DC Healthy Smiles

Administered By
Quality Plan Administrators, Inc.

BENEFICIARY HANDBOOK

Quality Plan Administrators Dental Plan
7824 Eastern Avenue, N.W., Suite 100
Washington, DC 20012
Telephone: (202) 722-2744
Fax: (202)291-5703
Website: www.qualityplanadmin.com
E-mail: qpa2000@aol.com

A. Availability of Dental services

To be eligible for covered dental services, an enrollee must be a current eligible Medicaid participant on the day services are performed.

QPA's network of practitioners provide a wide array of dental services including: preventive, interceptive, periodontal, general, orthodontic, oral surgical and hospital care whenever necessary. There is no need for cumbersome referral policies, although the referral program exists to afford patients the option to select a specialist, at will, from the network directory.

In the District of Columbia, QPA has a substantial network of private offices strategically placed in the high-density Medicaid neighborhoods of Southeast and Northeast, Columbia Heights, and the Georgia Avenue corridor. Howard University Hospital and College of Dentistry and the Washington Hospital Center both participate in our programs providing emergency and supportive care for our Medicaid programs.

Services will be available both during and after traditional hours since two major hospitals with dental programs are members of our network. After hour services would be limited to emergency care.

The enrollment broker will arrange for your appointments at private offices, clinics, group practices, the Howard University College of Dentistry and its affiliate Howard University Hospital Department of Oral and Maxillofacial Surgery, as well as their general dental program. Washington Hospital Center is also a participating member and their out-patient and in-patient facilities, like Howard University, are available for services.

B. Administrative Contact Information

Quality Plan Administrators Dental Plan
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Claims Customer Service (202) 722-2744 or (800) 900-4112

QPA has expanded customer services for the convenience of its providers and members seeking information. Our hours for direct customer service contact are Monday through Friday from 8:00 a.m. to 6:00 p.m.

In addition our institutional providers, Howard University Hospital and the Washington Hospital Center have 24-hour emergency services which are available to our members for after-hour and weekend emergency care. For eligible children, Children's Hospital is also accessible.

C. Accessibility Standards

Due to QPA's widely dispersed network of providers willing to participate with individuals who have Medicaid coverage, the requirement for emergency contact within 24 hours for dental treatment and within four weeks for routine care is currently being met. QPA's hospital affiliations are particularly valuable for meeting emergency access related needs especially during evenings, weekends and on holidays.

Beneficiaries may call any provider on our network depending on your needs. We encourage your selection of a Primary Care General Dentist who will be responsible for your comprehensive care. Although your primary care dentist will usually organize your referrals to a specialist on our network, you may access specialists directly without referral.

D. Eligibility Verification

In order to verify a member's eligibility, you may contact the customer service department at (202) 722-2744 or (800) 900-4112. Such verification does not guarantee payment for services rendered because patient eligibility data is subject to change. Each MCO member has an identification card. Even with presentation of the card, other identification may be necessary to verify identity.

E. Prior Authorization

E.1 Pre-authorization is required for the following services:

Prosthodontics (Dentures, full and removable partial)
Periodontal Care (gum disease)
Orthodontic Care (Braces: limited to individuals who have not achieved their 21st birthday).

E.2 Policies and Procedures: The purpose of a pre-authorization is to evaluate and manage use of resource-intensive services and to ensure that the patient receives services at the most medically appropriate, cost-effective level of care.

Pre-treatment estimates are strongly recommended for multiple services, i.e. prosthodontics, periodontal therapy, extensive restorations, etc. The process can be a useful tool in providing the QPA participants with information as to whether a service is covered or not covered by the plan. This can help avoid any potential billing disputes. Information regarding specific plan design information can generally be obtained by contacting QPA.

Most dental plans administered by QPA determine or estimate benefits only when there is evidence of dental necessity. Dental necessity requires that active disease or impaired function is present. Additionally, in cases where there is more than one course of treatment that meets generally accepted dental standards, most plans consider benefits for the least expensive alternative treatment that meets generally accepted standards of care.

These benefit determinations are not intended to be, nor should they be, construed as treatment decisions. All choices with respect to treatment are left to the participant and dentist.

The QPA pre-authorization process is designed to:

- Ensure that anticipated services or treatments follow sound dental practice
- Determine the type of service required
- Assure that there are no unnecessary delays in the proposed schedule for treating the patient
- Assure that after the initial evaluation, the appropriate practitioner and/or facility has been selected to provide the anticipated service
- Establish the need for specialty care
- Assure that there are no reimbursement misunderstandings between the provider and MAA.

Emergency care will not require prior authorization due to the nature of the response required; verification of the services provided is all that will be necessary.

E.3 Documentation required for pre-authorization:

Beneficiaries are not required to provide documentation for pre-authorization.

Your dental care provider will be required to submit pre-authorization documentation for the following:

Periodontal (gum) care: Periodontal charting and pre-operative x-rays.

Prosthodontics (dentures): pre-operative x-rays.

Orthodontics: Patients must meet medical necessity requirements. The treating Orthodontist must submit cephalometric x-rays of the bite, tracings and appropriate measurements as well as models of the teeth and jaws to QPA. A QPA consultant will then evaluate the medical necessity based upon the objective data submitted and a decision will be rendered and submitted to both the treating orthodontist and the patient as well.

F. Beneficiary Services

F.1 Covered Services

DESCRIPTION OF DENTAL SERVICES

(i) The categories of care are Preventative, Diagnostic, restorative (fillings), Prosthodontic, (full dentures and partials dentures), Oral Surgical and Periodontal.

(ii) The following is a description of the services which provide comprehensive dental care for you and your family as long as you are an eligible member of D.C. Medicaid.

SERVICES

Diagnostic: You are entitled to a full mouth series of dental X-Rays every three years.

(a) X-rays: These x-rays are important to determine the presence and extent of dental disease that is not readily discerned visually.

(b) Examinations: You are entitled to two examinations per year that are integrated with your x-rays determinations.

In addition, in the event that you require specialty care, provisions are available for the payment of the Specialty Examination/Consultation fees.

PREVENTION

(a) Prophylaxes i.e., cleaning.

You are entitled to two cleanings per year. They may not occur within the same 6^{th} month period.

In certain instances these may be increased.

Restorations (Fillings)

You are entitled to fillings wherever they may occur in your mouth. Whenever, possible, every effort will be made to save and maintain your functional teeth.

Periodontal Care

A significant percentage of all Americans suffer from some form of periodontal (gum) disease. To this end you are entitled to treatment when diagnosed by your dentist and authorization has been extended by QPA.

Prosthodontics (Dentures, full and removable partial)

A large percentage of adults, have several teeth missing. Missing teeth lead to a variety of undesirable health consequences.

This program permits the replacement of missing teeth by way of full removable or partial dentures once every 5 years. In the interim, should there be the need to repair or modify the appliance, this service is also covered.

A Fee Schedule is attached, and only those specific services outlined as mandated by DC Medicaid will be covered.

a. The plan benefit pays 100% of your actual charge up to the schedule published by MAA.

b. You are not required to pay any deductibles or co-pays.

Covered Services Adult Dental		
Proc Code	Description	DC Medicaid Fee
D0120	PERIODIC DENTAL SCREENING	$ 35.00
D0140	LIMIT ORAL EVAL PROBLM FOCUS	$ 50.00
D0150	COMPREHENSVE ORAL EVALUATION	$ 77.50
D0160	EXTENSV ORAL EVAL PROB FOCUS	$ 67.50
D0170	RE-EVAL,EST PT,PROBLEM FOCUS	$ 45.00
D0180	COMP PERIODONTAL EVALUATION	$ 77.50
D0210	INTRAOR COMPLETE FILM SERIES	$ 91.00
D0220	PERIAPICAL X RAY; FIRST FILM	$ 20.00
D0230	PERIAPICAL X RAY; EACH ADDITIO	$ 16.00
D0240	OCCLUSAL X RAY	$ 29.00
D0270	BITEWING,SINGLE,FIRST FILM	$ 21.00
D0272	DENTAL BITEWINGS TWO FILMS	$ 40.00
D0274	DENTAL BITEWINGS FOUR FILMS	$ 48.00
D0290	P.A. FILM	$ 100.00
D0330	PANOREX	$ 80.00
D0340	CEPHALOMETRIC FILM	$ 100.00
D0460	PULP TEST	$ 39.00
D0470	STUDY MODELS	$ 75.00
D1110	PREVENTIVE PROHYLAXIS (ADULT)	$ 77.50
D1204	TOPICAL FLUOR W/O PROPHY ADU	$ 26.00
D1351	DENTAL SEALANTS	$ 38.00
D1510	FIXED, BAND TYPE	$ 230.00
D1515	FIXED BILAT SPACE MAINTAINER	$ 325.00
D2140	AMALGAM ONE SURFACE, PRIMARY O	$ 90.00
D2150	AMALGAM TWO SURFACES, PRIMARY	$ 115.00
D2160	AMALGAM THREE SURFACES, PRIMAR	$ 139.00
D2161	AMALGAM FOUR SURFACES,PERMANEN	$ 165.00
D2330	RESIN-ONE SURFACE, ANTERIOR	$ 106.00
D2331	RESIN TWO SURFACES-ANTERIOR	$ 135.00
D2332	RESIN-THREE SURFACES, ANTERIOR	$ 165.00
D2335	RESIN-FOUR OR MORE SURFACES OR	$ 200.00
D2391	RESIN-BASED COMPOSITE - ONE SU	$ 120.00
D2392	RESIN-BASED COMPOSITE - TWO SU	$ 160.00
D2393	RESIN-BASED COMPOSITE - THREE	$ 200.00
D2840	Temporary crown	$ 55.00
D3220	PULPOTOMY	$ 134.00
D3310	ANTERIOR (EXCLUDING FINAL REST	$ 498.00
D3320	BICUSPID (EXCLUDING FINAL REST	$ 591.00
D3330	MOLAR (EXCLUDING FINAL RESTORA	$ 728.00
D3347	RETREATMENT OF PREVIOUS ROOT C	$ 657.00
D3351	APEXIFICATION/RECALC INITIAL	$ 248.00
D3410	APICOECTOMY	$ 467.00
D3426	ROOT SURGERY EA ADD ROOT	$ 248.00
D3430	RETROGRADE AMALGAM	$ 180.00
D4210	GINGIVECTOMY OR GINGIVOPLASTY	$ 446.00
D4211	GINGIVECTOMY OR GINGIVOPLASTY	$ 160.00
D4240	GINGIVAL FLAP PROC W/ PLANIN	$ 125.00
D4241	GNGVL FLAP W ROOTPLAN 1-3 TH	$ 125.00
D4263	BONE REPLCE GRAFT FIRST SITE	$ 452.00
D4264	BONE REPLCE GRAFT EACH ADD	$ 339.00
D4341	PERIODONTAL SCALING AND ROOT P	$ 181.00
D4355	FULL MOUTH DEBRIDEMENT	$ 130.00
D5110	COMPLETE UPPER DENTURE	$ 1,120.00
D5120	COMPLETE LOWER DENTURE	$ 1,125.00
D5211	DENTURES MAXILL PART RESIN	$ 838.00
D5213	DENTURES MAXILL PART METAL	$ 1,200.00
D5214	DENTURES MANDIBL PART METAL	$ 1,200.00
D5610	REPAIR BROKEN COMPLETE DENTURE	$ 145.00
D5640	REPLACE FX BROKEN & TOOTH ON D	$ 125.00
D7140	EXTRACTION ERUPTED TOOTH/EXR	$ 110.00

Covered Services Adult Dental		
Proc Code	Description	DC Medicaid Fee
D7210	SURGICAL REMOVAL OF ERUPTED TO	$ 192.00
D7220	REMOVAL OF IMPACTED TOOTH-SOFT	$ 210.00
D7230	REMOVAL OF IMPACTED TOOTH-PART	$ 285.00
D7240	REMOVAL OF IMPACTED TOOTH-COMP	$ 350.00
D7241	IMPACT TOOTH REM BONY W/COMP	REV REQ
D7250	ROOT TIPS	$ 350.00
D7270	REPLANTATION OF TOOTH WITH SPL	$ 375.00
D7280	SURGICAL EXPOSURE OF BONEY IMP	$ 341.00
D7282	MOBILIZE ERUPTED/MALPOS TOOT	$ 352.00
D7286	BIOPSY OF ORAL TISSUE SOFT	$ 201.00
D7310	ALVEOLOPLASTY IN CONJUNCTION W	$ 200.00
D7320	ALVEOLOPLASTY NOT IN CONJUNCTI	$ 295.00
D7340	STOMATOPLASTY PER ARCH UNCOMPL	$ 635.00
D7410	EXCISION OF BENIGN LESION TO 1	REV REQ
D7412	EXCISION BENIGN LESION COMPL	REV REQ
D7413	EXCISION MALIG LESION<=1.25C	REV REQ
D7414	EXCISION MALIG LESION>1.25CM	REV REQ
D7415	EXCISION MALIG LES COMPLICAT	REV REQ
D7460	EXCISION OF RANULA	$ 330.00
D7510	INCISION DRAINAGE ABSCESS, INT	$ 155.00
D7520	INCISION & DRAINAGE EXTRAORAL	$ 250.00
D7530	CURETTAGE OF FISTULOUS TRACT	$ 247.00
D7610	FX,OPEN REDUCTION MAXILLA	REV REQ
D7620	FX,CLOSED REDUCTION MAXILLA	REV REQ
D7630	FX,OPEN REDUCTION MANDIBLE	REV REQ
D7640	FX,CLOSED REDUCTION MANDIBLE	REV REQ
D7650	FX, OPEN REDUCTION ZYGOMATIC A	REV REQ
D7820	CLOSED REDUCTION OF DISLOCATIO	$ 112.50
D7840	CONDYLECTOMY	$ 675.00
D7850	MENISCECTOMY	$ 630.00
D7860	ARTHROTOMY	$ 450.00
D7870	ARTHROCENTESIS	$ 36.00
D7910	SUTURES	$ 190.00
D7911	DEBRIDEMENT & REPAIR OF SOFT T	$ 307.00
D7940	OSTEOPLASTY(PROGNATHISM,MICROG	$ 975.00
D7960	FRENULECTOMY	$ 313.00
D8050	INTERCEP DENTAL TX PRIMARY	REV REQ
D8080	COMPRE DENTAL TX ADOLESCENT	REV REQ
D8110	Bite Plane	$ 168.00
D8220	FIXED OR CEMENTED	$ 677.00
D8999	ORTHODONTIC PROCEDURE	REV REQ
D9110	PALLIATIVE TREATMENT OF DENTAL	$ 85.00
D9220	GENERAL ANESTHESIA	$ 260.00
D9221	GENERAL ANESTHESIA EA AD 15M	$ 112.00
D9230	ANALGESIA	$ 46.00
D9310	CONSULTATION	$ 112.50
D9420	HOSPITAL VISIT	$ 33.00
D9430	CONSULTANT EVALUATION EXAM	$ 67.50
D9940	OCCLUSAL EQULIBRATION	$ 40.00
D9951	LIMITED OCCLUSAL ADJUSTMENT	$ 116.00
D9952	COMPLETE OCCLUSAL ADJUSTMENT	$ 474.00

Proc Code	Description	DC Medicaid Fee
	Services not covered under regular adult Medicaid plan	
D1120	D1120 Prophylaxis - child	$47.00
D1201	D1201 Topical application of flouride w/prophy child	$73.00
D1203	D1203 Topical application of flouride child	$29.00
D2110	D2110 Amalgam one surface primary	$90.00
D2120	D2120 Amalgam two surfaces primary	$115.00
D2130	D2130 Amalgam three surfaces primary	$139.00
D2131	D2131 Amalgam four or more surfaces primary	$165.00
D2970	D2970 Temporary crown (fractured tooth)	$31.50
D7270	D7270 Tooth reimplantation/stabilization	$375.00
D9110	D9110 Palliative ER treatment of dental pain minor	$85.00
D1511	D1511 Lingual Archwire	$110.00
D4249	D4249 Clinical crown lengthening hard tissue	$490.00
D7272	D7272 Tooth Transplantation incls reimplantation	$469.00

F.2 Related Services

F.2.i Interpreter Services

Our organization has the ability to provide interpreter services for patients needing translation in English, Spanish, French, Haitian Creole and Amharic.

In the event that additional interpreter services are required, QPA will utilize the service currently utilized by the Medicaid Department.

F.2.ii Transportation

QPA interacts and utilizes transportation services that are currently provided by MAA

F.2.iii Health Education

QPA has traditionally participated in health education events that focus on providing feedback and suggestions to assist beneficiaries. These programs have included a broadcasted radio segment addressing dental health issues and listeners were extended an opportunity to call in and have their questions answered. Health fairs have proved to be particularly helpful and often allow QPA's staff to play an influential role in encouraging adults and children to consider the importance behind maintaining good oral hygiene.

F.3 Beneficiary Helpline

Between the hours of 8:00 am -6:00 pm, Monday thru Friday, QPA maintains a well-staffed customer service department that is trained to be responsive to all beneficiary request and concerns. . When personal service is not available, specifically after hours, on weekends and on holidays, automated prompts and directives are activated in order to direct inquiries regarding emergencies.

F.4 Beneficiary Written Materials Available

In addition to this Beneficiary Handbook, a summary plan brochure is available. Information regarding plan information and available services can also be accessed through our web site at www.qualityplanadmin.com

F.5 Claims Processing Process and Forms

If you use a participating provider, there is no need to submit a claim form. The participating provider will file the claim on your behalf.

Claims Submission Required Data Elements

Both paper and electronic professional claims should include the standard CMS required data elements. Please pay particular attention to the following items:

- Patient name
- Patient date of birth
- Patient demographic information
- Member identification number
- Rendering provider name
- Payee name and address
- Provider Signature
- Provider Federal Tax Identification Number
- Provider NPI number
- Date of Service
- All appropriate CDT codes
- Amount billed for each procedure
- Place of service code

- Type of service
- Anesthesia/sedation time in minutes (O.S.)
- Replacement of previous prosthodontic appliance
- Date of previous service
- Pre-authorization request
- Actual Service
- Pre- and/or post-operative radiographs as outlined in protocols
- Additional information as outlined under the "by report" sections outlined on protocols

Paper Claims Submission

Paper claims can be submitted to Quality Plan Administrators Claims Department at the address below. QPA requires a completely filled out ADA dental claim form. All appropriate sections must be completely addressed in order to facilitate speedy adjudication.

Quality Plan Administrators
7824 Eastern Avenue, N.W.
Suite 100
Washington, DC 20012

Upon receipt, "clean" paper claims are electronically scanned into our claims system and processed by our staff. Electronic scanning provides an effective and secure method to assure timely claims adjudication.

Electronic Claims Submission

As of January 2008, QPA accepts electronic claims submissions.

QPA electronic claims payor ID is: CX077

Although the vast majority of our network providers continue to utilize paper claims, we encourage submission of electronic claims. This form of claims management reduces errors and delays encountered by the routing of paper claims. Please feel free to call us regarding how you may utilize electronic billing, including the transmission of radiographs electronically.

Claims Inquiries

If a practitioner has not received payment for a claim within 45 days or has concerns regarding a claim issue, they can check the status of their claim by doing one of the following:

- Call the claims status line at **(202) 722-2744 or**
- Call the Customer Service Department at **(202) 722-2744 or (800) 900-4112** and speak directly with a Customer Service Representative

When calling to check the status of a claim, the following information must be provided:

- Recipient Medicaid identification number and member name
- Date of service(s)
- Practitioner Name & TIN, NPI
- Billed amount(s)
- Approximate date of claim submission

Claims Denials

When a claim is denied, a Remittance Advice (RA) with the appropriate denial code(s) detailing the reason for the denial will be sent to the practitioner. The denial reason(s) can include but are not limited to the following:

- The services were not covered
- The member is not eligible for that date of service
- Claim was not filed within the time limit (date of service to receipt date)

All denied claims may be resubmitted for reconsideration through the appeals process.

Claims Payment Review

It is QPA's policy to review all claims for irregularities. If the system uncovers coding irregularities such as unbundling, utilization of obsolete CDT codes, etc., the specific claims line will be denied using the appropriate denial code. All claims denied for these reasons may be appealed and submitted in writing with additional documentation for reconsideration.

Balance Billing Patients

Participating providers are prohibited from balance billing QPA patients unless specifically stated in that plan design. The practitioner shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against the involved patient.

In the event a practitioner refers a patient to a non-participating practitioner without prior-authorization, or provides excluded services to a patient, the practitioner must inform the patient in advance, in writing:

- The service(s) to be provided
- That QPA will not pay for or be liable for said services
- That patient will be financially liable for such services.

In the event the practitioner does not comply with the requirements of this section, the practitioner shall not be able to hold the patient liable as described above.

F.6 Complaints, Grievances, and Appeals

Complaints and Grievances

QPA maintains a defined process for members to resolve disputes regarding any aspect of service provision or administration. Patients, practitioners acting on behalf of a patient, or a patient's authorized representative may contact QPA by telephone, in writing, or in person to voice a complaint (grievance) regarding any aspect of service provision or administration of the QPA benefit plan, including complaints regarding QPA's provider network and/or quality of care concerns.

There is no time limit on filing a complaint if no notice of action (denial) was issued. If a notice of action was issued, the request to file a complaint or grievance must be received within ninety (90) days of such notice.

The member may elect to authorize a representative to act on the member's behalf in the complaint/grievance process. This representative may be:

1. The parent, guardian, or other legal representative of a minor child;
2. A person designated through written authorization of the member, including the patient's health care practitioner;
3. The executor of the patient's estate;
4. An attorney; or
5. A non-legal advocate

QPA will in no way penalize any patient, or any individual acting on behalf of the member, who files a complaint or grievance or requests a fair hearing.

Practitioners must report any complaint they receive to QPA as soon as reasonably possible after the complaint is received. In no case should the report be made more than seven (7) business days after receipt.

QPA will investigate the incident or action that generated the complaint by receiving written reports from all parties involved. This investigation could involve a site visit so that full resolution of the complaint can be achieved.

Please report complaints to:

Quality Plan Administrators, Inc.
Attention: Grievance Coordinator
7824 Eastern Avenue, N.W.
Suite 100
Washington, DC 20012
(202) 722-2744 or (800) 900-4112
Or
Compliance Hotline at: (202) 291-2974

If the complaint includes a potential quality of care issue, then our advisory committee will be asked to intervene and assist in the resolution. Should there be resistance to resolving a justified complaint, the DC Board of Dental Examiners will be brought into the process.

If a patient desires assistance in filing a complaint or grievance, the patient may contact Customer Service at (202) 722-2744. Customer Service is available to assist patients in filing grievances. QPA will ensure that the patient and his/her representative are notified. Complaints are resolved as expeditiously as the patient's dental condition requires (if there is a dental service component of the complaint). In no case will resolution take longer than thirty (30) days from receipt of the complaint unless the patient has agreed to an extension of the resolution due date.

Appeals

QPA offers three types of appeals: Expedited Appeal, Immediate Appeal and Standard Appeal. A patient, patient's representative, or attending practitioner or facility may request an appeal. The appeal may be initiated by a verbal or written request; however, for proper documentation, QPA prefers that verbal requests be followed by a written. Submit written appeals to:

Quality Plan Administrators, Inc
Attn: Appeals Coordinator
7824 Eastern Avenue, N.W.
Suite 100
Washington, DC 20012
Or
Fax: (202) 291-5703