or surfaces likely to be contaminated are difficult to clean and disinfect they shall be protected with disposable impervious barriers.
- Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using a Cal-EPA registered, hospital grade low- to intermediate-level disinfectant after each patient. The low-level disinfectants used shall be labeled effective against HBV and HIV. Use disinfectants in accordance with the manufacturer's instructions. Clean all housekeeping surfaces (e.g. floors, walls, sinks) with a detergent and water or a Cal-EPA registered, hospital grade disinfectant.
- Dental unit water lines shall be anti-retractive. At the beginning of each workday, dental unit lines shall be purged with air, or flushed with water for at least two (2) minutes prior to attaching handpieces, scalers and other devices. The dental unit line shall be flushed between each patient for a minimum of twenty (20) seconds.
- All disposable, single use only, patient treatment items are disposed of as medical waste or solid waste depending upon their classification and according to applicable local, state, and federal environmental standards.

Lab Areas

- Splash shields and equipment guards shall be used on dental laboratory lathes. Fresh pumice and a disinfected, sterilized, or new ragwheel shall be used for each patient. Devices used to polish, trim or adjust contaminated intraoral devices shall be disinfected or sterilized.
- Intraoral items such as impressions, bite registrations, prosthetic and orthodontic appliances shall be cleaned and disinfected with an intermediate-level disinfectant before manipulation in the laboratory and before placement in the patient's mouth. Such items shall be thoroughly rinsed prior to placement in the patient's mouth.

PREMIER ACCESS

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Optional Treatment

To define the process related to optional treatment plans offered by providers and to establish clear procedures in terms of claims handling, quality managements, and implementation.

Optional treatment is not an excluded benefit. It is an upgraded alternative procedure presented by the provider to satisfy the same function of the covered procedure and is chosen by the member. It is subject to the limitations and exclusions of the program. The optional treatment procedure should be appropriate for the clinical condition, be supported by the clinical finding and diagnosis or the member's dentist, and meet the clinical standards. Optional treatment may not be offered as an alternative procedure where prognosis is poor or guarded. It is inappropriate to present the covered treatment procedures as inadequate or of inferior quality.

When optional treatment is offered, the provider must fully inform the member in writing of the following:

- The recommended covered treatment
- The advantages and disadvantages of both the covered and the optional treatment
- All applicable fees

The member or guardian must verify his/her full understanding and sign a consent form for the treatment.

The member is responsible for any applicable copayments, and:

- If the provider has contracted fees for the covered procedure and optional procedure, the provider may charge the member the difference between the two fees;
- If the provider has a contracted fee for the covered procedure and there is no contracted fee for the optional procedure, the provider may charge the member the difference between the contracted fee for the covered procedure and the provider's usual and customary fee for the optional procedure; or
- If the provide does not have contracted fees for the covered procedure or optional procedure (e.g. capitated provider), the provider may charge the member the difference between his/her usual and customary fees for the covered and optional procedures.

"Contracted fee" refers to the provider's contracted fee schedule for the program in which the member is enrolled.

The member will not be responsible for any amounts in excess of those described above.

Premier will make an allowance for optional treatment based on the provider's contract and associated fee for the covered procedure, if applicable.

Providers who do not offer amalgam restorations and use composite resin on posterior teeth as their basic office procedure must provide the posterior composite to ***Premier*'s** members at the same copayment for the covered amalgam. The member cannot be charge for any amount in excess of the covered amalgam restoration.

Although some plans may provide coverage for Porcelain ceramic substrate crowns, members choosing to expedite the production of their crown and bypass the use of a lab, receiving a Cerec crown, will be subject to the optional treatment policy.

Procedures that are considered optional treatment are specific to benefit plans. Examples of Optional treatment include the following (except when the plan includes a coverage for the alternate procedure at a specified copayment(s)):

- Composite resin on posterior teeth, when the covered benefit is amalgam restoration.
- Porcelain ceramic crowns, Lava, Empress, Captek when the covered benefit is Porcelain fused to metal substrate or full cast crowns.
- Crowns when fillings are adequate.
- Crowns on children under the age of 12 years when the covered benefit is acrylic or stainless steel crowns.
- Fixed bridges when a partial could satisfactorily restore the case.
- Fixed bridges replacing missing posterior teeth when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial on the same arch.
- Treatments other than partial denture to replace missing bilateral posterior teeth.
- Any treatment specifically identified as optional in a specific benefit plan.

If coverage and/or copayment(s) for an alternative procedure is included in the member's program, the procedure is not considered optional treatment.

Compliance with these procedures will be monitored during the claims review process and through member grievances/appeals.

If a provider does not follow the standards defined in this policy and procedure, a corrective action plan may be implemented and monitored. Providers who do not comply with the corrective action plan may be subject to ***Premier's*** sanctions including, but not limited to, probation or termination.

PREMIER ACCESS

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Anti-Fraud Program and the Deficit Reduction Act of 2005

Pursuant to certain provisions of the Deficit and Reduction Act of 2005, **Premier** has established a Fraud and Abuse Prevention and Detection Program. As part of this program, **Premier** provides information to all employees, contractors, subcontractors and agents about the federal and State False Claims Acts; remedies available under these acts; and how employees and others can use them; and about whistleblower protections for individuals who report suspected false claims.

> **Abuse** is defined as practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2).
>
> **Fraud** is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutesfraud under applicable Federal or State law (42 CFR 455.2).

Federal False Claims Act (FCA)

Any person who does any of the following is liable for penalties under the Federal False Claims Act:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid;
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;

Examples of a False Claim:

Member fraud or misrepresentation includes, but is not limited to:

- Altering health records;
- Altering referral forms;
- Allowing another individual use of a Medicare or **Premier's** Membership card for the purpose of obtaining benefits.

Provider fraud and abuse includes, but is not limited to:

- Falsification of provider credentials;
- Billing for services not provided;
- Double billing, upcoding, and unbundling; and

Remedies:

- Violation of the Federal False Claims Act is punishable by a civil penalty of not less than $5,500 and not more than $11,000, plus three (3) times the amount of damages that the government sustains because of the violation.
- A Federal False Claims action may be brought by the U.S Attorney General.
- An individual also may bring a qui tam action for violation of the Federal False Claims Act. This means the individual files a civil action on behalf of the government.
- An individual who files a qui tam action receives an award only if, and after, the government recovers money from the defendant as a result of the lawsuit. Generally, the court may award the individual between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the individual substantially contributed to the prosecution of the action.

- Under the Federal False Claims Act, the statute of limitations is six years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation was committed.

California False Claims Act:

The California False Claims Act is similar to the Federal False Claims Act. The California False Claims Act makes it illegal, among other things, for any individual to knowingly present or cause to be presented to a state employee a false claim for payment or approval, knowingly make, use, or cause to be made or used a false record or statement to get a false claim paid or approved by the State, or to conspire to defraud the State or any political subdivision by getting a false claim allowed or paid by the State (California Government Code Section 12650-12656).

- Violation of the California False Claims Act is punishable by a civil penalty of up to $10,000 for each false claim, plus three (3) times the amount of damages that the State sustains because of the violation.
- The California False Claims Act also allows individuals to file qui tam actions.

Whistleblower Protections:

The Federal and California False Claims Acts provide protection for individuals who report suspected false claims (whistleblowers).

- **Premier** assures that whistleblowers will not be subjected to reprisal, harassment, retribution, discipline or discrimination by the company or any of its employees based on having made the report.
- Any employee or agent who engages in any such reprisal, harassment, retribution, discipline or discrimination against a good faith reporter may be subject to disciplinary action as deemed appropriate by **Premier**.
- Protection is also provided for employees who are discharged, demoted, suspended or discriminated against in retaliation for their involvement in false claims act cases.

Detecting Fraud and Abuse:

Premier's Departments identify potential member and provider fraud and abuse through various methods including, but not limited to, the review of following:

- Referrals, claims and utilization;
- Auditing/routine quality improvement audits;
- Provider billing patterns;
- Approvals or denials of health services to members;
- Complaints or grievances filed by members, providers or employees; specifically issues related to underutilization of services, refusal to refer and other treatment related issue.
- Member customer service inquiries; and
- Medical records, specifically for referral patterns and quality of care issues.

Plan personnel shall review all "red flags" or "red flag events," or other situations suspected as potential fraudulent activity. Information regarding red flags and red flag events is provided for personnel as part of the fraud and abuse employee training sessions.

Reporting Fraud and Abuse:

Possible False Claims Act violations should be reported to **Premier's** Fraud Officer for further investigation. The Fraud Officer can be contacted by phone at(916) 920-2500 or by mail at the following address: Anti-Fraud Officer, **Premier Access**, P.O. Box 659010, Sacramento, CA 95865-9010.
You may report possible violations directly to the Federal Department of Health and Human Services. The Office of the Inspector General also maintains a hotline, which offers a confidential means for reporting vital information. The Hotline can be contacted:

Phone:	1-800-HHS-TIPS
Fax:	1-800-223-2164
Email:	HHSTips@oig.hhs.gov
Mail:	Office of the Inspector General General HHS TIPS Hotline P.O. Box 23489 Washington, DC 20026