

2017 ODS OHP Dental Provider Handbook

A guide for dental office staff



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WELCOME TO OUR NETWORK OF MEDICAID (OHP) DENTISTS

First and most importantly, thank you for your participation in the ODS OHP Dental Provider network. The services that you provide ODS members directly impact the improved health of our fellow citizens of Oregon. Your services help them obtain not just a healthy mouth but also a healthy body.

The information in this handbook is intended to assist you in your interactions with ODS OHP and answer many of the questions we receive on an ongoing basis. Once you have had a chance to review this handbook, we welcome your comments and suggestions to improve it and make it your one-stop resource.

ODS offers OHP Plus Dental Plans to members residing in the following counties. Dentists in other counties may participate in our Medicaid network and see patients from these counties who are assigned to ODS:

Baker	Grant	Malheur	Wallowa
Benton	Hood River	Marion	Wasco
Clackamas	Jackson	Multnomah	Washington
Clatsop	Jefferson	Polk	Yamhill
Columbia	Josephine	Tillamook	
Crook	Lane	Umatilla	
Deschutes	Linn	Union	

ODS is committed to partnering with dentists to ensure the best possible service for information and eligibility, claims payment accuracy, timely claims processing and excellent customer service. We are here to help you via telephone, email or in person, or through our web-based tools and online service Benefit Tracker.

ODS periodically conducts Dental Workshops to bring you information on updates and changes. These also provide an opportunity to answer any questions you may have and to personally introduce you to our team members.

ODS is always looking for dentists to participate on the ODS OHP dental network. If you know of a dentist who is interested, please contact us.

Again, thank you for your support and your participation in the ODS OHP dental plan. Your contributions are significant and truly appreciated.

Sincerely,



Dr. Teri Barichello, DMD
VP, Chief Dental Officer

ODS OHP MISSION

The mission of ODS OHP is to ensure our members have access to and receive quality dental services. We are a dedicated team that works collaboratively with our Medicaid partners to achieve the Triple Aim vision of reducing costs and improving health outcomes and patient experiences for our members. We do this because we believe good oral health contributes to good overall health.

RULES FOR PARTICIPATING DENTISTS

Participating dentists agree to abide by the following rules of ODS, in addition to the OARs that govern OHP. You can locate these OAR rule books online at:

OREGON ADMINISTRATIVE RULES

www.oregon.gov/oha/healthplan/Pages/general-rules.aspx

OHP DENTAL SERVICES

www.oregon.gov/oha/healthplan/Pages/dental.aspx

OHP GENERAL RULES

www.oregon.gov/oha/healthplan/Pages/general-rules.aspx

Other rules established and set forth by ODS. Participating providers must agree:

1. To submit a completed ADA standard dental claim form to ODS for all services whether there is a charge or not at no charge to the patient.
2. To accept the ODS OHP Fee Schedule benefit payments for services rendered as payment in full.
3. To keep accurate and complete financial and patient records in a manner that meets generally accepted practices.
4. To allow ODS access at reasonable times and upon request to inspect and make copies of the books, records and papers of a participating dentist relating to the services provided to the members and to any payments received by the dentist from such patients.
5. To not charge the member an amount over the OHP fee listed for any procedure or for a non-covered service that is not funded by OHP unless the member signs a financial waiver before the treatment is rendered.
6. To not submit charges to ODS for payment for treatment that is not completed.
7. To not submit charges to ODS for services for which no charge is made or for which a charge increased because insurance is available.
8. To have the patient statement reflect the same billed charges as the amount submitted to ODS. For example, if a discount is offered to a patient, the discount needs to be reflected in the claim submitted to ODS.
9. If ODS fails to pay for covered healthcare services as set forth in the member contract, the member is not liable to the provider for any amounts owed by ODS in accordance with the provisions of ORS 750.095 (2)
10. To provide accurate and complete information to ODS.
11. To provide after-hours contact information to members for dental emergencies.
12. To maintain OHP par status by complying with credentialing standards. Credentialing needs to be completed for all dental associates prior to rendering treatment to ODS OHP members.

CREDENTIALING

Credentialing is the process of verifying elements of a licensed practitioner's training, experience and current competence. Credentialing is a healthcare industry standard and helps ensure ODS members have access to a high-quality dentist within the ODS dental provider networks. The ODS credentialing program is based on the standards of national, federal and state accrediting and regulatory agencies.

A practitioner is credentialed when initially joining an ODS dental provider network and is re-credentialed every three years thereafter. The practitioner completes an application that attests to his or her ability to practice and requires proof of liability insurance.

ODS verifies the information provided on the application and refers the application to a committee of peers for final review and participation decision. All information provided during the credentialing and re-credentialing process is kept confidential. If we do not have current credentials on file for the treating dentist, the claim may be paid at the out-of-network level or may be returned to your office.

At all times while participating with ODS, dentists must have and maintain in good standing all licenses, registrations, certifications and accreditations required by law to provide dental care as applicable. Each participating practitioner must promptly notify ODS in writing of any formal action against any licenses or, if applicable, against any certifications by any certifying boards or organizations. Participating practitioners also must notify ODS of any changes in practice ownership or business address, along with any other facts that may or will impair the ability of the participating practitioner to provide services to ODS members.

Dental practitioners have the right to appeal an ODS decision to restrict, suspend or take other adverse action against the dental practitioner's participation status.

Practitioners have rights during the credentialing and re-credentialing process and are notified of these rights through various means.

Practitioners have the right to:

- Credentialing and re-credentialing decisions that are not based on the practitioner's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed (provided such procedures are legal under US law) or patients in which the practitioner specializes.
- Review information the practitioner submitted to ODS to support their credentialing application.
- Correct erroneous information discovered during the verification process.
- Request and be informed of the credentialing application status.
- Withdraw, in writing, the application at any time.
- Have the confidentiality of the application and all supporting documents protected and the information used for the sole purpose of application verification, peer review and panel participation decisions, subject to any disclosures required under state or federal law.
- Be notified of these rights.

- Appeal application denials and adverse action taken by ODS as outlined in the Appeal of ODS Health Adverse Action.

Practitioners are notified of their rights in the ODS participating provider administrative manuals and on the Moda Health website.

PROFESSIONAL LIABILITY INSURANCE

ODS requires a \$1 million minimum per claim and a \$3 million minimum aggregate amount for participation in our network.

SERVICE COVERED BY ODS OHP PLUS

OHP PLUS is provided to children and adults who are eligible for traditional Medicaid programs or for the Children's Health Insurance Program (CHIP). It does not have premiums when enrolled with ODS as their managed care plan. Some adults who receive the OHP Plus benefit package have small copayments for some outpatient services and prescription drugs. Copayments do not apply to covered dental services.

Benefits on OHP are separated into the following three member categories:

- Pregnant women
- Non-pregnant women and adults age 21 and over
- Children under the age of 21

The following services may be covered by ODS for members on the OHP Plus:

DIAGNOSTIC

- Clinic oral evaluations
- Radiographs

ORTHODONTICS

- Covered for patients who have a diagnosis of cleft palate with cleft lip

PROSTHODONTICS (Removable)

- Complete and partial dentures
- Repairs to complete and partial dentures
- Denture rebase and reline procedures

ENDODONTICS

- Root Canal Therapy

PERIODONTICS

- Non-surgical services

RESTORATIVE

- Amalgam
- Composite resin restorations
- Build-ups
- Crowns

ORAL SURGERY

- Extractions
- Surgical extractions

PREVENTIVE

- Prophylaxis
- Fluoride treatment
- Sealants

PLUS SERVICE LIMITATIONS AND EXCLUSIONS NON-PREGNANT MEMBERS AGE 21 AND OVER

Based on the Oregon Administrative Rules (OAR) that govern OHP, the following service limitations apply for ODS members on OHP Plus:

CLASS I LIMITATIONS

A. Diagnostic

- Comprehensive and periodic oral evaluations are covered twice in any 12-month period. Limited oral evaluation and re-evaluation limited problem focused exams are covered five times in a twelve-month period.
- Detailed and extensive oral evaluations are covered once in a twelve-month period. Full-mouth X-rays or panoramic films are covered once in any five-year period.
- Bitewing X-rays are covered once in a twelve-month period.

B. Preventive

- Prophylaxis is covered twice in a 12-month period.
- Fluoride treatment is covered twice in a 12-month period.
- Sealants are not covered.
- Plaque control, oral hygiene and/or dietary instruction are not covered.

CLASS II LIMITATIONS

C. Restorative

- Amalgam restorations have no frequency limitation. Initial benefits for restorations include repair or replacement to the same surface within 24 months when performed by the same provider and/or office.
- Composite resin restorations are covered one time every five years.
- Refer to Class III Limitations for further guidelines when teeth are restored with crowns.
- A separate charge for anesthesia and/or IV sedation when used for non-surgical procedures is not covered unless the member is classed by Health Systems as special needs.

D. Oral Surgery

- Clinical information showing multiple symptoms is required for any surgical extraction of third molars.
- A separate, additional charge for alveoplasty done in conjunction with removal of teeth is not covered.

E. Endodontics

- A separate charge for cultures is not covered.
- Pulp capping is not covered.
- Retreatments are allowed for anterior teeth by review only. Retreatments are not covered on posterior teeth.
- Endodontics for molars is not covered.
- Root canal therapy is only covered when the final restoration on the tooth is covered.

F. Periodontics

- A separate charge for periodontal charting is not covered.
- Periodontal scaling and root planing is covered once per quadrant in any two-year period. Periodontal scaling and root planing four or more teeth (D4341) up to two quadrants may be performed on the same date of service. Periodontal scaling and root planing one to three teeth (D4342) all quadrants may be performed on the same date of service.
- Periodontal maintenance procedure is covered once in any six-month period. Additional periodontal maintenance may be allowed when dentally necessary.
- Full-mouth debridement is covered once in any two-year period.
- Separate charge for post-operative care done within six months following periodontal surgery is not covered.

CLASS III LIMITATIONS

G. Restorative

- Stainless steel crowns are covered on molars.
- Porcelain crowns are not covered.

H. Prosthodontics — Removable

- Full and/or immediate dentures (upper and/or lower) are covered once every 10 years regardless of when the last tooth was extracted (per arch).
- Partial dentures are covered once in a five-year period and require X-ray and clinical information for review.
- Cast partials are not covered.
- Adjustments to complete and partial dentures are allowed four times per calendar year.
- Denture rebase and reline procedures are covered once in a three-year period ages 16-20 and once in a five-year period over 21.
- Replacement of a partial denture with a full denture is allowed five years after the partial denture placement.

I. Orthodontics

- Orthodontic treatment (covered only for patients to age 20 who have a diagnosis at birth of cleft palate or cleft lip).

PLUS SERVICE LIMITATIONS AND EXCLUSIONS MEMBERS UNDER 21 YEARS OF AGE AND/OR PREGNANT

Based on the Oregon Administrative Rules (OAR) that govern OHP, the following service limitations apply for ODS members on OHP Plus:

CLASS I LIMITATIONS

A. Diagnostic

- Comprehensive and periodic oral evaluations are covered twice in any twelve-month period. Limited oral evaluation and re-evaluation limited problem focused exams are covered five times in a twelve-month period.
- Detailed and extensive oral evaluations are covered once in a twelve-month period. Full-mouth X-rays or panoramic films are covered once in any five-year period.
- Bitewing X-rays are covered once in a twelve-month period.

B. Preventive

- Prophylaxis is covered twice in a twelve-month period.
- Fluoride treatment is covered twice in a 12-month period.
- Sealant benefits are limited to the un-restored occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any five-year period for members ages 15 and younger.
- Plaque control, oral hygiene and/or dietary instruction are not covered.

CLASS II LIMITATIONS

C. Restorative

- Amalgam restorations have no frequency limitation. Initial benefits for restorations include repair or replacement to the same surface within 24 months when performed by the same provider and/or office.
- Composite resin restorations are covered one time every five years.
- Refer to Class III Limitations for further guidelines when teeth are restored with crowns.
- A separate charge for anesthesia and/or IV sedation when used for non-surgical procedures is not covered unless the member is classed by Health Systems as special needs.

D. Oral Surgery

- Clinical information showing multiple symptoms is required for any surgical extraction of third molars.
- A separate, additional charge for alveoplasty done in conjunction with removal of teeth is not covered.

E. Endodontics

- A separate charge for cultures is not covered.
- Pulp capping is not covered.
- Re-treatments are allowed for anterior teeth by review only. Retreatments are not covered on posterior teeth.
- Endodontics for second molars is covered for members under 21 if the final restoration is covered.
- Endodontics for third molars is not covered.

- Root canal therapy is only covered when the final restoration on the tooth is covered.

F. Periodontics

- A separate charge for periodontal charting is not covered.
- Periodontal scaling and root planing is covered once per quadrant in any two-year period. Periodontal scaling and root planing four or more teeth (D4341) up to two quadrants may be performed on the same date of service. Periodontal scaling and root planing one to three teeth (D4342) all quadrants may be performed on the same date of service.
- Periodontal maintenance procedure is covered once in any six-month period. Additional periodontal maintenance may be allowed when dentally necessary.
- Full-mouth debridement is covered once in any-two year period.
- Separate charge for post-operative care done within six months following periodontal surgery is not covered.

CLASS III LIMITATIONS

G. Restorative

- Stainless steel crowns are limited to posterior primary or permanent teeth and primary anterior teeth once in a five-year period.
- Porcelain Crowns are covered once in a seven-year period for members ages 16-20 and pregnant women of all ages and require clinical and X-ray information for review. Benefit is available for the following anterior teeth only: 6-11, 22 & 27.
- Permanent crowns are limited to a total of four crowns in a seven-year period.

H. Prosthodontics — Removable

- Full and/or Immediate Dentures (upper and/or lower) are covered once every 10 years regardless of when the last tooth was extracted (per arch).
- Partial Dentures are covered once in a five-year period and require X-ray and clinical information for review.
- Cast Partials are not covered.
- Adjustments to complete and partial dentures are allowed four times per calendar year.
- Denture Rebase and Reline Procedures are covered once in a three-year period.
- Replacement of a partial denture with a full denture is allowed ten years after the partial denture placement.

I. Orthodontics

- Orthodontic Treatment (covered only for patients to age 20 who have a diagnosis at birth of cleft palate or cleft lip).

OTHER SERVICE LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

1. Services for injuries or conditions that are compensable under worker's compensation or Employer's Liability Laws.
2. Procedures, appliances, restorations or other services that are primarily for cosmetic purposes are excluded.
3. Charges for missed or broken appointments are excluded.
4. Hospital charges for services, supplies or additional fees charged by the dentist for hospital treatment are excluded.
5. Experimental procedures or supplies are excluded.
6. Dental services started prior to the date the individual became eligible for such services under the OHP contract are excluded.
7. Any services related to the treatment of TMJ are excluded.
8. Claims submitted more than four months after the date of service shall be invalid and not payable. Claims that meet the criteria outlined in OAR 410-141-3420 must be submitted within 12 months of the date of service or they will be invalid and not payable.
9. Exclusions include all other services or supplies not specifically included in the OHP Plus Fee Schedule.

Please be sure to verify the member's eligibility prior to rendering services.

NON-COVERED SERVICES

ODS providers must inform OHP members of any charges for non-covered services prior to services being delivered. If a member chooses to receive a specific service that is not covered by ODS OHP, arrangements must be made between the provider and the member prior to rendering the service. You are required to:

1. Inform the member that the service is not covered
2. Provide an estimate of the cost of the service
3. Explain to the member their financial responsibility for the service
4. Complete the ODS OHP Patient Responsibility Waiver located in the back of this handbook.

The agreement between you and the member to pursue non-covered treatment must be documented using the OHP Patient Responsibility Waiver and must be signed by the member prior to rendering non-covered services. A sample of this Health Systems approved form has been included in the back of this handbook for your convenience. A copy of this form can also be downloaded from our website.

A member cannot be held financially responsible for the following (copayments do not apply):

- Services that are covered by ODS OHP
- Services that have been denied due to provider office error

A brief listing of non-covered services by OHP includes the following:

- Fixed prosthodontics

- Retreatment of previous root canal therapy to bicuspid and molars
- Veneers
- Implant and implant services
- Teeth whitening and other cosmetic procedures or appliances

For a list of allowed CDT codes and fees, contact dental professional relations at 503-265-5720, 888-374-8905 or dpr@modahealth.com. A complete CDT list with fees and frequency limitations is also available by selecting the OHP Covered/Non-Covered Services link in Benefit Tracker.

THE PRIORITIZED LIST

The Oregon Health Services Commission maintains a list of condition and treatment pairings known as the Prioritized List of Health Services. These pairings have been ranked by priority from most important to least important and subsequently assigned a line number.

Services prioritized as most important are funded by the state. The funding level is set at a line designated by the state. This means any pairing that occurs above the line is considered funded. Any pairing that occurs below the line is not funded. Below-the-line services include treatments that do not have beneficial results, treatments for cosmetic reasons and conditions that resolve on their own.

ODS OHP covers all funded services for dental. Legislative decisions may affect the funding line, therefore affecting covered services.

GETTING STARTED

To verify whether a dental service is covered by ODS, and to find out where the OHP line is currently set, check the Prioritized List of Health Services.

You can access the list by visiting the website:

- www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx. The list can be found by clicking on the link titled "Current Prioritized List."
- In addition to the list, Health Systems has provided a searchable index to assist you in locating the line(s) on which a condition or a treatment is listed.
- You may also find the covered/non-covered list helpful. This is located at www.modahealth.com/pdfs/covered_and_non_covered_dental_services.pdf.

IMPORTANT TO KNOW

- Due to legislative decisions, the funding line is subject to change. For the most current information, be sure to check with either Health Systems or ODS.
- Treatment may be covered for one condition but not covered for another. Remember that the pairing of the condition with the treatment determines which line the service is on.
- Oregon Administrative Rule 410-123-0000-1670-141-0860.

If the service is not covered by ODS OHP but treatment is deemed essential, additional information such as chart notes, narrative and any related X-rays can be submitted to ODS Dental Correspondence at 601 SW Second Ave., Portland, OR 97204.

MEMBER TRANSPORTATION

Transportation to dental appointments is available to patients who have no other means to the dental appointment. Non-urgent transportation is a benefit provided to the member by the member's

Coordinated Care Organization (CCO). Members should contact their CCO for transportation assistance by calling the transportation phone number listed in the following CCO section.

COORDINATED CARE ORGANIZATION (CCO)

OHP recipients select a Coordinated Care Organization (CCO) for their Medicaid coverage. CCOs bring together all types of health care providers (physical, mental health and dental care providers) in a community. The goal of the CCO is to help OHP members receive better care and stay healthy.

ODS began partnering with the CCOs in October 2013. There are a total of 16 CCOs in the state of Oregon. ODS has partnered with the following 13 CCOs:

CCO	General Contact	Transportation Contact	Counties Served
AllCare Health Plan	888-460-0185	800-479-7920	Curry, Douglas, Jackson, Josephine
Columbia Pacific CCO	800-224-4840	888-793-0439	Clatsop, Columbia, Coos, Douglas, Tillamook
Eastern Oregon CCO	888-788-9821	877-875-4657	Baker, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler
FamilyCare Tri-county CCO	800-458-9518	503-416-3955	Clackamas, Marion, Multnomah, Washington
Health Share of Oregon	888-519-3845	503-416-3955	Clackamas, Multnomah, Washington
InterCommunity Health Network CCO	800-832-4580	866-724-2975	Benton, Lincoln, Linn
Jackson Care Connect	800-224-4840	888-518-8160	Jackson
PacificSource Community Solutions – Columbia Gorge	800-431-4135	877-875-4657	Hood River, Wasco
PacificSource Community Solutions – Central	800-431-4135	866-385-8680	Crook, Deschutes, Jefferson, Klamath,
Primary Health of Josephine County	800-471-0304	888-518-8160	Douglas, Jackson, Josephine
Trillium Community Health Plan	877-600-5472	877-800-9899	Benton, Lane, Linn
Willamette Valley Community Health	866-362-4794	888-315-5544	Benton, Clackamas, Linn, Marion, Polk, Yamhill
Yamhill County Care Organizations	855-722-8205	844-256-5720	Clackamas, Marion, Polk, Washington, Yamhill

QUALIFIED INTERPRETER SERVICES

ODS covers and coordinates interpreter services for OHP member dental appointments for covered services.

To arrange for interpreter services, complete the ODS Interpreter Request form, which is available in the back of this handbook and on our website, and fax it to our customer service department at 503-765-3297 no less than 48 hours prior to the appointment.

For confirmation of interpreter services, please contact ODS Customer Service at 800-342-0526 to confirm that an interpreter has been arranged.

For urgent needs (less than 48 hours' notice), it is better to call the ODS Customer Service department at 800-342-0526 to arrange for an interpreter.

ODS OHP providers can choose to coordinate interpreter services themselves rather than coordinating them through ODS; however, the provider will be responsible for paying for the interpreter services. ODS does not reimburse for interpreter services that are not coordinated through the ODS Customer Service department.

REFERRALS

Effective July 1, 2016, we began only offering written referral services for special needs members. Referral requests for oral surgery, endodontics, pediatric dentistry, denturists and periodontics can now be handled personally between your office and the ODS OHP Specialist. You can search Find Care for a specialist in your area or call our customer service department at 800-342-0526, and they'll be happy to assist you.

REFERRAL REQUEST REQUIREMENTS

- Referrals for special needs members are accepted on the ODS OHP referral form located in the back of this handbook.
- All pertinent patient information (name, ID number, birth date, medical concerns, etc.)
- Procedure that is being requested.
- Provider contact information, including mailing address and a return fax number, when applicable.

SECOND OPINIONS

ODS provides for a second opinion from a qualified healthcare professional within the network or arranges for the enrollee to obtain a second opinion outside the network at no cost to the enrollee.

A dental second opinion is defined as a patient privilege of requesting an examination and evaluation of a dental health condition by the appropriate qualified healthcare professional or clinician to verify or challenge the diagnosis by a first healthcare professional or clinician.

The member or provider (on behalf of the member) contacts ODS to request a referral for a second opinion. ODS reviews the request according to its respective referral processing guidelines and assists the member or provider acting on behalf of the member to locate an appropriate in-network provider for the second opinion. If no appropriate provider is available in-network, the member may access an out-of-network provider at no cost.

The requesting provider may call 800-342-0526 or fax the completed referral request form to 503-765-3297.

THE REFERRAL PROCESS

REFERRAL PROCESS FOR GENERAL DENTISTS

- A written referral to a specialty provider is no longer required. The general dentist can call ODS OHP Dental Customer Service at 800-342-0526 for names of ODS OHP specialty providers. ODS will accept a referral request for patients with special needs or when a second opinion is needed. The general dentist can fax the completed ODS referral form request to 503-765-3297 (see form in the back of this handbook).
- ODS notifies the general dentist within 10 working days of receiving the request if the referral is approved, denied or pending for further review. Urgent referrals are processed within 1-2 working days.
- Once the referral is approved, ODS documents in the member record the specialist the member was referred to.
- If the referral request is denied, a formal written denial is mailed to the member and to the general dentist providing reason for denial. The notification includes the reason for denial and the member's right to appeal the denial.
- Referrals are not a guarantee of payment.

REFERRAL PROCESS FOR SPECIALISTS

- A written referral to a specialty provider is no longer required. Specialists must check eligibility before seeing a patient, regardless of the origin of the referral. If the patient was referred by the general dentist or contacted by the patient directly eligibility must be checked. The patient must be eligible with ODS on the date of service.
- Specialists requesting additional follow-up visits or wishing to send a patient to another specialist for consultation or treatment must consult with the patient's general dentist.
- Referrals are not a guarantee of payment.

ELIGIBILITY

Eligibility requirements for all OHP members are reviewed and granted by Health Systems, and a dental carrier is chosen by the member once enrolled. It is the responsibility of the provider to verify that the individual receiving dental services is an eligible individual on the date of service for the service provided and that ODS is the dental plan responsible for reimbursement. The provider assumes full financial risk of serving a person not confirmed by Health Systems as eligible for the service provided on the date of service. (OAR 410-120-1140)

ODS recommends that the provider always make a photocopy of the member's Medicaid ID card and photo identification for the patient each time they present for services.

Oregon residents can seek assistance with Medicaid enrollment through the federal health insurance exchange at HealthCare.gov. Oregon residents can also call 1-855-CoverOR for a list of people in the member's area who can assist. The assistance for completing an application from a community partner is free.

VERIFYING MEMBER ELIGIBILITY – ONLINE

There are two online systems available for verifying ODS Oregon Health Plan member eligibility and benefits. Health Systems' MMIS will display member's eligibility and CCO contact information (but not which DCO the member is assigned to) and the ODS Benefit Tracker will display eligibility information for our active dental members in all our partnered CCOs.

Medicaid Management Information System (MMIS):

MMIS provides a 24-hour, 7-days-a-week access for eligibility from Health Systems. MMIS will require a PIN issued by Health Systems for you to access information. For more information on MMIS, please visit <https://www.or-medicaid.gov/ProdPortal/>.

OHP providers that are not contracted directly with the State for fee for service reimbursement should confirm MMIS access with Health Systems.

Benefit Tracker:

Benefit Tracker (BT) is a free online service designed especially for dental offices that allows dentists and designated office staff to quickly verify dental benefits, claims status information and patient eligibility directly from ODS. For more information on how to register, please see the Benefit Tracker section in this handbook or visit our website at www.modahealth.com/dental

VERIFYING MEMBER ELIGIBILITY – TELEPHONE

ODS Customer Service staff is knowledgeable and helpful when it comes to your questions. They utilize Health Systems' MMIS system and Benefit Tracker to provide up-to-date information and policies so you can be confident you will receive the most current information available. You can reach them at 800-342-0526 from 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday, excluding holidays.

Due to HIPAA privacy rules, we require the following prior to verifying information about a member. Under OHP, each member has a separately assigned ID and a separate record.

Office information:

- First name of caller
- Provider's last name or clinic/provider office name
- Provider TIN

Member information:

- Member recipient ID number*
- Member last name and first name
- Member date of birth

*If the recipient ID is not known, please be prepared to provide the member Social Security Number (SSN) and member address.

VERIFYING MEMBER ELIGIBILITY – EMAIL AND FAX

Email ODS OHP Customer Service at dentalcasemanagement@modahealth.com.

You will need to identify yourself, as explained above, your patient and your request. Our goal is to send a response within 24 hours Monday through Friday, excluding holidays.

Fax ODS OHP Customer Service at 503-765-3297

You can fax a list of ODS OHP members including the member's first and last name, member ID and the member's date of birth. ODS Customer Service will use Health Systems' MMIS system, CCO web portals and Benefit Tracker to verify the member's eligibility. Faxes received by 3 p.m. will be returned no later than 9 a.m. on the following business day.

PLEASE NOTE: ODS receives daily eligibility updates, and these will be reflected in the Benefit Tracker system. ODS advises that whichever option you choose, you also obtain a photocopy of the member's ID card and photo ID for each visit.

ASSIGNED DENTISTS

Plus members who are assigned to a specific dentist or office must seek treatment from their assigned dentist for their benefits to be paid. If a patient presents for treatment and is assigned to one of the following offices, your office would need to direct the member to that office for treatment. Members assigned to a specific office can be identified on Benefit Tracker under Group Limitations.

Arrow Dental LLC Offices
1880 Lancaster Drive NE
Suite 121
Salem, OR 97305
971-600-3498

890 Seneca Road
Suite 101
Eugene, OR 97402
541-653-8610

OHSU Dental Clinics
2730 SW Moody Ave.
Portland, OR 97201
503-494-8867

James Klusmier
165 NW 1st Ave.
John Day, OR 97845
541-575-0363

Elisha B. Mayes
1400 Division Street
Elgin, OR 97827
541-437-6321

Yakima Valley Farm Workers Clinic
Family Medical Center
1120 West Rose Street
Walla Walla, WA 99362
509-525-0247

Yakima Valley Farm Workers Clinic
Salud Medical Center
1175 Mt. Hood Ave.
Woodburn, OR 97071
503-982-2000

ODS contracts with Tyack Dental Group to provide all dental care for ODS OHP Plus members who reside in Clatsop and Columbia counties. This allows ODS to remain an option in these counties and provide stable access for members.

Cities in Columbia and Clatsop County include the Following:

- Cannon Beach
- Columbia City
- St. Helens
- Astoria
- Clatskanie
- Seaside
- Rainier
- Vernonia
- Gearhart
- Prescott
- Warrenton
- Scappoose

TYACK DENTAL GROUP INFORMATION

Tyack Dental Group has several associates practicing in two offices located in Clatskanie and Astoria. The contact information is listed below.

400 S.W. Bel Air Drive
Clatskanie, OR 97016
503-728-2114

433 30th Street
Astoria, OR 97103
503-338-6000

EXCEPTIONS

If the member who has been assigned to a specific office travels outside of the service area and experiences a dental emergency, you can treat the member to relieve pain and in the case of a dental emergency. However, upon treatment completion for the dental emergency or pain relief, your office needs to refer the patient to their assigned dentist for follow up and future dental care.

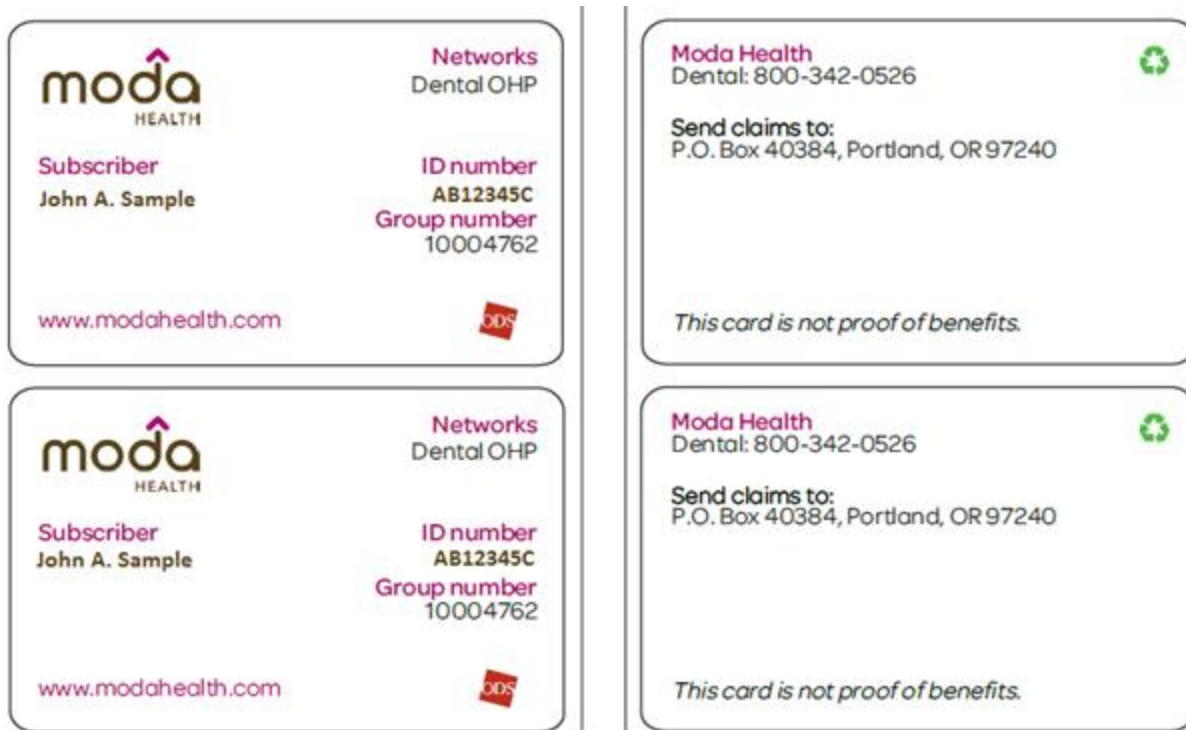
Payment to a different provider or an ODS OHP specialist (with the exception of a dental emergency outlined above) is only issued when the patient is referred by their general dentist. If a referral is needed to a specialist, please call our customer service department at 800-342-0526 or email dentalcasemanagement@modahealth.com for an ODS OHP specialist provider.

ODS OHP ID CARD

When an OHP member is assigned to ODS for dental care, ODS sends them an ID card to take to dental appointments in addition to the Health Systems Medical Care ID Cards.

Example #1:

This card shows the member is enrolled with Dental OHP. It does not show the member has an assigned dentist and is able to see any participating OHP ODS provider.



Example #2:

This card shows the member is enrolled with James Tyack DMD, PC and may only be seen by this Primary Care Provider. Refer to the *Assigned Dentists* section of the handbook for further details.



Members enrolled through a Coordinated Care Organization (CCO) will receive an ID card from the CCO; however, ODS will be indicated on the card as their dental plan if they have been assigned to ODS.

TIMELY ACCESS

To ensure that ODS OHP members have access to high-quality service and dental care in a timely manner, ODS has adopted the following Oregon Administrative Rule standards: These standards are monitored through the ODS after-hour's access survey and through member complaints.

A. Telephone Triage for Appointment Scheduling

Members calling to request dental care are assessed to determine if the level of care required is emergent, urgent or routine.

1. When members request an appointment, the receptionist/scheduler asks questions to determine the urgency of the dental need. Based on the responses, the member is scheduled appropriately.
2. The questions asked serve as guidelines and are not intended to substitute for the assistance of clinical staff in making determinations. Office staff consults with clinical staff or the practitioner to determine the appropriate length of time the member's condition requires for treatment.

B. Walk-in Triage

Walk-in members requesting dental care are assessed to determine if the level of care required is emergent, urgent or routine.

1. When a walk-in patient does not have an appointment, clinical personnel undertake triage. The triage process may consist of, but is not limited to:
 - a. Discussion with member or family to determine nature of problem
 - b. Superficial examination of affected area, if appropriate
 - c. Review of member's dental record and/or dental history
 - d. Assessment of needs based on discussion, examination and review
2. If clinical personnel are unable to assess the degree of need, the dentist is consulted.

C. Appointment scheduling

1. Emergent dental care

The member is seen or treated within 24 hours. Members calling or walking into the office with emergent problems are put in immediate contact with a clinical staff member.

If the dental condition requires treatment not available in the office, the member is sent to the appropriate facility or specialty dentist immediately. Referrals are provided if necessary.

2. Urgent dental care

Urgent care is made available within one to two weeks depending on the member's condition.

3. Routine care

A member with routine care needs is scheduled for an appointment within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason, which would make access longer than 12 weeks appropriate.

MONITORING ACCESS:

ODS periodically conducts telephone surveys to assess the access of our members for appointments and 24-hour after-hours access for dental emergencies. The purpose of the survey is to monitor compliance with the following rules:

- Oregon administrative rule 410-141-0220 for the Oregon Health Plan
- Board of Dentistry's rule 818-012-0010 under "Unacceptable Patient Care"

These rules require that the licensee provide or arrange for emergency treatment for established patients.

The after-hours survey is conducted between 6 p.m. and 7 a.m. to identify what type of coverage is in place. The expectation is that the dentist will have one of the following:

- An answering service that is able to reach the patient's primary dentist or an on-call dentist; or
- The patient's primary dentist office message will instruct an established patient to call a listed after-hours telephone number that will reach the primary dentist or an on-call dentist. The after-hours number is also called to determine whether the patient can leave a message.

Dentists who do not meet the criteria above are notified and must become compliant in order to continue as an OHP participating provider with ODS.

MEMBER RIGHTS AND RESPONSIBILITIES

A copy of these rights and responsibilities is also available to members in the Dental Member Handbook they receive from ODS upon enrollment.

MEMBERS HAVE THE RIGHT TO:

1. Be treated with dignity and respect.
2. Be treated by participating providers the same as other people seeking dental care benefits to which they are entitled.
3. Select or change primary care dentists (PCD).
4. Have a friend, family member or advocate present during appointments and at other times as needed within clinical guidelines.
5. Be actively involved in creating treatment plans.
6. Be given information about conditions, covered services and non-covered services in order to make an informed decision about proposed treatment(s).
7. Consent to treatment or refuse services and be told the consequences of the decision, except for court-ordered services.
8. Receive written materials describing rights, responsibilities, benefits available, how to access services and what to do in an emergency.
9. Have written materials explained in a manner that is understandable.
10. Receive necessary and reasonable services to diagnose the presenting condition.
11. Receive covered services under the Oregon Health Plan that meet generally accepted standards of practice and are medically appropriate.
12. Receive covered preventive services.

13. Have access to urgent and emergency services 24 hours a day, seven days a week.
14. Receive a referral to specialty providers for dentally appropriate covered services.
15. Have a clinical record maintained that documents conditions, services received and referrals made.
16. Have access to one's own clinical record, unless restricted by law, and request and receive a copy of their records and request that they be amended or corrected.
17. Transfer a copy of their clinical record to another provider.
18. Execute a statement of wishes for treatment (Advanced Directive), including the right to accept or refuse dental treatment and the right to obtain a power of attorney for healthcare.
19. Receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations.
20. Know how to make a complaint or appeal about any aspect of care or the plan.
21. Request an Administrative Hearing with Health Systems.
22. Receive interpreter services.
23. Receive a notice of an appointment cancellation in a timely manner.
24. Receive covered services under OHP, which meet generally accepted standards of practice, as is dentally appropriate.
25. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation and to report any violations to ODS or to the Oregon Health Plan.
26. Post-stabilization services after an emergency department visit.
27. A second dental opinion.

MEMBERS HAVE THE RESPONSIBILITY TO:

1. Choose, or help with, assignment to a provider or clinic, once enrolled.
2. Treat all providers and their staff with respect.
3. Be on time for appointments made with providers and call in advance either to cancel if unable to keep the appointment or if expected to be late.
4. Seek periodic dental exams, check-ups and preventive care from the member's dentist.
5. Use the member's dentist or clinic for diagnostic and other care except in an emergency.
6. Obtain a referral to a specialist from the general dentist before seeking care from a specialist.
7. Use urgent and emergency services appropriately and notify ODS within 72 hours of an emergency.
8. Give accurate information for the clinical record.
9. Help the provider obtain clinical records from other providers. This may include signing a release of information form.
10. Ask questions about conditions, treatments and other issues related to their care that they do not understand.
11. Use information to decide about treatment before it is given.
12. Help in the creation of a treatment plan with the provider.
13. Follow prescribed, agreed-upon treatment plans.
14. Tell providers that the member's dental care is covered under the Oregon Health Plan before services are received and, if requested, show the provider the Division Medical Care identification form.
15. Tell the Authority worker of a change of address or phone number.
16. Tell the Authority worker if she becomes pregnant and notify the Authority worker of the birth of the child.
17. Tell the Authority worker if any family members move in or out of the household.

18. Tell the Authority worker if there is any other insurance available.
19. Pay for non-covered services received under the provisions described in OAR 410-120-1200 and 410-120-1280.
20. Pay the monthly OHP premium on time if so required.
21. Assist in pursuing any third-party resources available and to pay ODS the amount of benefits paid from an injury from any recovery received from that injury.
22. Bring issues, complaints or grievances to the attention of ODS.
23. Sign an authorization for release of dental information so that ODS can get information pertinent and needed to respond to an administrative hearing request in an effective and efficient manner.

SECLUSION AND RESTRAINT POLICY

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

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

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

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

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

ODS requires their participating OHP dentists to have a policy and procedure regarding the use of seclusion and restraint as required under the Code of Federal Regulations and also requires the provider to provide ODS a copy of their policy upon request.

(42 CFR, 438.100, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation)

MEMBER DISMISSAL AND DISENROLLMENT GUIDELINES

DEFINITIONS

- Dismissal is when a member is removed from the care of their general dentist.
- Disenrollment is when a member is removed from their OHP dental plan.

REQUIREMENTS

ODS must follow the guidelines established by Health Systems regarding disenrolling members from the plan. ODS encourages members and their providers to resolve complaints, problems and concerns at the clinic level.

KEY POINTS WHEN CONSIDERING DISMISSING A MEMBER

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

- Timely, early communication
- Thorough documentation of events, problems and behaviors
- A plan generated by the dental office to attempt to address the problem or concern
- Use of contracts and case conferences
- Consideration of mental health diagnoses whenever dismissing or requesting disenrollment of a member

WHEN CAN A MEMBER BE DISMISSED?

A member may be dismissed from a dentist's office or disenrolled from ODS only with just cause. The list of just causes, identified by Health Systems, includes but is not limited to:

- Missed appointments
- Drug-seeking behavior
- Committing or threatening an act of physical violence directed at a dental provider, office staff, clinic, property, other patients, or ODS staff
- Dismissal from dentist by mutual agreement between the member and the provider
- Agreement between provider and ODS that adequate, safe and effective care can no longer be provided
- A fraudulent or illegal act committed by a member, such as permitting someone else to use their Health Systems Medical ID Card, altering a prescription, or committing a theft or another criminal act on any provider's premises

IF A DENTIST DETERMINES TO DISMISS A MEMBER

When the clinic management moves to dismiss a member, a letter is sent to the member informing of the dismissal, with a copy sent to ODS. Dentists are asked to provide urgent care for the dismissed member for 30 days following notification of the member. ODS Customer Service Representatives work with the member to establish a new dentist.

WHEN A MEMBER CANNOT BE DISMISSED

Oregon Administrative Rule 410-141-0080 states that members shall not be dismissed from a dentist or disenrolled from ODS solely because:

- The member has a physical, intellectual, developmental, or mental disability.
- There is an adverse change in the member's health.
- The provider or ODS believes the member's utilization of services is either excessive or lacking.

- The member requests a hearing against a provider or ODS.
- The member exercises their option to make decisions regarding their dental care, with which the provider or the plan disagrees.
- The member engages in uncooperative or disruptive behavior as a result of their special needs.

CAUSE FOR REQUEST FOR DISENROLLMENT

ODS requests immediate disenrollment when notified about any of the following circumstances:

- Disruptive, unruly or abusive behavior.
- The member commits a fraudulent or illegal act, such as permitting someone else to use their Medical ID Card, altering a prescription, or committing a theft or another criminal act on any provider's premises.
- The member commits or threatens an act of physical violence directed at a dental provider, office staff, property, clinic, other patient, or ODS staff.
- Missed appointments.

Send copies of relevant documentation, including chart notes and a police report, to ODS. ODS contacts Health Systems and requests immediate disenrollment.

MISSED APPOINTMENT POLICY

Providers should individually establish an office policy for the number of missed appointments they allow before dismissing a member from their practice. This policy must be administered the same for all patients. The provider's office must inform all members of their office policy on missed appointments at the member's first visit. The provider needs to have members sign an acknowledgement of the office policy.

When a member misses an appointment, the provider's office should attempt to contact the member to reschedule and notify ODS Customer Service of the missed appointment. ODS Customer Service will contact the member and educate them on the importance and expectation of keeping appointments and the necessity of advance notice of cancellation. A form has been included in the back of this handbook and on our website that your office can mail or fax to ODS Customer Service for your convenience.

If the member continues to miss appointments and the provider decides to dismiss the member, the provider must send a letter to the member informing them of the dismissal. A copy of the dismissal letter should be sent to ODS Customer Service along with a copy of the office policy on missed appointments and any other relevant documentation, including chart notes, correspondence sent to the member, signed contracts and/or documentation of case conferences. The patient will be asked to select a new provider. ODS requests disenrollment of a member after that member has been dismissed from two providers for missed appointments in a 12-month period.

MEMBER COMPLAINTS AND APPEALS

COMPLAINTS

A complaint is an expression of dissatisfaction to ODS or a provider about any matter that does not involve a denial, limitation, reduction or termination of a requested covered service. Examples of complaints include, but are not limited to, access to providers, waiting times, demeanor of dental care personnel, quality of care and adequacy of facilities. Providers are encouraged to resolve complaints, problems and concerns brought to them by their ODS patients. If a complaint cannot be resolved, inform the member that ODS has a formal complaint procedure. Members' complaints must be made to ODS Customer Service. If a member is not satisfied with the way ODS handles the complaint, the member has the right to file a complaint with the OHA Ombudsman's Office.

APPEALS

An appeal is a request by an ODS member or the member's representative to review an ODS decision to deny, limit, reduce or terminate a requested covered service or to deny a claim payment. Member appeals must be made to ODS in writing within 45 days of the decision. If the member calls ODS Customer Service, the member must follow up with a written appeal. Providers may also appeal on behalf of the member with the member's permission. The member also has the right to file an Oregon administrative hearing request with Health Systems.

RESOLVING COMPLAINTS AND APPEALS AT ODS

The ODS appeal staff facilitates the member complaint and appeal processes and seek input from appropriate parties, such as the provider, dental consultant or care coordination staff to reach decisions about the complaints and appeals. The appeal staff sends a written resolution to the member or the member's representative within five days of receipt of a complaint and within 14 days of receipt for an appeal.

STATE OF OREGON ADMINISTRATIVE HEARING PROCESS

- Health Systems has an appeal process for members who are dissatisfied with ODS's response to an appeal of a denial, limitation, reduction or termination of a requested covered service or denial of claims payment. This is the state of Oregon Administrative Hearing process.
- When ODS denies, limits, reduces or terminates a requested covered service, or denies a claim payment, the ODS Notice of Action letter outlines the member's right to file an appeal with ODS and the appeal timelines. The letter also informs the member of the right to request a state of Oregon Administrative Hearing and the timelines if the member continues to be dissatisfied with the ODS appeal decision.
- Members may obtain more information about this process by contacting their Authority worker or contacting the ODS OHP Customer Service department at 503-243-2987 or toll-free at 800-342-0526.

Below are the methods in which a member can submit a Complaint or Appeal to ODS OHP:

Write

Member Appeal Unit
ODS P.O. Box 40384
Portland, OR 97240

Fax

503-412-4003
Attention: Appeals Unit

Telephone

ODS OHP Customer Service 503-243-2987 or toll-free at 800-342-0526 (TTY 711)

OHP Complaint Form

A member may file a complaint or appeal using an OHP Complaint Form 3001. The form can be found online at: <http://dhsforms.hr.state.or.us/Forms/Served/HE3001.pdf>.

SUBMITTING CLAIMS

ACCEPTABLE CLAIM FORM

Please file all claims using the most recent ADA Dental Claim form. If you would like information on billing claims electronically, please contact our Electronic Data Interchange (EDI) department at 1-800-852-5195 or 503-228-6554.

TIMELY FILING GUIDELINES

ODS requests that all eligible claims for covered services be received in our office within four months from the date of service. Claims received later than four months from the date of service shall be invalid and not payable. Claims that meet the criteria outlined in OAR 410-141-3420 must be submitted within 12 months of the date of service or they will be invalid and not payable.

If a payment disbursement register (PDR) is not received within 45 days of submission of the claim, the billing office should contact ODS Customer Service or check Benefit Tracker to verify that the claim has been received. Please verify if your initial claim was received prior to submitting a duplicate. When submitting a claim electronically using an electronic claims service or clearing house, check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing.

All information required to process a claim must be submitted in a timely manner (e.g., clinical notes, X-rays, chart notes). Any adjustments needed must be identified and the adjustment request received within 12 months of the date of service.

CORRECTED BILLINGS

All claims submitted to ODS as corrected billings to previously submitted claims need to be clearly marked in the remarks section of a paper claim as a "corrected billing," or noted on the electronic claim. In addition, dental records need to accompany the corrected billing if the change involves a change in procedure or the addition of procedure codes.

ELECTRONIC CLAIMS SUBMISSION

Providers can reduce administrative time shorten turnaround time by submitting claims electronically.

ODS is able to accept claims from the following electronic connections:

- DMC (Dentist Management Corporation)
- APEX EDI
- CPS (Claims Processing System)
- EHG (EDI Health Group, Inc.)
- TESIA/PCI Corp.
- QSI (Quality System Incorporated)

The EDI Department at ODS will work with your office to advise you of the options available.

For information on setting up this process, please call or write:

Moda Health
EDI Department
601 SW Second Ave.
Portland, OR 97204
503-228-6554
800-852-5195
Email: edigroup@modahealth.com

DENIALS AND APPEALS OF PREDETERMINATIONS, REFERRALS AND PAYMENT

DENIALS

When ODS denies a service or referral, a written notice of action is mailed to the member and requesting provider.

The notice of action includes the following information:

- Service requested
- Reason for denial
- Member's appeal rights and instructions
- Member's right to file an OHP administrative hearing request and instructions

APPEALS

Letters denying authorization or referral inform members they have a right to file an appeal and/or an OHP administrative hearing request. Appeals must be submitted to ODS in writing. Providers can also appeal on behalf of the member. Members would need to indicate in writing that they want the provider to appeal on their behalf.

An appeal may be requested as follows:

Write

Member Appeal Unit
ODS P.O. Box 40384
Portland, OR 97240

Fax

503-412-4003

Telephone

ODS OHP Customer Service 503-243-2987 or 800-342-0526 (TTY 711)

Oregon Health Plan Complaint Form

Complaint forms are available on the ODS website at:
www.modahealth.com/pdfs/grievance_form_ohp.pdf

An appeal must be requested within 45 days of the date on the member's notice of action letter. The appeal will be processed by the ODS appeal staff, who seek input from appropriate parties, such as the provider or the ODS dental consultant to reach an informed decision about the appeal. The decision to uphold the denial or approve the requested service is communicated in writing to the member, PCD or requesting provider and specialist (when applicable) within five days of receipt of a complaint and within 14 days of receipt of an appeal.

The member also has the right to request an administrative hearing through Health Systems. The ODS denial letter informs the member on how to request an administrative hearing.

Claims indicating treatment beyond which a claims auditor is trained to review, or where special information has been furnished by the treating dentist, are reviewed by the ODS dental consultant. The consultant reviews the information submitted and determines if a service is within the covered benefits specified in the OHP contract. Contract benefit determination is made following the consultant's review.

COORDINATION OF BENEFITS

OHP will always be secondary to all other insurance coverage. If the member has private insurance, that carrier's Explanation of Benefits (EOB) should be submitted with the claim as soon as the EOB is received. Exceptions to this rule include Indian Health Services or Tribal Health Facilities and Veterans Administration plans.

CALCULATING COORDINATION OF BENEFITS

As secondary payer, ODS issues benefits when the primary carrier paid less than the ODS OHP allowed amount for each procedure. Payment is the difference between ODS OHP total allowed amount and the primary carrier's total payment.

If the primary plan's payment is more than the ODS allowed amount, no additional benefit will be issued. All remaining balances, including primary plan deductibles and/or co-insurances, are to be included in the provider discount. The deductible and/or co-insurance may be collected when treatment is performed by a Delta Dental Provider who does not participate in the ODS OHP network.

PREDETERMINATION OF BENEFITS

A predetermination of benefits gives the provider a response to an inquiry regarding benefits, is based on current history and eligibility at the time the predetermination is processed, and is subject to change.

A current ADA form may be submitted with the following information:

- The request for predetermination box at the top of the form should be checked.
- The appointment date fields should be blank.
- Use current ADA codes for all procedures proposed.

Predeterminations are an option for partials, dentures, and third molar extractions.
Predeterminations are not a guarantee of payment.

BENEFIT TRACKER (BT)

Benefit Tracker (BT) is a free online service designed especially for dental offices that allows dentists and designated office staff to quickly verify dental benefits, claims status information and patient eligibility directly from ODS.

There are many benefits to using Benefit Tracker.

- Find benefit information.
- Access the most up-to-date information at the most convenient times for you, whether it's during office hours or after hours.
- Use benefit information to quickly determine the best treatment plan for your patient.
- Check the latest claims status of a patient or use the search filters to find the status of older claims.
- Print out hard copies for patient files, statement plan presentations and easy updates to plan benefit software.

BENEFIT TRACKER CONTACT INFORMATION

Registration and additional information can be obtained by contacting our Benefit Tracker Administrator or by accessing the ODS website at www.modahealth.com/dental/.

Benefit Tracker Administrator
601 SW Second Ave.
Portland OR 97204
877-337-0651 (choose option 1)
Email: ebt@modahealth.com

BILLING THE MEMBER

State and federal regulations prohibit billing OHP members for OHP covered services. Providers must inform OHP members of any charges for non-covered services prior to the services being rendered.

The following are examples of when members cannot be billed.

- For covered services that were denied due to a lack of referral
- For covered services that were denied because the member was assigned to another general dentist other than the one who rendered the services
- For services that are covered by ODS or OHP – this includes balance billing the member for the difference between the ODS allowed amount and the provider's billed charges.
- For broken or missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the member.

There are very limited circumstances when a provider may legally bill an OHP member:

1. A provider may bill a member if the service provided is not covered by OHP and the member signed a waiver before services were rendered.
 - The waiver must be the Health System's approved waiver located in the back of this handbook.
 - The waiver must be written in the primary language of the member.
2. A provider may also bill a member if the member did not advise the provider that they had Medicaid insurance and attempts were made to obtain insurance information.
 - The provider must document attempts to obtain information on insurance or document a member's statement of non-insurance.
 - Merely billing or sending a statement to a member does not constitute an attempt to obtain insurance information.
 - **For a complete description of the rules, please refer to the General Rules, 410-120-1280 at: www.oregon.gov/oha/healthplan/Pages/general-rules.aspx**

PROFESSIONAL REVIEW

The professional review department reviews selected claims to determine if a service is necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury. When a claim is selected for review, your office will be notified via a letter. You can then send in the clinical, referencing the claim number on the letter. It is important to send the recommended information and ensure your X-rays are of diagnostic quality and clearly labeled to expedite the process.

By selecting claims randomly and based on practice and billing patterns (focused review), we are able to reduce the number of codes requiring 100 percent review. Supporting documentation such as X-rays are usually needed on only a portion of all claims, and we recommend reviewing the following sections *Professional Review Procedure Codes* and *Clinical Review Requirements* for specific clinical submission guidelines.

When a claim is selected for review, additional information from the treating dentist may be requested. All pertinent information should be submitted when requested by professional review. Re-evaluation requests made by your office are handled in the same manner; however, claims are not re-evaluated in the absence of additional, pertinent information.

PROFESSIONAL 100% REVIEW PROCEDURE CODES

The following list of procedure codes will always go through the Professional Review process, requiring clinical documentation for benefit determination.

To expedite the processing of your claim, it is requested you submit the clinical information with your initial claims submission using the Clinical Review Requirements on the following pages. Our Clinical Review Requirements outline the necessary documentation and/or clinical information required for review of specific procedure codes.

DIAGNOSTIC	ENDODONTICS	ORAL SURGERY	ORAL SURGERY	ADJUNCTIVE SERVICES
D0310	D3331	D7251	D7770	D9211
D0472	D3332	D7261	D7911	D9212
D0473	D3333	D7270	D7912	D9440
D0474	D3346	D7287	D7960	D9610
D0480	D3351	D7340	D7963	D9612
D0502	D3352	D7350	D7970	D9630
RESTORATIVE	D3353	D7490	D7971 D7980	D9920
	D3354			
D2751	D3410 D3430	D7530	D7981	
D2752	PERIODONTICS	D7540	D7982	
D2980	D4920	D7550	D7983	
	PROSTHODONTICS	D7560	D7990	
	D5211	D7670		
	D5212			

CLINICAL INFORMATION REQUIREMENTS

Please refer to the *Professional 100% Review Procedure Codes* list in this handbook for a list of procedure codes that will always require documentation for payment determination. Information provided below includes codes that are not on the 100% review list. The Submission Request information is for your office to use as a guideline in the event a claim is randomly selected for Professional Review.

The below requirements are necessary for our professional review team to adequately determine necessity. Chart notes should always include diagnosis and justification for all treatment rendered.

DIAGNOSTIC SERVICES: D0100-D0999		
Code	Description of Service	Submission Request
D0140	Limited Oral Evaluation – Problem Focused	Chart notes regarding the necessity of the treatment rendered including the diagnosis. Include any additional diagnostic information to assist in determining benefits.
D0220, D0230	Periapical X-Rays	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D0310	Sialography	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D0320	Temporomandibular Joint Arthrogram	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D0321	Temporomandibular Joint Films	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D0472, D0473, D0474, D0480, D0486, D0502	Accession of tissue, gross examination, preparation and transmission of written report, other oral pathology procedures, by report	Pathology report indicating specific location of tissue. Services performed on the lip, cheeks or tongue are not covered.

SPACE MAINTENANCE D1510 – D1525		
Code	Description of Service	Submission Request
D1510, D1515, D1520, D1525	Space Maintainers	Please specify the teeth being replaced and the teeth being clasped. Include detailed narrative regarding the reason this treatment is being done instead of a bilateral removable partial denture.
CROWNS D2390 - D2799		
Code	Description of Service	Submission Request
D2390	Resin-based composite crown, anterior	Current periapical radiographs and chart notes outlining necessity.
D2710, D2712, D2751, D2752	Crowns – single restorations only	Current radiographs (periapical radiographs are preferred), intraoral photographs if available. Chart notes outlining necessity, symptoms and diagnosis. It is preferred that panoramic radiographs are NOT submitted for anterior crowns.
D2980	Crown Repair	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
BUILDUP/POSTS: D2950 - D2957		
Code	Description of Service	Submission Request
D2950, D2951, D2954, D2955, D2957	Core buildup for single restorations	Current periapical radiographs. Intra-oral photo, if available. Chart notes outlining diagnosis, or completion date of RCT. If replacement crown, periapical radiographs and/or photos after existing crown removed, Per the ADA, buildups should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.

ENDODONTICS: APEXIFICATION D3351-D3353		
Code	Description of Service	Submission Request
D3310, D3320, D3330	Endodontic Therapy	Current periapical radiographs with chart notes. Please also indicate the type of final restoration being placed after completion of the endodontic treatment.
D3331, D3333	Obstruction and root repair	Pre-operative and post-operative periapical radiographs, if applicable, with chart notes regarding the necessity of the endodontic procedure.
D3332	Incomplete root canal	Please provide chart notes indicating why this tooth is inoperable or unrestorable.
D3346	Retreatment of Previous Root Canal Therapy – anterior	Current periapical radiographs and chart notes. Please also indicate the type of final restoration being placed after completion of the endodontic treatment.
D3351, D3352, D3353	Apexification/recalcification procedures	Current periapical radiographs and chart notes. Please also indicate the reason for treatment and if apexification/recalcification procedure is the first step of root canal therapy.
D3410, D3430	Retrograde Filling	Pre-operative and post-operative periapical radiographs, if applicable, and chart notes regarding the necessity of the endodontic procedure.

PERIODONTAL PROCEDURES: D4211-D4268		
Code	Description of Service	Submission Request
D4210, D4211	Gingivectomy	Periodontal charting (probing done within past 12 months), diagnosis, bitewing X-rays, and chart notes regarding the necessity of the periodontal treatment, and date of last active periodontal therapy, if applicable.
D4341, D4342	Periodontal scaling and root planing	
D4910	Periodontal maintenance	
D4355	Full-mouth debridement to enable comprehensive evaluation and diagnosis	Chart notes regarding necessity, and any additional diagnostic information to assist in determining benefits.
D4920	Unscheduled dressing change	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.

PROSTHETICS: D5213 - D5214		
Code	Description of Service	Submission Request
D5211, D5212	Removable prosthetic services	Current periapical radiographs, periodontal charting done within past 12 months and definitive treatment plan for entire mouth. Please indicate missing teeth to be replaced and teeth to be clasped, as well as any additional teeth that will be extracted.
D5820, D5821	Interim Partial Denture	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.

BIOPSY: D7285-D7410		
Code	Description of Service	Submission Request
D7285, D7286, D7287, D7288, D7410, D7440, D7450, D7460, D7465	Surgical procedures	Pathology report indicating specific location of tissue. Services performed on the lip, cheeks or tongue are not covered.

ORAL AND MAXILLOFACIAL SURGERY: D7111- D7997 (EXCLUDING BIOPSY)		
Code	Description of Service	Submission Request
D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7490,	Oral and maxillofacial surgery	Current periapical X-rays and chart notes regarding the necessity of the treatment. Include any additional diagnostic

D7510, D7530, D7540, D7550, D7560, D7960, D7963, D7971		information to assist in determining benefits.
D7320, D7340, D7350, D7471, D7520, D7670, D7770, D7910, D7911, D7912, D7970, D7980, D7981, D7982, D7983, D7990, D7997	Oral and maxillofacial surgery	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
ADJUNCTIVE PROCEDURES: D9910- D9940		
Code	Description of Service	Submission Request
D9211, D9212, D9310, D9440, D9610, D9612, D9630, D9920, D9930	Adjunctive procedures	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.

Information required only when clinical is requested.

Photographs are always beneficial in determining cracked teeth, build-ups, crowns and anterior restorations.

DENTAL RECORDS STANDARDS

CLINICAL RECORDS

The provider is required to:

- Have all active dental records available for ODS.
- Have a filing system that provides retrievable dental records.
- Maintain dental records for seven years after the date of service for which claims are made.
- Participating OHP providers are required to release requested information to ODS according to OAR 410-141-0180 (3).

FRAUD AND ABUSE

It is the policy of ODS that its employees and providers comply with all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste and abuse in the provision of health care services to ODS members and payment for such services to providers. Complete descriptions of the applicable federal and state laws are listed at the bottom of this policy.

Two common types of healthcare fraud are member fraud and provider fraud. Examples of member fraud include:

- Using someone else's coverage or allowing someone besides the member to use the member's insurance card or coverage to receive treatment
- Filing for claims or medications that were never received
- Forging or altering bills or receipts

Examples of provider fraud include:

- Billing for services or procedures that were not provided
- Performing medically unnecessary services in order to obtain insurance reimbursement
- Incorrect reporting or unbundling of procedures or diagnoses to maximize insurance reimbursement
- Misrepresentations of dates, description of services or subscribers/providers

TO ENSURE THAT AS A PROVIDER YOU ARE NOT THE VICTIM OF HEALTHCARE FRAUD, TAKE THE FOLLOWING PRECAUTIONS:

- Always ask for photo identification of new patients. Take a copy and put it in his/her chart. If you are able to take a photo of your patients, do so.
- Make sure to have a signature on file in the patient's handwriting.
- Thoroughly check the PDR that ODS sends you. Make sure as you review the PDR that the dates, patient and services are correct. Also, make sure this was an appointment the patient actually attended — it is not uncommon for criminals to bill for services not received and ask for the payment to be sent to them.

ODS has a fraud, waste and abuse prevention, detection and reporting plan that applies to all ODS employees and providers. ODS has internal controls and procedures designed to prevent and detect potential fraud, waste and abuse activities by groups, members, providers and employees.

This plan includes operational policies and controls in areas such as claims, predeterminations, utilization management and quality review, member complaint and grievance resolution, practitioner credentialing and contracting, practitioner and ODS employee education, human resource policies and procedures, and corrective action plans to address fraud, waste and abuse activities. Verified cases of fraud, waste or abuse are reported to the appropriate regulatory agency. ODS reviews and revises its Fraud and Abuse policy and operational procedures annually.

If you suspect you are the victim of fraud or if you suspect a member is committing fraud, please call ODS immediately at 877-372-8356. ODS will investigate all reports of fraud to protect our providers and members.

Information identified, researched or obtained for or as part of a suspected fraud, waste or abuse investigation may be considered confidential. Any information used and/or developed by participants in the investigation of a potential fraud, waste and abuse occurrence is maintained solely for this specific purpose and no other. ODS assures the anonymity of complainants to the extent permitted by law.

FEDERAL LAWS:

False Claims Act: The federal civil False Claims Act (“FCA”) is one of the most effective tools used to recover amounts improperly paid due to fraud and contains provisions designed to enhance the federal government’s ability to identify and recover such losses. The FCA prohibits any individual or company from knowingly submitting false or fraudulent claims, causing such claims to be submitted, making a false record or statement in order to secure payment from the federal government for such a claim, or conspiring to get such a claim allowed or paid. Under the statute, the terms “knowing” and “knowingly” mean that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Examples of the types of activity prohibited by the FCA include billing for services that were not actually rendered, and upcoding (billing for a more highly reimbursed service or product than the one actually provided).

The FCA is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years of a violation or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than 10 years after the date on which the violation was committed. Individuals or companies found to have violated the statute are liable for a civil penalty for each claim of not less than \$5,500 and not more than \$11,000, plus up to three times the amount of damages sustained by the federal government.

Qui Tam and Whistleblower Protection Provisions: The False Claims Act contains qui tam, or whistleblower provision. Qui tam is a unique mechanism in the law that allows citizens to bring actions in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with the federal government. A qui tam action brought under the FCA by a private citizen commences upon the filing of a civil complaint in federal court. The government then has 60 days to investigate the allegations in the complaint and decide whether it will join the action. If the government joins the action, it takes the lead role in prosecuting the claim.

However, if the government decides not to join, the whistleblower may pursue the action alone, but the government may still join at a later date. As compensation for the risk and effort involved when a private citizen brings a qui tam action, the FCA provides that whistleblowers who file a qui tam action may be awarded a portion of the funds recovered (typically between 15 and 25 percent), plus attorneys’ fees and costs.

Whistleblowers are also offered certain protections against retaliation for bringing an action under the FCA. Employees who are discharged, demoted, harassed or otherwise encounter discrimination as a result of initiating a qui tam action or as a consequence of whistle blowing activity are entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay with interest and compensation for any special damages, including attorneys’ fees and costs of litigation.

Federal Program Fraud Civil Remedies Act Information: The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against persons who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services.

Any person who makes, presents or submits, or causes to be made, presented or submitted, a claim that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil money penalties of up to \$5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

STATE LAWS:

Public Assistance: Submitting Wrongful Claim or Payment. Under Oregon law, no person shall obtain or attempt to obtain, for personal benefit or the benefit of any other person, any payment for furnishing any need to or for the benefit of any public assistance recipient by knowingly: (1) submitting or causing to be submitted to the Department of Human Services any false claim for payment; (2) submitting or causing to be submitted to the department any claim for payment that has been submitted for payment already unless such claim is clearly labeled as a duplicate; (3) submitting or causing to be submitted to the department any claim for payment that is a claim upon which payment has been made by the department or any other source unless clearly labeled as such; or (4) accepting any payment from the department for furnishing any need if the need upon which the payment is based has not been provided. Violation of this law is a Class C Felony.

Any person who accepts from the Department of Human Services any payment made to such person for furnishing any need to or for the benefit of a public assistance recipient shall be liable to refund or credit the amount of such payment to the department if such person has obtained or subsequently obtains from the recipient or from any source any additional payment received for furnishing the same need to or for the benefit of such recipient. However, the liability of such person shall be limited to the lesser of the following amounts: (a) the amount of the payment so accepted from the department; or (b) the amount by which the aggregate sum of all payments so accepted or received by such person exceeds the maximum amount payable for such need from public assistance funds under rules adopted by the department.

Any person who, after having been afforded an opportunity for a contested case hearing pursuant to Oregon law, is found to violate ORS 411.675 shall be liable to the department for treble the amount of the payment received as a result of such violation.

False Claims for Healthcare Payments: A person commits the crime of making a false claim for healthcare payment when the person: (1) knowingly makes or causes to be made a claim for healthcare payment that contains any false statement or false representation of a material fact in order to receive a healthcare payment; or (2) knowingly conceals from or fails to disclose to a healthcare payer the occurrence of any event or the existence of any information with the intent to obtain a healthcare payment to which the person is not entitled, or to obtain or retain a healthcare payment in an amount greater than that to which the person is or was entitled. The district attorney or the attorney general may commence a prosecution under this law, and the Department of Human Services and any appropriate licensing boards will be notified of the conviction of any person under this law.

Whistle blowing and Non-retaliation: ODS may not terminate, demote, suspend or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith reported fraud, waste or abuse by any person, has in good faith caused a complainant's information or complaint to be filed against any person, has in good faith cooperated with any law enforcement agency conducting a criminal investigation into allegations of fraud, waste or abuse, has in good faith brought a civil proceeding against an employer or has testified in good faith at a civil proceeding or criminal trial.

Racketeering: An individual who commits, attempts to commit, or solicits, coerces or intimidates another to make a false claim for healthcare payment may also be guilty of unlawful racketeering activity. Certain uses or investment of proceeds received as a result of such racketeering activity is unlawful and is considered a felony.

CONFIDENTIALITY

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

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

Health information contained in dental or financial records is to be disclosed only to the patient or the patient's personal representative—unless the patient or the patient's personal representative authorizes the disclosure to some other individual (e.g., family members) or organization. The permission to disclose information and what information may be disclosed must be documented in either verbal approval or written authorization. Health information may be disclosed to other providers involved in caring for the patient without the patient's or patient's personal representative's written or verbal permission. Patients must have access to, and be able to obtain copies of, their dental and financial records from the provider as required by federal law.

Information may be disclosed to insurance companies or their representatives for the purposes of quality and utilization review, payment or medical management. Providers may release legally mandated health information to the state and county health divisions and to disaster relief agencies when proper documentation is in place.

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

Confidentiality of Protected Health Information: ODS and provider each acknowledge that it is a "Covered Entity," as defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) adopted by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rule"). Each party shall protect the confidentiality of Protected Health Information (as defined in the Privacy Rule) and shall otherwise comply with the

requirements of the Privacy Rule and with all other state and federal laws governing the confidentiality of medical information.

ODS staff adheres to HIPAA-mandated confidentiality standards. ODS protects a member's information in several ways:

- ODS has a written policy to protect the confidentiality of health information.
- Only employees who need to access a member's information in order to perform their job functions are allowed to do so.
- Disclosure outside the company is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law.
- Most documentation is stored securely in electronic files with designated access.

RELEASE OF INFORMATION

In general, information about a member's health condition, care, treatment, records or personal affairs may not be discussed with anyone unless the reason for the discussion pertains to treatment, payment or plan operations. If member health information is requested for other reasons, the member or the member's healthcare representative must have completed an authorization allowing the use or release of the member's protected health information (PHI). The form shall be signed by the patient or their personal representative and must be provided to ODS for their records.

Release forms require specific authorization from the patient to disclose information pertaining to HIV/AIDS, mental health, genetic testing, drug/alcohol diagnosis or reproductive health.

For your convenience, a sample authorization form has been included at the back of this provider manual. A current authorization form and instructions on how to complete the form can be downloaded from the ODS website at www.modahealth.com/members/forms?dn=ods.

QUALITY IMPROVEMENT

PROGRAM GOALS

The goal of the ODS Dental Quality Improvement (QI) program is to ensure delivery of appropriate, cost-effective and high-quality oral healthcare to ODS members.

PROGRAM OBJECTIVES

ODS QI program objectives are to:

- Implement review processes to facilitate the evaluation of dental aspects of care, such as:
 - Use of services
 - Adequacy of dental record keeping
 - Operation and outcome of referral process
 - Access (the appointment system, after-hours call-in system, etc.)
 - Grievance system
 - Encounter data management
- Continuously evaluate and identify opportunities for improvement of:

- The quality of dental care and service delivery
- Barriers to services at the plan and practitioner level
- Communication within the organization, and between the organization and its practitioners and members
- Progressively improve member care through communication of QI activities to members and practitioners
- Identify and address continuing education needs of practitioners and members.
- Ensure compliance with regulatory requirements.

ODS meets these objectives by focusing on QI projects that have a significant impact on the oral health of plan members and have measurable outcomes in terms of quality of life.

QI COMMITTEE

The Dental Quality Improvement Committee (DQIC) has operational authority and responsibility for the ODS Dental Quality Improvement Program. It reviews and evaluates the quality of dental care and services provided to ODS dental members.

SCOPE OF SERVICE

ODS defines an annual QI work plan. This includes the processes that will be measured and monitored. Major plan components include the processes involved with quality outcomes, use of services and access. The scope of service includes any and all regulatory requirements, including internal and external quality review activities, for which ODS ensures access to dental records, information systems, personnel and documentation requested by the state division of medical assistance programs.

Member-specific or provider-specific data are considered confidential and treated according to the ODS confidentiality and privacy policy.

DENTAL HEALTH PROMOTION AND EDUCATION

ODS provides health promotion and education information for ODS members and their families. The brochures listed below are available for your patients on the ODS website. You may print copies of these brochures for your patients or contact the ODS Healthcare Services department at 503-948-5548, 877-277-7281 or by email at careprograms@odscompanies.com for a supply. (A sample of these brochures is included in this manual.)

“Your Guide to Immediate Dentures”

This brochure educates members on how to take care of immediate dentures and what to do after surgery.

“Dental Health During Pregnancy”

This flyer informs pregnant women of the importance of taking care of their teeth while they are pregnant.

“Take Time for Teeth”

This brochure educates parents about caring for their young child’s teeth in order to prevent early childhood caries.

TOBACCO CESSATION

"Even brief tobacco dependence treatment is effective and should be offered to every patient who uses tobacco." — Public Health Service (PHS) Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update

ODS asks that all providers take an active part in tobacco cessation by helping members who are ready to quit tobacco to find the resources available to them.

OHP members have benefits for tobacco cessation services through their OHP medical plan.

Please help your patients who use tobacco by doing the following:

Ask

Ask about tobacco use at every visit.

Implement a system in your clinic that ensures that tobacco-use status is obtained and recorded at every patient visit.

Advise

Advise all tobacco users to quit.

Use clear, strong and personalized language. For example:

"Quitting tobacco is the most important thing you can do to protect your health."

Assess

Assess readiness to quit.

Ask every tobacco user if he/she is willing to quit at this time.

- If willing to quit, provide resources and assistance (go to Assist section).
- If unwilling to quit at this time, help motivate the patient:
 - Identify reasons to quit in a supportive manner.
 - Build patient's confidence about quitting.

Assist

Assist tobacco users with a quit plan.

Assist the smoker to:

- Set a quit date, ideally within two weeks.
- Remove tobacco products from their environment.
- Get support from family, friends and coworkers.

Refer

Refer OHP members:

- To their medical plan to arrange for quitting.
- To the Oregon Tobacco Quit Line

Call these numbers for free from anywhere in Oregon:

1-800-QUIT-NOW (1-800-784-8669)

Español: 1-877-2NO-FUME (1-877-266-3863)

TTY: 1-877-777-6534

Or register online at: www.quitnow.net/oregon/ The Quit Line is open seven days a week, 4 a.m. to 12 a.m. (Pacific Time)



INTERPRETER REQUEST FORM



Community Health, Inc.

Interpreter Request Form – Passport to Languages

Oregon Health Plan - Dental
Today's Date:
Appointment Date:
Appointment Start Time:
Appointment Length (total):
Language:
Interpreter Preference (if applicable):
Recipient ID:
Patient Name:
Patient Date of Birth:
Patient Phone Number:
Other Patients included in Appt (name, recipient ID, date of birth):
Provider/Facility Name:
Street Address:
City, State and Zip:
Phone Number:
Fax Number:
Contact Person:
Special Requests:

ODS Community Health, Inc.

800-342-0526

503-243-2987

Fax 503-765-3297

Interpreters are scheduled based on availability. For best availability, please request interpreters by fax or phone call to Dental Customer Service no less than 48 hours prior to the appointment.

OHP DENTAL REFERRAL REQUEST FORM

When submitting a referral request, please follow these instructions and submit all requested information in accordance to the type of referral being completed. Incomplete request forms and/or information may result in a denial of the referral. Detailed instructions by specialty, including information required for each referral type, is indicated below.

General instructions for the referral form:

1. Verify your patient's OHP ID number and current enrollment with OHP Plus or Standard plan.
2. Enter the most current name and address that you have on file for your patient. Please note that ODS will send all correspondence to your patient at the address on file in the ODS OHP system and will notify you of an address discrepancy.
3. Enter complete referring dentist/clinic information. ODS OHP requests a fax number for the referring provider for communication purposes.
4. When requesting sedation, indicate the type of sedation you are requesting, member's history of sedation, reason for the sedation request and if hospital access is needed. Sedation requests should be placed in the comments section of the referral form.

PEDIATRIC

Some OHP pediatric providers have an age restriction for the members they treat. If a pediatric provider is not available for your patient, ODS will contact the referring dentist and provide him or her with a list of general dentists who are able to treat your patient comfortably.

ENDODONTIC

Root canal therapy is now only covered in conjunction with a final restoration that is **covered** under the OHP plan. The following is required for completion of an endodontic referral:

- Tooth number
- Treatment plan for final restoration
- CDT code for final restoration

ORAL SURGERY

When requesting a referral for OHP Plus members for the extraction of third molars or when requesting a referral for OHP Standard members for all extractions, the following information is required for EACH tooth. Teeth must be symptomatic to be eligible for extraction:

- Tooth number
- Pain level on a scale of 1-10, with 10 the most painful
- Swelling and/or bleeding
- Tooth-specific narrative or chart notes
- X-ray(s), all teeth for which a referral is requested must be visible

PERIODONTAL

Please note that OHP benefits are very limited for periodontal services. ODS requests general dentists attempt to treat their patients for covered services such as root planing and full-mouth debridement in their office prior to requesting a specialist referral. All periodontal referrals require the following:

- History of periodontal scaling and root planing within the last two years
- Periodontal charting (pockets must be at least 5mm in two or more quadrants)

Completed referral forms can be submitted by mail or fax (please see referral form for address and fax number). ODS customer service representatives can also take the referral information over the telephone. Please contact the customer service department at (800) 342-0526 with questions.



OHP dental referral request form

FOR ODS USE ONLY

ODS CSR-call/fax received by _____
 Referral to _____
 Eligibility _____
 Date Received _____
 Date Completed _____

Please read instructions before completing

Note: Incomplete forms may result in denial of referral.

SECTION 1 | Patient information

Plan <input type="checkbox"/> Plus <input type="checkbox"/> Standard	Is emergency treatment needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	OHP client ID no.		
Patient last name		First name		MI
Date of birth		Patient phone		
Address	Street	City	State	ZIP code

SECTION 2 | Referral information

Name of referring dentist and/or clinic			Contact name	
Address			City	State ZIP code
Office phone		Office fax		
Type of referral: <input type="checkbox"/> ENDO <input type="checkbox"/> Oral surgery <input type="checkbox"/> PERIO <input type="checkbox"/> PEDO <input type="checkbox"/> Special needs/general dentist				
Date of last appointment with referring provider _____ / _____ / _____			Is patient experiencing any pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tooth no.	Pain level (1-10)	Swelling?	Infection?	Notes
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has pain relief been provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		Any medication given? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please list the medications given to the patient or any other pain relief provided
X-rays available: <input type="checkbox"/> PA <input type="checkbox"/> Bitewings; how many? _____ <input type="checkbox"/> FMX <input type="checkbox"/> Panoramic film				
Please indicate how the X-rays will be submitted. <input type="checkbox"/> NEA; NEA no. _____				
<input type="checkbox"/> Emailed to ohpdentalcoordinator@odscompanies.com <input type="checkbox"/> Mailed to the attention of the OHP Dental Coordinator at 601 SW 2nd Ave Portland, OR 97204				
Note: If X-rays are not submitted with original request, referral may be denied. Tooth needing treatment must be visible on film.				
For ENDO referral, are canals of tooth/teeth: <input type="checkbox"/> Curved <input type="checkbox"/> Calcified Final Restoration: _____				
For PERIO referral, date of last root planing and scaling: _____ / _____ / _____ Bone Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No (please attach perio charting)				
Additional comments				

PLEASE SEND COMPLETED FORMS TO:

MAIL: ODS Community Health, Inc., Attn: OHP Dental Coordinator, 601 SW 2nd Ave Portland, OR 97204
EMAIL: ohpdentalcoordinator@odscompanies.com **FAX:** 503-765-3297

If you have questions, please contact ODS Community Health, Inc. toll free at 800-342-0526. (TTY users, please dial 711.)
www.odscompanies.com

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Member Authorization - Release of Personal Health Information to ODS

Member authorization allows the healthcare provider to use/disclose protected health information to ODS (Oregon Dental Service, ODS Health Plan, Inc. and/or ODS Community Health, Inc.)

(Member Name) Last	First	M.I.
ID Number		
DOB		
Employer or Group Name		
Group Number		

I authorize: _____
 (Name of healthcare provider(s)/entity(ies) disclosing information.)
 to use and disclose a copy of my protected health information to: **ODS**
 for the purpose of: _____
 (Describe each purpose of the use/disclosure.)

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes) and any personal or medical information related to the purpose of this authorization.

I authorize the release of (initial one option):
 All protected health information, OR
 The most recent two years of protected health information, OR
 Specific information _____

I understand that the Healthcare Provider needs my specific authorization to release information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case. (Initial all that apply. Leaving a space blank indicates that no information about the item is to be released.)

HIV/AIDS test or result information and related records
 Mental health information
 Genetic testing information
 Drug/alcohol diagnosis, treatment or referral information

(continued on next page)

ODS Community Health, Inc.

OHP 01/2006

MEMBER AUTHORIZATION — RELEASE OF PERSONAL HEALTH INFO

I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in a health plan or eligibility for health benefits.

I have the right to revoke this Authorization in writing at any time. If I revoke this Authorization, the information described above will no longer be used or disclosed for the reasons covered by this written Authorization. Any uses or disclosures already made with my permission cannot be taken back.

To revoke this Authorization, please send a written statement to ODS Community Health, Inc., Privacy Office at 601 S.W. 2nd Avenue, Portland OR, 97204 and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this Authorization will be in force and effect until the following (check one):

Date: _____ (not to exceed 24 months), OR

Event: _____

(The event will be limited to 24 months maximum.)

I have reviewed and I understand this Authorization.

Signed _____ Date _____
(Individual)

-OR-

Signed _____ Date _____
(Individual's representative)

Relationship to Member: Parent Legal Guardian* Holder of Power of Attorney*

*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

INSTRUCTIONS: ALL RELEVANT FIELDS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID. MEMBER SHOULD RETAIN A COPY OF THE SIGNED ORIGINALS.

Mail the signed originals to: ODS Community Health, Inc.
Privacy Office
601 S.W. 2nd Avenue
Portland, OR 97204

OHP 01/2006

OHP General Authorization: Disclosure to ODS Form 2 of 2

MISSED APPOINTMENT FORM



<p>MISSED APPOINTMENT NOTIFICATION FORM</p>
--

Member Name: _____ Member ID#: _____

Dentist Name and Address: _____

Office Phone: _____ Office Fax: _____

TO REPORT A MISSED APPOINTMENT

Complete the following and fax this form to ODS.

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: Rescheduled appointment,
 Referred Member to case worker for help with transportation,
 Member is being dismissed, referred Member to ODS to find another dentist,
 Other _____

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: Rescheduled appointment,
 Referred Member to case worker for help with transportation,
 Member is being dismissed, referred Member to ODS to find another dentist,
 Other _____

**See back to report additional missed appointments

TO REPORT A DISMISSAL DUE TO MISSED APPOINTMENTS

Attach copies of the following to this form and fax all to ODS.

- Your office dismissal for missed appointments policy (signed by the Member) **and**
- Your dismissal letter to the Member.

**Fax this form if applicable, and any necessary dismissal attachments to ODS
Attn: Customer Service at (503) 765-3297 after each missed appointment.**

Oregon Administrative Rule 410-141-0080(2) (a) (A) (i)

Missed appointments: The number of missed appointments is to be established by the Provider or PHP. The number must be the same as for commercial Members or patients. The Provider must document they have attempted to ascertain the reasons for the missed appointments and to assist the OHP Member in receiving services.

ADDITIONAL MISSED APPOINTMENTS

The number of additional missed appointments allowed prior to dismissal is set by your office for missed appointments policy.

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: Rescheduled appointment,
 Referred Member to case worker for help with transportation,
 Member is being dismissed, referred Member to ODS to find another dentist,
 Other _____

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: Rescheduled appointment,
 Referred Member to case worker for help with transportation,
 Member is being dismissed, referred Member to ODS to find another dentist,
 Other _____

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: Rescheduled appointment,
 Referred Member to case worker for help with transportation,
 Member is being dismissed, referred Member to ODS to find another dentist,
 Other _____

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: Rescheduled appointment,
 Referred Member to case worker for help with transportation,
 Member is being dismissed, referred Member to ODS to find another dentist,
 Other _____

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: Rescheduled appointment,
 Referred Member to case worker for help with transportation,
 Member is being dismissed, referred Member to ODS to find another dentist,
 Other _____

**Fax this form if applicable, and any necessary dismissal attachments to ODS
Attn: Customer Service at (503) 765-3297 after each missed appointment.**

DENTAL HOSPITAL REFERRAL

If a patient needs dental treatment in the hospital, a hospital referral form needs to be submitted to the medical carrier prior to treatment being rendered. An example form has been included, or you can access the form and save to your desktop at: <http://dhsforms.hr.state.or.us/Forms/Served/OE3301.pdf>

Dental Hospital Referral		
Caller Name	Date of call	Coverage Verified
Dentist Name	Phone	Fax
Address		
Client Name	ID#	Date of Birth
Parent/Guardian Name	Client Phone	
Address		
Medical Plan Name	Phone	Contact Name
PCP Name	PCP Phone	
Hospital Facility Requested	Date(s) Requested	
Patient special needs (i.e. interpreter, etc.)		
Clinical Information		
Give a detailed description of the dental treatment needed (or a copy of the treatment plan can be attached if it details treatment needed)		
Give a detailed explanation why a dental hospitalization is being requested. In the explanation state whether office oral sedation was used, and the results. Also, list other important information contributing to the need for hospitalization, such as the condition of the teeth/mouth, physical or mental disability, behavior issues, etc.		
For use by Medical Plan Staff		
Date services approved	Referral #	
Dates referral valid	Approved by	
Comments		

OMAP 3301 (5/06)

INSURANCE NOTIFICATION FORM

Insurance Notification Form

Providers: Use this form to report information about Medicaid clients (including Oregon Health Plan) who are covered by other insurance.



Private Health Insurance

Date: _____

Policyholder name: _____ Date of birth: ____ / ____ / ____

Insurance company name: _____ Phone: (____) _____

Insurance company address: _____

Private Health Insurance ID no. (include any alpha prefix): _____

Group number: _____ Policyholder's SSN: _____

People covered by this insurance (use additional sheets if necessary):

Individual Detailed Health Information

Name	DOB	Medicaid Case #	Start Date	End Date	Social Security Number

Name of provider or person submitting this report: _____

Contact Person: _____ **Phone:** (____) _____

Comments: _____

**Please return this form to the ODS Community Health Insurance Group.
 If you have questions, please contact ODS Community Health Customer Service.**

Medical:
 By fax: (503) 765-3570
 By Mail: PO Box 3550, Portland, OR 97208
 Customer Service: (888) 788- 9821

Dental:
 By Fax: (541) 962-2171
 By Mail: PO Box 40384, Portland, OR 97240
 Customer Service: (800) 342-0526

OHP PATIENT RESPONSIBILITY WAIVER



OHP Client Agreement to Pay for Health Services



This is an agreement between a “client” and a “provider,” as defined in OAR 410-120-0000. The client agrees to pay the provider for health service(s) not covered by the Oregon Health Plan (OHP), coordinated care organizations (CCOs) or managed care plans. For the purposes of this Agreement, “services” include but are not limited to health treatment, equipment, supplies and medications.

Provider Section

① Healthcare services requested:

Procedure codes (CPT/HCPCS):

② Expected date(s) of service:

③ Condition being treated:

④ Estimated fees \$ to \$

Check one: There are no other costs that are part of this service.

There may be other costs that are part of this service, and you may have to pay for them, too. Other procedures that usually are part of this service may include:

Lab X-ray Hospital Anesthesia Other

⑤ As your provider:

- Where applicable, I have tried all reasonable covered treatments for your condition.
- I have verified that the proposed services are not covered.
- Where appropriate, I have informed you of covered treatments for your condition, and you have selected a treatment that is not covered.

Provider Name:

NPI:

Provider Signature:

Date:

OHP Client Section

⑥ Client Name:

DOB:

Client ID#:

⑦ I understand:

- That the health care services listed above are not covered for payment by OHP, my CCO or managed care plan.
- If I get the services above I agree to pay the costs. After having the services, I will get bills for them that I must pay.
- I have read the back of this form and understand my other options.

I have been fully informed by the provider of all available medically appropriate treatment, including services that may be paid for by the Division of Medical Assistance Programs (DMAP) or DMAP-contracted CCOs or managed care plans, and I still choose to get the specified service(s) listed above.

Client (or representative's) signature: _____

Date: _____

If signed by the client's representative, print their name here: _____

⑧ Witness signature: _____

Date: _____

Witness name: _____

This agreement is valid only if the estimated fees listed above do not change and the service is scheduled within 30 days of the member's signature.

Client – Keep a copy of this form for your records.

DMAP 3165 (Rev.11/1/13)

Attention OHP Client – Read this information carefully before you sign.

Before you sign you should be sure the service is not covered by OHP or your Coordinated Care Organization (CCO) or managed care plan. Here are some things you can do:

① ***Check to make sure the service is not covered***

DMAP, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an Appeal and/or Hearing***

Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other Appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ ***Check to see if there are other ways to get the service***

Ask your provider if:

- They have tried all other covered options available for treating your condition.
- There is a hospital, medical school, service organization, free clinic or county health department that might provide this service, or help you pay for it.

Will your OHP benefits, or any other health insurance you may have, change soon? If so, try to find out if this service will be covered when your benefits change.

④ ***Ask about reduced rates and discounts***

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers – like hospital, anesthesia, therapy or laboratory services – that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call ODS Customer Service at 800-342-0526, TTY 711 or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3395, Member Protection Provisions. These rules can be found online at:

http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html

http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html

DMAP 3165 (Rev.11/1/13)

IMMEDIATE DENTURE BROCHURE

What is a reline and when will a denture need one?

A loose denture makes it harder to chew and may cause irritation, sores or infection in your mouth. If your denture is loose, have your dentist check it. You may need a temporary reline or a laboratory reline.

- A temporary reline is done in the office while you wait. It is usually done during the healing phase. The dentist adds a soft material that bonds to the underside of the denture. This material helps keep the denture close and comfortable. It is removed when a laboratory reline is needed.
- A laboratory reline depends on how many teeth were removed, your health and many other factors. Most people are ready for a permanent laboratory reline in six to eight months, when the healing has completed. You need to leave your dentures with the dentist for up to eight hours. The dentist removes any temporary relines and makes an impression of the space between your gums and the denture. A permanent reline is then made with the same type of material used to make the pink portion of your denture.
- A reline generally does not change how the denture or your face looks. A reline does not make a lower denture fit "tighter," but it fits the tissue closer and better.

900558 (9/10)

Care of your dentures

Dentures, like natural teeth, must be cleaned to keep your mouth healthy and odor free.

- Brush the surfaces of your denture inside and out morning and night. Brush with the solution from denture cleanser soaking solutions, liquid soaps or special toothpaste designed for dentures.
- After the first night, store your dentures in water or denture cleanser soaking solution when you are not wearing them. This helps keep the shape and prevents drying out.
- Don't adjust or repair a denture yourself. You can permanently damage the denture and cause harm to the tissue in your mouth.
- Don't use hot water on your denture. It will warp.
- Don't use scouring powders on your denture, as they can remove the denture materials or roughen the surface.
- Don't use abrasive cleaners or bleach to remove stains. They can change the color of gum-colored acrylic.



www.odscpanies.com

Insurance products provided by Oregon Dental Service and ODS Health Plan Inc.



Your guide to immediate dentures





What are immediate dentures?

Immediate dentures are dentures that are placed in your mouth right after your teeth are extracted. The shape of your mouth changes quickly for about a month. As the healing process continues, your gums, which support the denture, will shrink. Changes can continue for several months. During this time, it is important that you keep your dentist office appointments for adjustments. Following are tips to help you adjust to, and take care of your immediate denture.

What to do right after surgery

Day 1

Keep your head up. Take your medication and rest. Put gentle biting pressure on your denture during the first four hours. Use cold packs to reduce swelling.

Eat soft healthy foods such as mashed potatoes, soups, eggs or cottage cheese. Drink cool liquids. Be careful with hot foods. The plastic part of the denture may not allow you to feel hot food in some areas of your mouth.

Don't remove your denture during the first 24 hours. There may be some oozing of blood. The denture acts as a bandage to protect the extraction sites and helps to control bleeding and swelling.

Day 2

The dentist removes your denture and makes any needed adjustments. The dentist shows you how to remove and clean it.

Day 3-4

(or until your stitches are removed)
Remove your denture three to four times a day and gently rinse your mouth with warm saltwater (1/2 teaspoon salt in 8 ounces of warm water). Lightly brush your denture at the same time, and then place in your mouth.

Getting used to your denture

- A new denture is uncomfortable for the first several weeks. It may feel loose while the muscles of your cheeks and tongue learn to hold it in place. Saliva may increase. You may feel minor irritation or soreness. You may bite your cheeks or tongue as you learn to use your new denture.
- It takes practice and patience to eat with dentures. Start with soft foods cut into small portions. Chew slowly and use both sides of your mouth at the same time to keep the denture from moving out of place. Don't bite with your front teeth. That causes your denture to tip and come loose. As you adjust to the denture, add other types of foods until you're back to your normal diet.
- Speaking with a new denture takes time and practice. Read aloud and repeat difficult words in front of the mirror. Speak slowly to help reduce muffled, blurred or thickened speech. You may lisp

or whistle your "s" when you first try to talk. Your denture may sometimes slip out of place when you laugh, cough or smile. Put it back in place by gently biting down and swallowing.

- Although your denture is custom made to fit your mouth, your dentist may suggest using a denture adhesive while you get used to wearing it. Keep in mind that a denture adhesive is only a temporary fix.

Denture facts

- A lower denture is never as "tight" as an upper denture. The lower denture doesn't have the "suction" to keep it in place like the upper one does. The lower denture is held in place by the muscles of the lips, tongue and cheeks. It should not "pop" out of place, but it does not have a tight feeling. It usually takes four to five times longer to master a complete lower denture compared to an upper denture.
- Getting used to a denture takes time and patience. Remember, your gum tissue changes, not your denture. For some patients, many visits to the dentist for adjustments are needed.
- A big gain or loss in body weight can change the fit of your denture.

Yearly dental checkup

After you adjust to wearing a denture, see your dentist yearly for a complete checkup.



*Happy mouth,
healthy child*

Did you know that healthy teeth and a healthy mouth can help your baby become a healthy child? By following some simple steps you can make a big difference in your child's health.



BIRTH TO SIX MONTHS

- Gently wipe your baby's gums and teeth with a clean, soft cloth after every feeding.
- Ask your doctor about giving your baby fluoride.

ONE YEAR

- Get your baby used to using a regular cup instead of a bottle or "sippy" cup by his or her first birthday.
- At one year of age, help your baby use a toothbrush. You will need to brush your baby's teeth to make sure they are clean.
- Speak with your dentist if you see white or brown spots on your baby's teeth.

TODDLERS

- At age two or three, the last of your child's baby teeth are coming in.
- Try to make good oral care fun for your child. Turn on music and brush together.
- Help your child brush twice a day. Toothpaste can be used starting at age two, or when your dentist recommends it.
- Floss your child's teeth daily to help prevent the build-up of plaque.



over >

HEALTHY HABITS FOR LIFE

- > Give your child healthy snacks, and limit sweet snacks and drinks.
- > Visit the dentist every six months.
- > Brush and floss twice a day.

REMEMBER:

- > Decay is preventable. The bacteria that causes decay is usually passed from mother to child through saliva.
- > Avoid contact from your mouth to your baby's bottles, pacifiers or sippy cups. This passes the bacteria to your baby.
- > Always hold your baby when bottle feeding.
- > Never put your baby to bed with a bottle.
- > Never put soda or juice in a bottle.



YOUNG CHILDREN

- At age six or seven, most children start to lose baby teeth and get permanent teeth.
- To help keep baby teeth and permanent teeth healthy, have your child rinse with water after every meal and brush at least twice every day.
- You will need to check to make sure your child brushed for at least three minutes and cleaned thoroughly.
- Encourage healthy snacks that are low in sugar. Sugary juices and sodas are harmful to your child's teeth and cause tooth decay.

PRE-TEENS AND TEENS

- By age 13, most teens have about 28 permanent teeth.
- Sports and energy drinks, soda and junk food stain and damage teeth.
- Let your teen know that good oral hygiene helps prevent bad breath, missing teeth and stains.
- Encourage your child to drink plenty of water and carry a toothbrush, floss and toothpaste with them.

DID YOU KNOW?

It is important to help children brush their teeth until they can write in cursive. That is when the muscles they use to brush their teeth are coordinated enough to do it on their own.

If you need the name of a dentist or have questions about your coverage, please call ODS Customer Service at 800-342-0526. Or, visit www.odscpanies.com/ohp.



*Una boca feliz,
un niño sano*

¿Sabía usted que una boca y dientes sanos pueden ayudar a su bebé a ser un niño sano? Tomando algunas medidas sencillas, usted puede marcar una gran diferencia en la salud de su hijo.



DESDE EL NACIMIENTO HASTA LOS SEIS MESES DE VIDA

- Frote suavemente las encías y los dientes del bebé con un trapo suave y limpio después de cada vez que come.
- Pregúntele al médico si puede darle flúor al bebé.

AL AÑO DE VIDA

- Haga que el bebé se acostumbre a usar una taza común en lugar de un biberón o de una taza con tapa sorbete, aproximadamente cuando cumpla el primer año de vida.
- Cuando tenga un año, ayude al bebé a usar un cepillo de dientes. Deberá cepillar los dientes del bebé para asegurarse de que estén limpios.
- Hable con el odontólogo si ve manchas blancas o marrones en los dientes del bebé.

NIÑOS PEQUEÑOS

- A los dos o tres años de vida, a los niños les salen los últimos dientes de leche.
- Intente que el buen cuidado bucal sea divertido para su hijo. Ponga música y cepíllense los dientes juntos.
- Ayude a su hijo a cepillarse los dientes dos veces por día. Se puede comenzar a utilizar pasta dental a partir de los dos años o cuando lo recomiende el odontólogo.
- Use hilo dental en los dientes de su hijo diariamente para ayudarlo a evitar la acumulación de placa.



[Ver al dorso >](#)

HÁBITOS SALUDABLES PARA TODA LA VIDA

- › Dele a su hijo bocadillos saludables y limite la cantidad de bocadillos y bebidas dulces.
- › Visite al odontólogo cada seis meses.
- › Cepílese los dientes y use hilo dental dos veces por día.

RECUERDE:

- › La caries se puede evitar. Las bacterias que la causan generalmente se transmiten de madre a hijo a través de la saliva.
- › Evite el contacto entre su boca y los biberones, los chupones o las tazas con tapa sorbete del bebé. Esto transmite las bacterias a su hijo.
- › Siempre sostenga al bebé en brazos cuando le dé el biberón.
- › Nunca ponga al bebé en la cama con un biberón.
- › Nunca coloque refrescos o jugo en el biberón.



NIÑOS

- A los seis o siete años, a la mayoría de los niños se les comienzan a caer los dientes de leche y les salen los dientes permanentes.
- Para ayudar a tener dientes de leche y permanentes sanos, haga que su hijo se enjuague la boca con agua después de cada comida y que se cepille los dientes al menos dos veces por día.
- Usted deberá controlarlo para asegurarse de que se cepille los dientes durante tres minutos, como mínimo, y que se limpie meticulosamente.
- Aliente los bocadillos saludables que tengan bajo contenido de azúcar. Los jugos y los refrescos con azúcar son dañinos para los dientes de su hijo y causan caries dental.

PREADOLESCENTES Y ADOLESCENTES

- A los 13 años, la mayoría de los adolescentes tienen aproximadamente 28 dientes permanentes.
- Las bebidas energéticas y deportivas, los refrescos y la comida chatarra manchan y dañan los dientes.
- Infórmele a su hijo adolescente que una buena higiene bucal ayuda a evitar el mal aliento, la caída de dientes y las manchas.
- Aliente a su hijo a beber mucha agua y a llevar un cepillo de dientes, hilo y pasta dentales.

¿SABÍA USTED?

Es importante ayudar a los niños a cepillarse los dientes hasta que puedan escribir en letra cursiva. Ése es el momento en el que los músculos que utilizan para cepillarse los dientes tienen la coordinación suficiente como para hacerlo por sí mismos.

Si necesita el nombre de un odontólogo o si tiene preguntas sobre su cobertura, llame a Servicio al Cliente de ODS al 800-342-0526 o visite www.odscompanies.com/ohp.

DENTAL HEALTH DURING PREGNANCY FLYER



Pregnancy and your teeth

Taking care of your teeth is especially important while you are pregnant. The health of your teeth and gums can affect the health of your baby.



TAKE CARE OF YOUR TEETH AND TAKE CARE OF YOUR BODY

Your oral health matters. As an ODS member, you can see your dentist every six months for a cleaning. You can get an additional cleaning in your third trimester even if you have already had a two cleanings in the past twelve months. Your dentist will help make sure your mouth is healthy, which will help you have a healthy baby.

X-rays can be taken if necessary, even if you are pregnant. Just ask your dentist to use a lead apron with a thyroid collar when taking X-rays. **Going to the dentist is safe during pregnancy.**

YOUR MOUTH MATTERS, BECAUSE:

- Germs in your mouth can be passed on to your baby while you are pregnant.
- Gum disease is linked with premature delivery and low-birthweight babies.

YOU HAVE SUPPORT

If you can't find a ride to or from a dental appointment, call your local Department of Human Services (DHS) office or DHS worker one week before. You'll find those numbers on your medical care ID form.

If you need the name of a dentist or have questions about your OHP coverage, call ODS Customer Service at 800-342-0526 or visit us online at www.odspanies.com/ohp

EAT HEALTHY AND TAKE CARE OF YOUR TEETH

Here are a few tips to help you have a healthy pregnancy:

- › Be sure to include foods high in calcium and Vitamin D in your diet.
- › Snacking during the day can cause more tooth decay. Try to limit sweet snacks.
- › Brush your teeth after eating.
- › Remember to brush twice a day and floss every day.
- › Stop smoking. Smoking can cause dental problems and hurt your baby.

If you currently smoke and would like help to quit, call the Oregon Tobacco Quit Line at 800-QUIT-NOW (800-784-8669) or visit www.oregonquitline.org



Insurance products provided by Oregon Dental Service and ODS Health Plan, Inc.

DENTAL HEALTH DURING PREGNANCY FLYER (SPANISH)



El embarazo y los dientes

Cuidarse los dientes tiene una importancia especial cuando usted está embarazada. La salud de los dientes y las encías puede afectar a la salud del bebé.

CUÍDESE LOS DIENTES Y EL CUERPO

Su salud bucal es importante. Como miembro de ODS, usted puede visitar al odontólogo cada seis meses para hacerse una limpieza. Puede obtener una limpieza extra en el tercer trimestre, si ya se ha realizado dos limpiezas durante los últimos doce meses. El odontólogo la ayudará a asegurarse de que su boca esté sana, lo cual la ayudará a tener un bebé sano.

Se pueden tomar radiografías si es necesario, incluso si está embarazada. Sólo solicítele al odontólogo cuando se saque una radiografía, que utilice un "delantal de plomo" con un cuello que proteja la glándula tiroides. **Visitar al odontólogo durante el embarazo es seguro.**

SU BOCA ES IMPORTANTE PORQUE:

- Los gérmenes que se encuentran allí pueden transmitirse al bebé durante el embarazo.
- Se relaciona a la enfermedad de las encías con el parto prematuro y con bebés que tienen bajo peso al nacer.

USTED TIENE AYUDA

Si no puede trasladarse hacia o desde una cita con el odontólogo, llame a la oficina local del Departamento de Servicios Sociales (DSS, por sus siglas en inglés) o a un empleado de dicho departamento, con una semana de anticipación. Encontrará los números de teléfono en el formulario de identificación de atención médica.

Si necesita el nombre de un odontólogo o si tiene preguntas sobre su cobertura de OHP, llame a Servicio al Cliente de ODS al 800-342-0526 o visítenos en Internet en www.odspanies.com/ohp



TENGA UNA DIETA SALUDABLE Y CUÍDESE LOS DIENTES

Aquí tiene algunos consejos para ayudarla a tener un embarazo saludable:

- › Asegúrese de incluir en su dieta alimentos con altos contenidos de calcio y de vitamina D.
- › Comer bocadillos durante el día puede producir más caries. Intente limitar los bocadillos dulces.
- › Cepílese los dientes después de comer.
- › Recuerde cepillarse los dientes dos veces por día y usar hilo dental todos los días.
- › Deje de fumar. Fumar puede ocasionar problemas dentales y dañar al bebé.

Si actualmente fuma y desea abandonar el hábito, llame a la línea para dejar de fumar "Oregon Tobacco Quit Line" al 800-QUIT-NOW (800-784-8669) o visite www.oregonquitline.org



Productos de seguro suministrados por Oregon Dental Service y OHS Health Plan, Inc.

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CONTACT INFORMATION

Send Dental Claims to:

ODS Dental Claims
PO Box 40384
Portland, OR 97204

Send Complaints and Appeals to:

ODS
Attn: Appeals Unit
P.O. Box 40384
Portland, OR 97240
Fax: 503-412-4003

OHP Customer Service:

Provides information regarding benefits, eligibility, claim status, etc.
503-243-2987
800-342-0526
dentalcasemanagement@modahealth.com

Dental Professional Relations:

Provides information regarding contracts and fee schedules
503-265-5720
888-374-8905
Fax: 503-243-3965
dpr@modahealth.co

Benefit Tracker (BT):

Provides registration and assistance for utilizing this online resource
877-337-0651, (choose option 1)
ebt@modahealth.com

Electronic Data Interchange:

Provides information regarding electronic billing and NEA
503-228-6554
800-852-5195
edigroup@modahealth.com

Health Systems MMIS System and AVR

(Provides information for OHP and eligibility requirements)
MMIS: <https://www.or-medicaid.gov/ProdPortal/Default.aspx>

Automated Voice Response: 866-692-3864

The most recent version of this handbook is available online at
www.modahealth.com/dental/handbooks.shtml



Questions? Visit modahealth.com or contact
Customer Service at 800-452-1058 or
Professional Relations at 888-374-8905.

601 S.W. Second Ave.
Portland, OR 97204-3154