Healthplex Provider Manual

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Healthplex.com

HEALTHPLEX MISSION STATEMENT

Mission	Healthplex is committed to providing access to high quality affordable dental care and to improving the oral health of our community. Our comprehensive, innovative solutions serve to build trust and deliver value.
For Our Clients	This means providing comprehensive administrative services that alleviate the burdens associated with offering dental programs.
For Our Subscribers and Enrollees	This means ensuring access to a network of dental professionals whose offices and services are monitored through Healthplex's intensive quality assurance program.
For Our Participating Providers	This means being a partner that is easy to do business with through simple administrative procedures, and communications that are clear and easy to understand.

ABOUT THIS MANUAL

The Manual

The manual is an extension to your Healthplex Provider agreement. It has been organized for easy access to information about our plans, policies and procedures, administration, claims, and utilization.

Quick References

The Plan Summaries in Section I and the Claims Reference Sheet in Section II are intended to be reproduced for your office staff for quick reference.

Let Us Know

Whether you are new to Healthplex, or a long-standing provider of care to Healthplex members, we thank you for your participation in our network and welcome your feedback regarding this manual. Kindly forward your suggestions or comments via email to ProviderRelations@healthplex.com.

Contact Information for Providers

Provider Hotline: 888-468-2183 (Monday – Friday, 8am – 5pm)

UM Clinical Review: 516-542-5182 (Monday – Friday, 9am – 5pm)

Web Support: 888-468-5171 (Monday – Friday, 8am – 5pm)

Provider Relations Fax: 516-228-9571

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I. PLAN SUMMARIES

Healthplex, Inc. is the administrator for various plans which follow various government guidelines outlined in this procedure manual.

Member Co-Pays	Please visit the Provider Web Portal on Healthplex.com for member specific cost sharing information.
Member Eligibility	Please verify the member is eligible the day of service by using the Healthplex website - www.healthplex.com or through our IVR system at 888-468-2183, option 1.
Specialty Referrals	Referrals are required for all specialists on managed care plans. Referrals are not required on PPO plans.
Prior Authorizations	Prior authorizations **are not a requirement** for payment; however, to ensure coverage, a predetermination is recommended for all major services.

II. CLAIMS

A. CLAIM SUBMISSION

Healthplex Claims Payment

Send Completed Forms to: Healthplex, Inc.
Attention: Claims Dept.
PO Box 9255
Uniondale, NY 11553-9255

A Clean Claim is. . .

A claim that is clean has been submitted with all fields properly filled out

Healthplex Claims Need

- Member's name and date of birth
- Member's address
- Member's social security number or ID number
- Patient's name and date of birth
- Group name or number
- COB if there is primary insurance
- CDT code and description of service
- Date of service
- Tooth number and/or surface (if applicable)
- Doctor's fee charged
- Member signature
- Assignment of benefits (if applicable)
- Provider's information:
  - -Tax identification number or social security number
  - -NPI number
  - -License number
  - -Address where treatment is rendered
  - -Billing address
  - -Taxonomy code
  - -Provider signature

Timely Claim Submission

- Claims must be submitted within 90 days of service.
- Requirements for Healthplex commercial plans may vary.

Claim Turnaround Time

- Pre-Authorizations and specialist referrals are processed within three business days.
- Clean e-claims are paid within 30 days of receipt, clean paper claims within 45.

X-Rays and Paper Claims

- Ensure x-rays are secure and attached to the claim.
- X-rays must be labeled correctly with the name of the patient and the social security number or ID number of the insured.
- Healthplex will not return any supporting documentation which is submitted, regardless of if a self-addressed envelope is included; please only send copies.

Electronic Claims

When filing an electronic claim:

- You must set up an electronic account with an authorized clearinghouse to submit claims using Healthplex Payor ID #11271.
- You must input correct data, including assignment of benefits.
- Please specify if the information being submitted is a claim or a predetermination.

- If submitting COB information, charting, or x-rays as an electronic attachment through NEA, you must indicate the NEA attachment number on the electronic claim. Contact NEA/Fast Attach for more information.

Healthplex Claims Payment

Paper Claims

Paper claims for major services must include the required documentation mentioned below.

When Does a Claim Require Professional Review?

The following services require professional review:

Service	Healthplex Needs for Commercial Plans	Healthplex Needs for Government Services Plans
Crowns	• Pre-operative X-Rays • If replacement crown, date of prior placement needed	• Full Arch Pre-operative X-Rays • If replacement crown, date of prior placement needed
Bridges	• Full Arch Pre-operative X-Rays • If replacement bridge, date of prior placement needed	• Full Arch Pre-operative X-Rays • If replacement bridge, date of prior placement needed
Dentures - Complete or Partial	• If replacement denture, date of prior placement needed	• If replacement denture, date of prior placement needed • Full Arch Pre-operative X-Rays
Periodontal Therapy	• Pre-operative X-Rays • Periodontal Charting	• Periodontal Charting • Full Arch Pre-operative X-Rays
Root Canals	• Pre-operative and Post-operative X-Rays	• Full Arch Pre-operative X-Rays
Oral Surgery	• Pre-operative X-Rays	• Pre-operative X-Rays
Orthodontic Cases	• Study Models and/or Photographs	• Study Models • X-Rays(Panoramic/Cephalometric) • Photos

Coordination of Benefits (COB) Refers to a member having more than one dental plan

- Must accompany claim being submitted
- Must come completed and dated by the other carrier along with the dates of service and amounts paid. This ensures that Healthplex can remit correct payment.

Healthplex Claims Payment

Provider Hotline

The direct number for **providers** is **1-888-468-2183.**

Options:

- Eligibility/Claims (IVR) #1
- Urgent Referrals #2
- Website Support #3
- Customer Service #4
- Provider Relations (Commercial) - Contracting & Participation #5
- Provider Relations (Government) - Contracting & Participation #6
- Provider Recruitment #7

Using the Web

Go to **www.Healthplex.com**.

The direct number for **web support** is **1-888-468-5171**.

- Please fill out the website registration form to obtain a username and password.

Features:

- Eligibility
- Claims or predetermination status
- Provider directory
- PPO plan fee schedules
- Service history
- Estimate a Procedure
  - to view benefit information and patient responsibility
  - not a guarantee of payment
  - guidelines and limitations apply
- Capitation statements
- Member rosters
- HEDIS reports
- Financial reports (direct deposit and check report)

Coordination of Benefits (COB)

- Refers to Member's Primary/Secondary Insurance.
- If Member has other insurance coverage, that information must accompany the claim being submitted.
- An EOB from the other carrier along with the dates of service must accompany the claim.
- If the patient is a dependent child, the primary coverage would be that of the parent whose date of birth is earliest in the calendar year.
- Medicaid is always the payor of last resort.
- Federal law takes precedence over State law and private contracts. Medicare is the secondary payor regardless of state law or plan provisions.

Ensuring Claims Processing Compliance

Healthplex reviews its policies and procedures for claims processing to ensure compliance with governing laws, timely payment guidelines, and established national standards.

Overpayment Recoupment

Healthplex cannot go back more than two (2) years for a recoupment unless it is for fraud and recovery efforts required by state or federal governments (Insurance Law Section 3224-b).

In the case of government Managed Care Plans, overpayments discovered as a result of an audit by a Health Plan can be recouped going back as far as six (6) years.

Healthplex must allow our providers the opportunity to challenge an overpayment recovery of previously paid claims. Within thirty (30) days of the provider receiving the Refund Request Letter, the provider may challenge Healthplex's request for reimbursement in writing. The challenge should outline the specific groups on which they are challenging the recovery. Copies of relevant Explanation of Benefits, Coordination of Benefits information, and/or the calculation used to base the refund request can be supplied to the provider upon request. If the provider needs additional time after receiving the relevant information, Healthplex will allow fifteen (15) days for the provider to submit a final summary of their challenge, including any supporting documentation. Once Healthplex receives the final summary from the provider, Healthplex will respond in writing with the final determination in a timely manner.

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III. ADMINISTRATIVE GUIDELINES

A. GUIDELINES FOR PARTICIPATING PROVIDERS

Patient Records

All patient records must be retained for 10 years. Healthplex reserves the right to access these records and expects the office to have procedures in place to retrieve any necessary records if stored off site during this time period.

Administrative Fees

These plans do not reimburse the provider an administrative fee for the following:

- **No Show/Missed Appointments -** The Federal Centers for Medicare and Medicaid Services (CMS) has advised the State that government plan providers are prohibited from billing beneficiaries, including but not limited to, Medicaid and CHP managed care enrollees, for missed appointments.

Healthplex general dentists may have members who continually miss appointments removed from their roster by faxing a written request to the Customer Service Department at (516) 227-1143.

- **Medical Record Copy Fee -** If it is a provider's practice to charge patients for copies of their medical records (private pay and third party insurance), providers may bill the plan enrollee. **Note**: Sections 17 and 18 of the Public Health Law stipulate that the maximum amount that may be charged for paper copies of health records and/or patient information furnished pursuant to such sections may not exceed seventy-five cents per page.

B. GUIDELINES FOR GENERAL DENTISTS

Member Enrollment

For managed care plans, a complete patient roster is available on www.Healthplex.com.

Member Eligibility

To verify member eligibility, log onto **www.Healthplex.com**, or call the Provider Hotline: **888-468-2183,** Option 1.

Member status should be "active".

Checking eligibility through the automated Provider Hotline or the Healthplex.com web site will generate an automated message entered into the member's Healthplex record. This will serve as proof that eligibility was verified on a given date.

Eligibility should be verified at every visit.

New Patients

- Check Member Eligibility
- Check patient history/treatment dates
- New patient appointments should be offered within 28 calendar days of request.
- Urgent appointments must be offered within 24 hours. Healthplex will fax member eligibility to you if needed for your records.
- You may check member photo identification to ensure they are the subscriber.

Referrals

- For managed care plans, specialist referral forms are sent from the primary dental provider to Healthplex in advance of treatment.
- For plans on the Medicaid line of business only, orthodontic referrals may be submitted electronically through our website at www.Healthplex.com.
- Healthplex will authorize the referral, fill in the specialist name, and notify the primary dental provider, specialist, and member within three business days of receipt.
- Specialty referral request forms, with indications for necessity for referral along with any appropriate supporting diagnostic materials, are sent from the Primary Care Dentist ("PCD") to Healthplex in advance of non-urgent treatment via email: referrals@healthplex.com, or via fax: 516-228-5025.
- Urgent Care Referrals may be obtained by the PCD or the treating specialist by calling the Provider Hotline at: **888-468-2183, Option 2.** Determinations will be issued by Healthplex immediately to the requesting provider.
- For non-urgent referral requests, Healthplex will issue a determination directly to the PCD, member, and specialist (if approved) within three (3) business days of receipt.
- A copy of the referral's determination is available on the Healthplex.com website.

Prior Authorization

- Prior authorization is suggested for major dental services if you intend to charge the member for non-covered services, or if you are unsure if a service is covered.
- Consideration for prior authorization of services should consider the overall general health of the member, member compliance and dental history, condition of the oral cavity, and complete treatment plan that is both judicious in the use of the program funds, and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of treatment.
- In order to charge the member for non-covered services, a detailed waiver signed by the member and provider is required. It is recommended that providers use the Healthplex disclosure sheet,

"Sample for Cosmetic or Uncovered Treatment". This form can be found on the Healthplex.com website under the Forms section.

- Submit claim forms in accordance with supporting documents listed under the Claims section of this manual.
- In the event a prior authorization is denied, you may request a reconsideration of the denial and you may speak to a Customer Service Representative by calling the Provider Hotline, 1-888-468-2183, option 3. You may also speak with a dental professional to discuss clinical issues by calling the UM hotline: 1-888-468-5182.
- Please refer to the Guidelines for Covered Services section for criteria used to make utilization decisions pertaining to the most frequently billed services. To obtain criteria related to a specific service not addressed in this manual, please call the UM hotline: 1-888-468-5182.
- We recommend that you use the EOB with approved treatment as your claim form for payment – just add the treatment date. Alternatively, include the original claim/authorization number on your claim for payment.

Capitation

- If you are contracted on a capitated arrangement, capitation rates are listed on your monthly roster on a per member, per month basis.
- Encounter form submission to Healthplex is required for all services rendered and can be submitted directly to Healthplex via www.Healthplex.com.
- Capitation checks are sent monthly.

Fee-For-Service

- For each covered procedure, the dental office agrees to accept the amount on the fee-for-service schedule of allowance for each respective plan.
- The reimbursement rate on the schedule of allowance is inclusive of any lab fees.

C. HOSPITAL BASED SERVICES

Requirement

The provider of hospital-based services must submit a letter of medical necessity to Healthplex. All requests should be submitted a minimum of 10 business days prior to the proposed date of service when possible. The request should include the following:

- Member ID Number
- Group Name or Number
- COB if there is a primary insurance/secondary insurance
- Provider Tax Identification Number
- CDT Code
- Proposed Date of Service
- Proposed Treatment Plan
- Rationale for Request
- Supporting Documentation
- Hospital Name and Address

Mail to: Healthplex, Inc.
Hospital Authorization Unit
333 Earle Ovington Blvd, Suite 300
Uniondale, NY 11553-3608

Healthplex will review and obtain hospital authorization from the member's medical plan and respond to the provider.

Healthplex will obtain the operating room and anesthesia authorization from the member's plan. The authorization number will be indicated on the pre-determination.

Urgent Requests

Please call ***or*** fax the request

- Provider Hotline: 888-468-2183; speak with a Healthplex representative.
- Fax the request to 516-228-1743, Attention: Hospital Authorization Unit.
- Healthplex will process the request immediately and respond via phone or fax.

D. GUIDELINES FOR SPECIALISTS

Member Eligibility

To verify member eligibility, log onto **www.Healthplex.com**, or call the Provider Hotline: **888-468-2183,** Option 1.

Member status should be "active".

Checking eligibility through the automated Provider Hotline or the Healthplex.com web site will generate an automated message entered into the member's Healthplex record. This will serve as proof that eligibility was verified on a given date.

Eligibility should be verified at every visit.

Referrals

- Specialist referral forms are sent from the primary dental provider to Healthplex in advance of treatment.
- A referral for non-urgent treatment can be requested via mail, fax (516-228-5025), or email (referrals@healthplex.com). Healthplex will issue a determination directly to the PCD, member, and specialist (if approved) within three (3) business days of receipt.
- Urgent Care referral requests can be obtained by the PCD or the treating specialist by calling the Provider Hotline (888-468-2183, option #2). Healthplex will issue an immediate determination directly to the requesting provider.
- Standard referrals are valid for 6 months, subject to member eligibility at time of service.
- Healthplex will respond directly to the request as it is presented. This means:
    - If a necessary consultation or evaluation is requested, it will be approved (regardless of whether or not the resulting treatment will be covered).
    - If a specific service/treatment is requested, a determination shall be rendered and the request shall be approved or denied based on guideline criteria.
- Referral determinations for extractions will be issued as simple extractions (D7140). Upon completion of services, the oral surgeon shall bill for treatment rendered using an appropriate extraction code

with supporting pre-operative radiographs.

- ♦ The referral determination will appear on Healthplex's website (www.Healthplex.com) in the claims/predeterminations section as a reference.
- ♦ **A referral is not a prior authorization**. In order to determine if a specific service will be covered, please submit a standard prior authorization request and the request will be processed under standard procedures.

Prior Authorizations

- ♦ Prior authorization is recommended for major dental services if you intend to charge the member for non-covered services, or if you are unsure if a service is covered.
- ♦ Consideration for prior authorization of services should consider the overall general health, patient compliance and dental history, condition of the oral cavity, and complete treatment plan that is both judicious in the use of both the program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment plan.
- ♦ Submit a claim form in accordance with supporting documents listed under the Guidelines for Covered Services section of this manual.
- ♦ In the event a prior authorization is denied, you may request a reconsideration of the denial and you may speak to a Customer Service Representative by calling the Provider Hotline, 1-888-468-2183, option 3. You may also speak with a dental professional to discuss clinical issues by calling the UM Hotline 1-888-468-5182.
- ♦ Refer to the Guidelines for Covered Services section for criteria used to make utilization decisions pertaining to the most frequently billed services. To discuss criteria or to obtain criteria related to a specific service not addressed in this manual, call the UM Hotline at 1-888-468-5128.
- ♦ We recommend that you use the EOB approving services as your claim form for payment **~OR~** include the original claim/authorization number on your claim for your payment.

Covered Services

- Guidelines listed in the MMIS Guidelines of the state the provider is practicing in are all-inclusive for covered services and conform to generally accepted standards of dental practice (please see Section V of this Manual).
- For those plans that follow the Commercial Managed Care Guidelines, see Section VI.
- All covered services are rendered without charge to the patient with the exception of coinsurance, which are collected at the time of service.
- Submit a claim form with required documentation to Healthplex.
- For prosthetic services, claim forms should be submitted upon completion (insertion).

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IV. TREATMENT GUIDELINES

A. COVERED PROCEDURES - DIAGNOSTIC

Diagnostic Procedures Summary

Diagnostic services include the oral examination and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the patient's oral health.

Reimbursement for Radiographs

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation.

Reimbursement for multiple x-rays of the same tooth or area may be denied if Healthplex determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. Healthplex utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health, and the American Dental Association. These guidelines were developed in conjunction with the Food and Drug Administration.

The maximum reimbursement for radiographs shall be limited to the fee for a complete series.

Comprehensive Exams

Comprehensive examinations are used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, prosthetic appliances, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

This applies to new patients, established patients who have had a significant change in health conditions or other unusual circumstances such as established patients who have been absent from active treatment for three or more years.

Periodic Exams

A periodic examination is performed on a patient of record to determine any changes in the patient's dental and medical health status since their previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

B. COVERED PROCEDURES – PREVENTIVE

Preventive Services Summary

Preventive services include routine prophylaxis (including supragingival scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures. Prophylaxis includes necessary scaling and polishing.

Fluoride

The topical application of fluoride treatment is allowed once every 6 months.

Fluoride treatments can be rendered to adults only in the following situations:

- Adults with systemic illnesses that cause xerostomia (dry mouth), or those taking medications with the same result.
- Adults treated with radiation therapy to the head and neck that resulted in xerostomia.
- Adults with a high rate of interproximal caries.
- Adults wearing orthodontic appliances that make it difficult to remove plaque.
- Adults who have been treated for periodontal disease and exhibit recession (exposure of the root surfaces) and sensitivity.

Fluoride treatment should not be routinely rendered to adults who display poor oral hygiene and request to receive the procedure as a substitute for brushing and flossing.

Sealants

- Sealants are covered for patients between age 5 through 15 once in a 60-month period per tooth.
- Sealants should be applied to the occlusal surfaces of all erupted and previously un-restored first and second permanent molars.
- Priority should be given to applying sealants to newly erupted molars.
- Sealants will not be covered when they are placed over restorations.

Space Maintainers

- Space maintainers are a covered service for patients with deciduous or mixed dentitions when determined by a Healthplex Consultant to be indicated due to the premature loss of a posterior primary tooth.
- Space maintainers will not be covered for the loss of a first deciduous molar if the first permanent molar is fully erupted.

A lower lingual holding arch placed when there is no premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

C. COVERED PROCEDURES – RESTORATIVE

Restorative Services

- Restorative services (amalgams and composites) are provided upon removal of decay and restoration of dental structures (teeth) to a reasonable condition.
- Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.
- Restorations are expected to last a reasonable amount of time. Repeated unexplained failures will result in Peer Review and may necessitate removal of the dentist from the network. The material used is clinically determined by the dentist.
- Total restoration per tooth by amalgam and/or composite is not to exceed the allowable fee for a four surface filling within a reasonable amount of time.
- If amalgam fillings are not routinely done by an office, the office must use the procedure which is routinely used and must not charge the patient extra.
- Crowns will not be routinely covered if eight points of posterior contact are present or if functional replacement of tooth structure with other restorative material is possible.
- Crowns will not be routinely approved on molars that have been endodontically treated without prior approval (patients 21 and older).

D. COVERED PROCEDURES – ENDODONTIC

Endodontic Services Summary

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

Claims must be submitted with pre and post-operative radiographs.

Pulpotomies

Pulpotomies will only be covered on primary or permanent teeth with no evidence of internal resorption, furcation or periapical pathology for patients up to age 21.

An emergency pulpotomy should be billed as Palliative Treatment.

Root Canals

- Root canal therapy for permanent teeth includes pulpectomy shaping and enlarging the canals, temporary fillings, filling of root canal(s), and progress radiographs. The fee does not include the final restoration.
- The acceptable standard employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet Healthplex's treatment standards, Healthplex can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the Healthplex Consultant reviews the circumstances.
- Claims submitted for root canal treatment services done in an emergency situation should be submitted with recent pre-operative and post-operative periapical x-rays for retrospective review.

Please note that radiographs are included in the fee for the root canal procedure.

When Root Canal Therapy and Pulpotomy may NOT be covered

- Root resorption has started and exfoliation is imminent.
- Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal), deeming tooth non-restorable.
- General oral condition does not justify root canal therapy due to the loss of arch integrity.
- Tooth does not demonstrate adequate bone support.
- Tooth demonstrates active untreated periodontal disease.
- Posterior endodontic procedures will generally not be covered if eight points of posterior contact are present.

Molar Root Canal Therapy

Molar root canal therapy is not covered as a routine procedure under this program.

Exceptions may be considered as follows:

- Patient is under age 21 for Medicaid or under age 19 for CHP, and:
  - displays good oral hygiene, and;
  - has adjacent and opposing teeth, and;
  - has a low caries index, and;
  - has a full complement of teeth, and;
  - the tooth is restorable, or;
  - the patient is undergoing orthodontic treatment.
- Patient is over age 21 for Medicaid, and the tooth is a **critical** abutment for an **existing** partial denture or bridgework.

Prior approval is required for all root canal therapy.

E. COVERED PROCEDURES – PERIODONTAL

Periodontic Services

Periodontal scaling and root planing, gingivectomy (associated with drug therapy, hormonal disturbances or congenital defects), and certain other procedures may be considered for coverage (see state MMIS Guidelines for limitations).

The state MMIS Guidelines may provide basic periodontal coverage. Scaling and Root Planing are covered when clinically indicated, but only when documentation is submitted to justify the service. This would include periodontal charting to show pocket depths, a description of the soft tissue, the type and amount of bone loss, the presence of mobility and the prognosis. Periodontal maintenance may also be covered for patients who have previously been treated for periodontal disease.

Gingivectomies may also be covered, but only to treat severe hyperplasia documented by a history of drug therapy, hormonal imbalances or congenital defects.

F. PROSTHETIC SERVICES

Removable Prosthetic Services

Provisions for removable prosthesis include initial placement when masticatory function is impaired or when the existing prosthesis is at least four years old and unserviceable.

- All necessary restorative work must be completed before fabrication of a partial denture.
- Abutments for a partial denture must be free of active periodontal disease, and have adequate bone support.
- Removable prosthetics require prior approval. To be considered, mounted full mouth x-rays and complete treatment plans must be submitted for review.
- No replacement of full or partial dentures in less than eight years from the initial placement will be allowed.
- After eight years prosthetics must be unserviceable or unrepairable to be considered for replacement.
- No replacement for loss due to negligence.
- In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with dentures is required for authorization.
- Partial dentures will generally not be covered if eight points of posterior contact are present.

Reimbursement for Dentures

- Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six (6) month period following delivery of a new prosthesis.
- Relines are covered once every 24 months.

Fixed Prosthetic Services

Fixed bridgework is generally considered beyond the scope of the Medicaid, and Child Health Plus programs.

Covered

Fixed bridgework may only be considered for the replacement of permanent anterior teeth in a mouth exhibiting low caries rate and sound periodontal condition, and only in cases where there is a documented physical/neurological disorder that would preclude placement of a removable prosthesis or in those cases requiring cleft palate stabilization.

Not Covered

Approval will be denied if:

- periodontal involvement is present within the arch.
- root canal therapy is necessary on any tooth in the arch.
- there are any additional missing teeth in the arch.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

In cases other than for cleft palate stabilization, treatment would generally be limited to replacement of a single maxillary anterior tooth or replacement of two adjacent mandibular teeth.

G. ORAL AND MAXILLOFACIAL SURGERY

Covered Services

Local anesthesia and routine post-operative care are included in the fees for extractions and will not be reimbursed separately.

"Erupted surgical extractions" are defined as extractions requiring elevations of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Claims for all oral surgical procedures except non-surgical extractions must include a pre-operative x-ray, biopsy report & narrative to be considered for reimbursement.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Not Covered

Prophylactic removal of asymptomatic teeth or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

Extractions for orthodontic reasons are not covered under CHP.

When to Refer to an Oral Surgeon

Oral surgery procedures may be referred to participating surgeons in the following situations:

- Surgery unable to be performed by the general practitioner.
- Patient's medical condition requires special care and/or general anesthesia.

Referrals to an Oral Surgeon

To refer a surgical case, the participating general dentist must:

- Complete a Specialist Referral Form.
- Include recent pre-operative radiographs and send this to Healthplex for pre-authorization.

In the event of an emergency, you must call Healthplex at 516-542-2600 or 888-468-2183, option 2 for an authorization number. Acute situations should be handled at your discretion, provided Healthplex is notified as soon as possible.

H. ORTHODONTIC SERVICES

Medicaid

Please submit a Healthplex Orthodontic Referral Form to Healthplex for an approval to an in-network orthodontist.

Child Health Plus and Medicare

No orthodontic benefit is available. This includes any orthodontic services.

Patients may see any orthodontist they choose, but will have to self-pay.

Orthodontic Services Summary

Orthodontic services include Limited, Interceptive and Comprehensive orthodontic treatment based on plan benefit guidelines.

For Medicaid plans, state MMIS Guidelines are applied using the Handicapped Labio-Lingual Deviation (HLD) Index Report.

Orthodontic records submitted for review must be of acceptable quality standards and of diagnostic value. Records of poor quality will be returned to the provider, and result in the pending of the prior authorization.

Disparities between the condition, or scores, indicated by the provider on the HLD Index Report, and the orthodontic records provided may result in the prior authorization request being returned without being reviewed.

The pre-orthodontic treatment visit does not require prior authorization. Reimbursement is available once per twelve (12) months prior to initiation of

orthodontic treatment and includes the consultation; therefore, consultation will not be reimbursed separately.

For an approved course of orthodontic treatment, the orthodontist should retain an Informed Consent Form which must be signed by the patient and parent (or guardian) after they are advised of the following:

- Age limits for orthodontic coverage (if applicable);
- Projected length of treatment;
- Expectations of patient compliance with noted consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner; and,
- The patient responsibility for payment should coverage be lost for any reason.
- Itemized list of services and fees not covered as per contract.

If a provider initiates discontinuation of treatment as dictated by the American Association of Orthodontics, please notify Healthplex as soon as possible.

In an effort to support suitable billing practices, Healthplex utilizes a case fee reimbursement structure for all comprehensive orthodontic treatment approved. Under this structure, a provider agrees to accept this payment in full for orthodontic cases regardless of length of treatment whether short or in excess of the time period allotted to reimbursement. Insertion and retention must be paid by Healthplex for the case fee to apply.

The following orthodontic templates are available for your office use under the Forms section of the Healthplex website:

- ♦ Dental Clearance Note
- ♦ Dismissal Letter
- ♦ Braces Removal and Retainer Consent Form
- ♦ Orthodontic Treatment Progress
- ♦ Consent Form
- ♦ Release From Treatment – Provider
- ♦ Release From Treatment – Patient Request

Limited Orthodontic Treatment

Limited orthodontic treatment can be considered for the permanent dentition that does not require, or will eliminate the need for, a full course of comprehensive treatment.

For prior authorization the following shall be submitted:

- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- Orthodontic treatment plan to include description of appliance(s);
- Diagnostic photographs; and
- Diagnostic panoramic radiographs and cephalometric radiographs.

Reimbursement is available once per lifetime and includes appliances, insertion, adjustments, treatment visits, repairs, removal, passive retention visits up to a year and initial retainers.

The case start date is considered to be the insertion date of the appliance(s) which must occur within six (6) months of approval.

Interceptive Orthodontic Treatment

Interceptive orthodontic treatment can be considered for the primary or mixed dentition.

Consideration is given when interceptive orthodontic treatment may eliminate the need for or reduce the severity or duration of comprehensive orthodontic treatment.

For prior authorization requests the following shall be submitted:

- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- Orthodontic treatment plan to include description of appliance(s);
- Diagnostic photographs; and
- Diagnostic panoramic radiographs and cephalometric radiographs (when applicable).

Reimbursement is available once per lifetime and a one-time payment is issued to include all appliances, insertion, adjustments, treatment visits, repairs, removal and retention. When treatment is not part of the comprehensive case, the provider shall complete the interceptive treatment even if eligibility is terminated.

If comprehensive treatment is required following a course of interceptive treatment, a period of twelve (12) to eighteen (18) months should be allowed

prior to requesting comprehensive treatment for stabilization of the result.

The case start date is considered to be the insertion date of the appliance(s) which must occur within six (6) months of approval.

Comprehensive Orthodontic Treatment

Comprehensive orthodontic treatment can be considered for the late mixed or permanent dentition, and will not be approved if significant number of primary teeth remain.

For Medicaid plans, the member must meet the criteria outlined by state MMIS Guidelines to be eligible for treatment. The member's dentition must exhibit an automatic qualifier listed on the HLD Index or score a minimum of twenty-six (26) points on the HLD Index in order to qualify for treatment.

For prior authorization requests the following shall be submitted:

- The completed HLD Assessment Tool;
- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- Orthodontic treatment plan to include description of appliance(s);
- Diagnostic casts or digital study models (when requested);
- Diagnostic photographs;
- Diagnostic panoramic and cephalometric radiographs (when applicable);
- For orthognathic surgical cases: the surgical consult, complete treatment plan and a statement signed by the parent/guardian and recipient that they understand and accept the proposed surgical treatment, and that the approval for orthodontic treatment is contingent upon the adherence to the surgical treatment plan; and
- Medical diagnosis (when applicable).

Please note: All needed dental treatment (preventive and restorative) should be completed prior to initiating orthodontic treatment.

For Medicaid plans, in cases where treatment was approved based upon the presence of an impacted anterior tooth (or teeth) not indicated for extraction, an attempt must be made to align the impacted tooth (or teeth). Benefits may be terminated if impacted tooth (or teeth) are extracted.

In addition to submission requirements already noted, the following must be met:

- The prior authorization request to start a case must include treatment visits. Treatment visits will be considered at four (4) quarterly intervals. The maximum number of quarterly intervals to be considered on any

one prior authorization is four (4);

- After the initial four (4) quarterly intervals, recertification for the remainder of the treatment is necessary. Please submit current progress photographs with a copy of the treatment record for review.
- The case start date is considered to be the banding date which must occur within six (6) months of approval;

The case fee includes the active and retention phases of treatment, and is based on eligibility and age limitations.

Documentation for Completion of Comprehensive Cases – Final Records

Attestation of case completion must be submitted on the provider's letterhead to document that active treatment had a favorable outcome and that the case is ready for retention. Procedure code D8680, orthodontic retention, shall be submitted on the visit to remove the bands and place the case in retention.

Continuation of Treatment / Transfer Treatment

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NY Medicaid Program

For continuation of care for transfer cases, a prior authorization must be submitted to request the remaining treatment visits for case completion. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval if applicable;
- A copy of the orthodontic treatment notes if available from provider who started the case;
- A copy of ledger showing payments made by previous carrier when the patient changes insurance;
- Recent diagnostic photographs and/or panoramic radiographs and pre-treatment photos and/or panoramic radiographs if available;
- The date when active treatment was started and the expected number of months for active treatment; and
- If re-banding is necessary: a new treatment plan, estimated treatment time and documentation to support the treatment change is required.

I. ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services Summary

Adjunctive general services include general anesthesia, intravenous sedation, consultations, and emergency services provided for relief of dental pain.

Palliative Treatment

Procedure code 9110 is used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph.

If any other services (filling, endodontic, oral surgery, etc.) are billed for on the same day, the palliative treatment code will be denied.

Please include tooth number or area involved.

Intravenous Sedation and General Anesthesia

Intravenous sedation and general anesthesia will only be a covered service for a participating dentist who holds current certification and licensure to administer such anesthesia per state and federal guidelines.

Requests for intravenous sedation and general anesthesia will be reviewed on a case-by-case basis.

A case will be covered for clients with physical and mental health problems of such severity that treatment cannot be reasonably attempted without the use of intravenous sedation or general anesthesia.

Intravenous sedation or general anesthesia may be allowed when a surgical procedure is being rendered.

Claims for sedation must include a narrative of medical necessity.

For cases requiring intravenous sedation or general anesthesia, providers must document the following in the clients chart for appropriate psychosomatic disorders:

- diagnosis,
- description of past evidence of situational anxiety or uncontrolled behaviors, and
- in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group.

Apprehension alone is not typically considered medically necessary.

Intravenous Sedation and General Anesthesia Reimbursement

Services not documented as required may be denied for payment.

Claims for intravenous sedation and general anesthesia should be submitted with the proper procedure code. A narrative should be included indicating the medical necessity.

General anesthesia, intravenous sedation and conscious sedation are only covered in conjunction with covered restorative or surgical dental procedures.

Payment for general anesthesia or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure Code 9310

Procedure Code 9310 – Consultation

- Will only be reimbursed to a specialist other than the one providing definitive treatment.
- A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist.
- When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure Code 9999

Procedure code 9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described in the current CDT.

Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

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V. MEDICAID GUIDELINES

Please refer to www.emedny.org for the most current information on the New York State MMIS Guidelines.

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VI. COMMERCIAL MANAGED CARE GUIDELINES

Please note that some Medicare plans administered by Healthplex follow Commercial Managed Care Guidelines; some follow Medicaid Guidelines.

A. GUIDELINES FOR COSMETIC PROCEDURES

These services include posterior facings, cosmetic bonding, diastemas, etc.

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1. Inform the patient that the services requested are cosmetic and possibly outside of plan coverage and that they must pay the full fee for such treatment.
2. In the event that the patient insists the treatment is covered by the plan, you may send a pre-certification form to Healthplex stating the conditions of the case.
3. If authorization is *received*, inform the patient and proceed with the treatment.
4. If authorization is *denied*, inform the patient of the costs and treatment time involved and proceed accordingly.
5. Complete and have the patient (or member if patient is a dependent) sign the disclosure form prior to starting treatment. The recommended disclosure form "Cosmetic or Uncovered Treatment Information Disclosure Sheet" is located in Section VIII in this manual.

B. GUIDELINES FOR REPAIR OF DAMAGED FACINGS

1. Stained or discolored facings or restorations are cosmetic problems which are not covered, and must be paid for by the patient.

2. Cracked, chipped or missing facings:

   a) If the appliance can be rebuilt and/or rendered smooth and non irritating without being removed from the mouth, the patient should not be charged as this is a covered procedure.

   b) If the appliance must be removed in order to restore or establish function, this treatment is covered and the patient may be required to pay a fee according to the Group Benefit Profile.

   c) If the appliance was originally made under the program within three years, the patient cannot be charged.

C. GUIDELINES FOR ENDODONTIC TREATMENT

Goal

To perform Root Canal Therapy for patients who have demonstrated effective home care and a willingness to have the tooth restored.

Method

Root Canal Therapy will be performed if:

- The tooth is periodontally sound. If the tooth is periodontally involved, it must be determined that the periodontal situation can be reversed.
- The tooth can be restored to a functional level.
- The patient has previously demonstrated that he/she can maintain the tooth by maintaining an adequate level of oral hygiene.

D. GUIDELINES FOR ORAL SURGERY

Goal

To treat patients requiring oral surgery in the most effective and efficient manner, and thereby eliminate any present or future dental difficulties.

Method

Routine oral surgery is to be provided by the individual participating dentist.

Oral surgery may be referred to participating surgeons in the following situations:

- Surgery unable to be performed by the general practitioner due to inadequate facilities
- Procedure is beyond the scope of the general practitioner
- Patient whose medical condition requires special oral surgery care

To refer a surgical case, the participating dentist must:

1. Complete a Specialist Referral Form and send it to Healthplex for pre-authorization.
2. In the event of an emergency, you must call Healthplex for an authorization number. Acute situations should be handled at your discretion, providing we are notified as soon as possible.

E. GUIDELINES FOR PERIODONTAL TREATMENT

Goal

To render the mouth in a condition that will enhance the patient's ability to maintain their natural teeth. Approval of this service will be based upon factors that indicate that the treatment will have the highest probability of success as well as being indicative of intelligent economic planning.

Method

1. Perform a complete oral examination including a full series of x-rays; note any significant factors in the patient's medical history and fully chart the condition of the mouth including: existing prostheses, missing teeth, bone loss/pocketing and tooth mobility.
2. Prepare a comprehensive treatment plan including all other anticipated specialty referrals. Please submit a copy of this report with the appropriate referral forms.
3. Inform the patient about all adjunctive dental services necessary to support the periodontal therapy. The patient must agree to pay for those services which may not be covered. (The program DOES NOT cover periodontal splinting.) A disclosure form must be completed, signed and placed in the patient's file.
4. Provide initial periodontal therapy including: prophylaxis, scaling and root planing, and home care instruction.

   The patient must demonstrate his/her ability and desire to maintain oral hygiene for a period of six months.
5. After the completion of periodontal care, the responsibility for routine dental maintenance will revert to the general dentist.
6. Any extenuating circumstances requiring an exception to the above guidelines will be evaluated by a Healthplex dental consultant.

Upon completion of the above steps, submit a **Specialist Referral Form** (Section VII Administrative Reports & Forms).

NOTE:

TMJ cases are not covered and will not be considered for referral. Arthritis cases or other systemic illnesses also will not be eligible for treatment.

F. GUIDELINES FOR PROSTHETIC TREATMENT

Goal

To provide restorative services that best meet the patient's long term oral health needs. To this end, participating providers will consider the patient's ability to maintain proper oral hygiene and willingness to care for a prosthetic device.

Method

If the patient does not agree with your decision regarding prosthetic replacements, please submit a pre-authorization with the following information to Healthplex**:**

- Full mouth series (mounted)
- Chart missing teeth
- Chart pocket depth of abutment teeth
- State reason for replacement
- Describe need for replacement
- Indicate patient's oral hygiene history
- Indicate patient's past prosthetic experience

HEALTHPLEX WILL EVALUATE THE CASE AND INFORM YOU DIRECTLY OF ITS FINDINGS.

NOTE:

As with most dental plans, Healthplex programs cover the most economic treatment alternative that will satisfactorily restore a given condition. This means that intracoronal restorations are covered unless a crown is the only adequate option. Partials may be covered instead of fixed bridges if multiple edentulous areas or free end saddles exist in a given arch.

G. SPECIALIST REFERRAL FORM INSTRUCTIONS

This form should be used for emergency care as well as for specialist referrals and Healthplex co-payments. Please observe the treatment guidelines explained in this section and only refer those cases that are symptomatic and cannot be treated in your office.

FOR SPECIALIST SERVICES

1. Complete Section I of the form including the patient's signature.
2. Send the form to Healthplex with all necessary radiographs.
3. The form will be returned to you, and if the referral is approved, will include the name of a specialist in your area and if applicable, the member co-payment.
4. The member and the specialist will receive a copy of the referral form.
5. A copy of the form should be retained for your records. This protects you from being charged for non-authorized cases.

VII. MEDICARE

What is Medicare?

- Healthplex administers various Medicare Plans.
- Medicare is a health insurance program for members who are
  - 65 years or older, or;
  - Under 65, but who have certain disabilities or conditions.
- The Original Medicare Plan is offered to members through the Federal Government. This is a fee for service plan that eligible members belong to unless they choose coverage through a Medicare Health Plan.
- Medicare dental benefits are administered by Healthplex through various Medicare Health Plans. Members generally receive all their health benefits through the Plans, and the Plans contract with Healthplex for the dental services. Not all Medicare Health Plans include a dental benefit. But some that do, offer this benefit through Healthplex. The exact dental benefit administered by Healthplex varies by Plan.

Please refer to your Welcome Letter for details on Medicare plans you participate with.

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VIII. ADMINISTRATIVE REPORTS & FORMS

Monthly Roster

- Monthly rosters for providers with assigned members are available on the Healthplex website.
    - Includes member names, member ID numbers, and Group numbers.
    - Reflects all changes made during the previous month.

Encounter Forms

- Completed and submitted weekly to Healthplex by capitation providers for each treatment visit.
- Must include an entry for each service rendered.
- Encounter data may be submitted through the Healthplex web site or mailed to Healthplex.
- Information gathered from Encounter Forms is used to submit statistics to the plans, for auditing entities, and to determine rates for the following fiscal year.

Claim Forms

- Used for prior authorization and for reimbursement for fee for service plans.
- Healthplex claim forms or ADA claim forms may be used.
- See Claims section of this Manual for details on claim submission.

Specialist Referral Forms

- Used to refer any patient to a specialist. This includes referrals to in-house specialists.
- The referral must be authorized by Healthplex.

Request for Hospital Authorization

- A prior authorization with a narrative must be submitted to request hospital authorization.
- The narrative can be mailed to Healthplex / Hospital Authorization Unit or faxed to 516-228-1743.
- To be submitted to Healthplex by the treating dental provider.

HEDIS Eligible Member Listings

- A HEDIS eligible member is a child who is between 2 years old and 20 years old as of December 31st of the measurement year AND is enrolled for at least 11 months during the measurement year (December must be one of the 11 months).
- Lists of HEDIS eligible members assigned to a general dentist's office are available on the Healthplex website.
    - The list includes member name and contact information.
    - The list is a tool to be used by the office staff in contacting members to schedule appointments.

Direct Deposit Forms

- Used to arrange for reimbursements from Healthplex to be directly deposited into your account.
- Find out more by emailing Accounting@healthplex.com, by visiting www.healthplex.com, or by calling the Provider Hotline, 888-468-2183**,** option 3**.**
- **When changing your office TIN, please include a new Direct Deposit Form with your written notification.**

Web Site Registration Forms

- Used to register a provider user name and password for www.healthplex.com.
- Providers can use the Healthplex website to check member eligibility, claim status and prior authorization.
- Find out more by emailing WebSupport@Healthplex.com, by visiting www.healthplex.com, or by calling the Provider Hotline, 888-468-2183, option #3**.**
- **When changing your office TIN, please complete a new Web Site Registration Form with your written notification.**

TIN Change Forms

Along with written notification of TIN change, please include Healthplex form F-2357 “Substitute W9 Form”. Submit to Healthplex, Provider Relations, by faxing to 516-228-9571, or by emailing ProviderRelations@healthplex.com.

Sample Forms

For all necessary forms, please visit www.healthplex.com.

A. ADDITIONAL COMMUNICATIONS

Contract Amendments

- Written notifications from Healthplex specifying material changes to Participating Provider Agreements.
- These are legal documents and are part of your contract with Healthplex.

Provider Updates

- Written notifications from Healthplex to our dental providers to disseminate new or changed policies, procedures, or plans.
- Provider Updates are considered additions to this Manual and should be added to this manual as they are received by your office.

Provider Newsletters

- Quarterly communications including articles of interest to the dental community, local dental events, Healthplex reminders and regular features.
- These newsletters can be found on the Healthplex Provider Web Portal.

IX. QUALITY CONTROL

Quality Control Methods

Healthplex employs various methods to ensure quality control. Included are provider credentialing, site visits, and the use of forms.

Provider Credentialing

- Ensures that all providers meet the requirements established by the federal and state governments, the State Education and Licensing Department and the Health Plans regarding qualifications to provide dental services to patients.
- Healthplex follows the guidelines established by the National Committee for Quality Assurance (NCQA).

Encounter & Claim Forms

- Encounter and Claim forms submitted by our dental providers yield data on the type and quantity of dentistry being done at each site.
- Observed frequencies are compared to established norms. The office submitting statistics deviating from these norms is notified and the matter is referred to the Quality Management Department.

Specialist Referral Forms

- Specialist Referral Forms submitted by general dentists provide an analysis of the patients being referred out of the office to specialists.
- Analysis of these forms indicates the ratio of referrals to patients, and the nature of referrals.
- Those offices deviating from the pattern established by all providers are contacted for review.

Member Satisfaction Questionnaire

The purpose of the questionnaire is to elicit from plan members vital information pertaining to satisfaction levels, appointments, waiting times and service indicators.

Data from these questionnaires identifies:

- Timeliness of appointments.
- Recall effectiveness.
- Satisfaction levels.

Identified issues are addressed by Healthplex.

Provider Dental Satisfaction Survey

The purpose of the Provider Survey is to elicit information annually from our providers to determine their level of satisfaction with Healthplex administered plans and services.

Chart Reviews

- Chart reviews are performed to evaluate the diagnostic, preventive and restorative quality, type and frequency of services being rendered to Healthplex members.
- Random charts from offices are audited for diagnostic and other clinical service checks.
- Identified issues are addressed by Healthplex.

Site Visits

- Provider Relations Field Representatives evaluate all existing and prospective participating sites on the following criteria:
  - Cleanliness and proper sterilization techniques
  - Functional equipment in satisfactory condition
  - Accessibility of care both in timeliness of appointments and in access to the site
- Each office is evaluated initially and routinely thereafter.
- Site visits may be scheduled or unannounced.
- Spore testing of autoclaves is required on a weekly basis.

A. UTILIZATION MANAGEMENT

Utilization Management Program

A comprehensive program to determine medical necessity for health care services that are proposed, are currently being provided, or have already been provided based on standard clinical and/or utilization criteria.

The goal of the Healthplex Utilization Management program is to utilize healthcare benefit resources, improve medical appropriateness and monitor the quality of services provided. The program's objectives are to:

- Provide access to dental care services in the most appropriate and cost-efficient setting.
- Support providers to enhance patient care and/or access of services.
- Identify members considered "at risk" for incurring extensive health care expenses or requiring extensive and ongoing dental care for chronic or catastrophic illness to promote the most efficient use of available benefit resources.
- Reduce overall dental and healthcare expenditures by developing and implementing programs which encourage preventive health and dental care behaviors.

The program consists of the following components:

Prospective Review

Involves prior review and certification of services including, but not limited to, specialty care services, elective surgeries and selected dental treatments. It also includes review and certification of out-of-plan referrals.

Concurrent Review

Involves the ongoing review of the medical necessity of patient care. The review involves communication with the patient's dentist, chart review and communication with other health professionals involved in the patient's care. The review also involves discharge planning to ensure that services are available to meet the patient's home health planning needs.

Retrospective Review

Involves a review of medical records to make a coverage determination after services that have not been previously authorized have been rendered.

Technology Review

Involves the evaluation of new developments in equipment, dental devices, treatments, dental procedures, surgical procedures, pharmaceuticals and

clinical trials.

Scientific evidence and determinations from regulatory bodies are components of the review and form the basis for the decision-making.

Reconsideration of Adverse Determination

Involves a review of clinical data and criteria used in the determination when the member's dental care provider was not involved in the initial determination.

The review is conducted by the dental clinician who made the initial determination.

Appeal of a Denial or Limitation of a Dental Service

In any case where a health plan Member, or a Provider acting on behalf of a health plan Member, with the Member's consent, is not satisfied with the denial, termination or limitation of a dental service, as determined by Healthplex, he/she may file an Appeal. An Appeal received from a Provider without the health plan Member's written consent will not qualify as an Appeal and shall be deemed a dispute of payment of a claim. No health plan Member or Provider who files an Appeal to a Denial, Termination or Limitation of a dental service with Healthplex will be discriminated against and Healthplex will take no retaliation response to the filing of an Appeal to a Denial, Termination or Limitation of a dental service. The goal is to review and conduct all appeals in an expedited manner.

Appeal Procedure

- Healthplex shall establish and maintain a system for the resolution of appeals initiated by members or by providers, acting on behalf of a member and with the member's written consent, with respect to the denial, termination or other limitation of covered dental services ("Denial of Service"). This is referred to as utilization management determinations. Appeals received from a provider without a member's consent will not quality for this process and will be processed as a dispute of payment of claim.

- No member or provider who exercises the right to file an appeal will be subject to disenrollment or otherwise penalized solely due to such an appeal. At no time will Healthplex cease provision of services pending an appeal investigation.

Member Appeals may be oral or written to:

Healthplex, Inc.
Complaints and Appeals
333 Earle Ovington Blvd, Suite 300
Uniondale, NY 11553
Member Services at 1-888-468-2183

Overview of Program

The Utilization Review Program is designed to monitor the frequency and appropriateness of care received by enrollees through utilization reports.

These reports compare group norms to historical fee-for-service utilization/service patterns, and comparatively to similar provider utilization patterns.

The source document for the utilization report information is the patient encounter form or claim form, which is completed by the provider of services at each patient visit.

The data is compiled and reports are analyzed to determine service utilization patterns.

We cannot over-emphasize the importance of encounter data.

This data is the only means by which our client can track provision of services to their members who are assigned to capitated offices.

Once the above analysis is complete, the Utilization Management Committee determines whether a provider is in compliance with group performance standards.

Program Non-Compliance

Providers who are not in compliance undergo review by the Utilization Management Committee to determine the following:

- Reason for Non-Compliance
  - Circumstances beyond the provider’s control. (e.g. few visits that quarter lead to a low utilization rate, and provider has demonstrated appropriate outreach mechanisms).
  - Circumstances within the provider’s control. (i.e. provider providing fewer services to managed care recipients than other providers in the peer group, provider over utilizing adult fluoride treatment as compared to peer group, etc.).
- Need for a Corrective Action Plan

Corrective Action Plans

- Corrective Action Plans may include
  - On-site visits for chart review.
  - On-site visits for staff orientation.
  - Proof of outreach program. This may include demonstration of an active recall system, including written and/or verbal communication with the patient pool, patient education materials, etc.
  - Sanctions against provider – sanctions range from a warning to removal of the provider from the network. All sanctions are subject to the provider's right to due process and appeal.
  - Written statement from the provider outlining and/or confirming their plan to correct any issues.

X. PROBLEM SOLVING/TROUBLE SHOOTING

GOAL: **To provide a brief guide for handling common problems that may occur in the treatment of plan patients.**

IF….	**THEN…**
Patient does not accept your treatment plan	Send a pre-authorization form to Healthplex with an explanation of your diagnosis. We will consider your opinion in our determination.
Patient is not assigned to your office	Call Healthplex for verification eligibility and treatment authorization. **888-468-2183**
Patient is abusive in the office	Every provider is within their rights to turn away abusive members and refuse treatment. Please call Healthplex's Provider Services hotline at **888-468-2183** to report any incident and have the member reassigned to another office.
Rendering treatment before determination of prior authorization	Prior authorization is not required in order to render treatment. In the event that a Provider charges a member for treatment that was later approved by Healthplex, the Provider shall reimburse the member in full and accept payment in full from Healthplex. In the event that a Provider renders treatment for services that were later not approved by Healthplex, the member is considered "private pay" and the member is responsible for payment of treatment rendered. In the case of urgent treatment where Provider and Member decide to move forward with treatment without a prior authorization, Healthplex strongly recommends that Provider have Member sign off on a treatment plan with financial responsibilities in the event that treatment is not approved.
Patient does not seem to understand the way their Plan works regarding a particular issue or treatment	Please have the member contact Healthplex Member Services. This number can be found on the back of their ID cards or on the denial letter that they receive from Healthplex in the mail.

IF YOU SUSPECT THAT A PATIENT IS DISSATISFIED AND YOU CANNOT RECTIFY THE SITUATION ALONE, INFORM US OF THE PROBLEM SO THAT WE MAY ASSIST YOU.

XI. POLICIES & PROCEDURES

A. GENERAL REQUIREMENTS

Non-discrimination

- Healthplex providers agree to not discriminate in the treatment or quality of services provided to members on the basis of race, color, religion, sex, sexual orientation, age disability, national origin, Veteran's status, ancestry, health status or need for health services of such members and without regard to source or amount of payments made for health services rendered to such members.
- Providers will make their services accessible to health plan members during the same hours and with the same intensity as they do non-health plan members.

Federal and State Laws

- Provider agrees to comply with all applicable federal and state laws relating to nondiscrimination and equal employment opportunity, including the Civil Rights Act of 1964 (42 U.S.C § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R Parts 80 and 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, any applicable state anti-discrimination laws, and all rules and regulations issued hereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. Provider agrees to provide physical and program accessibility of dental services to persons with physical and sensory disabilities pursuant to Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by any applicable DHFS regulations (45 C.F.R. Part 84) of CMS regulation (42 C.F.R. Parts 417 and 434) and all guidelines and interpretations issued pursuant thereto.

B. PROVIDER RIGHTS & RESPONSIBILITIES

Channels of Communication

- Provider and Healthplex understand that in order to maintain a functional business relationship, open channels of communication are imperative between both parties.
- Provider agrees to comply with any of the following requests in a prompt manner:
  - Additional documentation for services rendered
  - Responses to grievances and appeals
  - Inquiries for additional information pertaining to a Member or Member's experience in their office
  - Any additional requests of which timing is a critical factor

Policies and Procedures

- Provider agrees to comply with any and all policies, rules and regulations of Healthplex including, but not limited to, claims processing, credentialing, quality or cost containment standards established by Healthplex and Plans. Provider agrees to refer patients that require covered specialty services (oral surgery, endodontics, prosthetics, periodontics and orthodontics, if covered through the Member's benefit plan in the applicable state) that Provider does not perform, only to dental specialists designated by Healthplex.

Amendment or Restated Agreement

- Healthplex may amend or restate the Provider Agreement by sending a copy of the amendment or restated agreement to the Provider at least 30 days prior to its effective date. If the Provider does not object to the amendment or restated agreement in writing within the 30-day notice period, then the Provider will have accepted the proposed amendment or restated agreement as of the end of the 30-day notice period. The Provider can object within the 30-day notice period, by providing written notice to Healthplex, then the parties shall confer in good faith to reach an agreement. If such agreement cannot be reached, Healthplex may terminate the Agreement.

Status Changes

- ♦ Provider understands that any and all changes in the provider's legal and contractual relationship must be communicated in writing to Healthplex.
- ♦ Provider also agrees to provide Healthplex with 30 days advance notice if: (1) their practice will be closed to additional members; or (2) if provider plans on moving or opening a new office location where he/she anticipates seeing members. Provider understands that Healthplex is under no obligation to maintain the existing contract with the provider at the new location.
- ♦ Follow the table below for appropriate office changes:

If…	**Then…**
A new practitioner is joining the practice	• Notify Provider Relations in writing, and Healthplex will provide your new practitioner with an application and agreement if applicable. *<u>Note:</u> Each practitioner must meet Healthplex's credentialing criteria prior to rendering services to health plan members.*
• A Practitioner leaves your practice, or • You are planning to move your office, or • You open a new location, or • You leave your current practice, or You change your Tax ID Number	• Notify Provider Relations in writing thirty (30) days prior to any change. *<u>Note:</u> For office location changes, Healthplex must approve the new location and reserves the right not to maintain the existing contract with the provider at the new location.*

By providing this information, you will ensure:

- ♦ That your practice is properly listed in all Participating Provider Directories to members, health plans, and regulatory agencies.
- ♦ All payments made to you or your associate(s) are properly reported to the Internal Revenue Service.
- ♦ That health plan members are notified in time to change their Primary Care Dentist, if they so desire as a result of the change, if applicable.

Panel Closures

General dentists may request that Healthplex close their panel to new members.

Provider Relations must be notified in writing and be given at least 30 days

advance notice of the requested closure date.

Provider/Member Communication

Appropriate Treatment: A determination by Healthplex that a particular course of treatment is not a covered service does not relieve the Provider from providing or recommending such care to Members as he/she deems to be appropriate, and that determination may not be considered to be a medical determination made by Healthplex.

Healthplex expects participating practitioners to communicate with each of their health plan members in the same manner and to the same extent that they would with any patient, consistent with ethical principles and good patient care.

Participating practitioners are free to advise their health plan patients of any particular decisions affecting their treatment in any way, and of any treatment recommendation or coverage decisions made by Healthplex. Practitioners may fully disclose their recommendations regarding a course of treatment or alternative courses of treatment regardless of whether such treatment may or may not be provided by the patient’s health benefit program. In the event the recommended course of treatment is not covered by the patient’s benefit plan, Healthplex expects participating practitioners to advise their patients accordingly.

This affirms Healthplex’s understanding of participating practitioners right to full and open disclosure to their patients of any information determined by them to be necessary and/or appropriate for the diagnosis and care of that patient.

Groups or Additional Offices

The following outlines the requirements for groups or additional offices:

If…	Then…
The dentists are practicing in a group setting	The minimum office hours apply to the group and not to the individual dentists.
The practitioner has more than one approved office	The number of hours from each approved location may be combined to meet the standard.

C. FRAUD, WASTE, ABUSE

Fraud, Waste and Abuse Prevention

Healthplex is committed to identifying and preventing fraud, waste and abuse involving dental benefits and services. The Healthplex Special Investigations Unit (SIU) is charged with maintaining a program to detect, investigate prevent, and recover the loss of corporate, government and customer assets resulting from fraudulent and abusive actions committed by providers, members, subcontractors and employees.

- Fraud: An intentional deception or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- Abuse: Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Plan or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes enrollee practices that result in unnecessary cost to the Plan.

Fraud may involve inappropriate treatment or poor quality of care, or the submission of false, misleading, or incomplete information. Fraud and/or abuse can occur in the following areas:

- Overcharging of fees
- Unbundling of services
- Improper coding
- Duplicate services or statements
- Unnecessary services
- Services not rendered

Participating providers are required to bill for services in accordance with plan covered benefits and the Healthplex billing guidelines located in this manual. Claims are routinely reviewed for appropriateness of care, coding violations, unusual billing or treatment patterns and fees charged. Duplicate services from claims previously submitted are automatically flagged and rejected by the claims system. Cases where fraud is suspected are referred to the Special Investigation Unit (SIU) for investigation and resolution. Questionable billing patterns and/or requests to change information submitted on a claim following a denial may require written verification by the provider.

If you suspect or identify fraud and abuse, please contact the Healthplex SIU at **1-516-542-2797**. SIU acts on referrals received from internal and external sources of potential fraud and/or abuse. You can also make a report directly to the state's CMS office.

Healthplex Billing Verification

Healthplex has a billing verification process in place for prevention of possible fraud, waste, and abuse. This program evaluates submission patterns and/or billing practices for appropriateness and compliance with expectations. Your office may receive a phone call or letter requesting information necessary for validation of a billing practice or claim amendment according to the below grid:

Change Requested	Verification Letter	No Verification Letter*	Notes
Provider submits request for payment – when should have been prior-authorization	✓		
Services submitted in error	✓		
Date or Code Change	✓		Affects benefit payout (eligibility, time limitation, maximum allowable, etc.)
Prosthetics	✓		Provider should bill upon date of completion (insertion) as based on plan guidelines.
Palliative Treatment on same date as other services	✓		Based on plan guidelines.
Unbundled Services	✓		Based on Healthplex/Provider agreement; for tracking purposes only.
Consultations to Comprehensive Oral Evaluations	✓		Based on plan guidelines.
Periodontal Scaling 4 Quads Performed on Same Date and/or changed	✓		Based on plan guidelines.

to separate dates to allow for payment, or Prophy changed to Perio Scaling or Full Mouth Debridement			
Incidental Date or Code change		✓	Does not affect benefit payout
Tooth # Changed		✓	
Dentist Refunds Money		✓	Cases not involving formal complaint investigations only. For tracking purposes only.

***Tracking – Verification Letter, Site Visit and/or Chart Audit only if pattern detected.**

Orthodontic Treatment – Orthodontists are allowed to submit claims for contracted amount regardless of actual dates of service. *Should a member file a complaint, they will be advised that offices are allowed to charge for the contracted amount not the specific dates of service. Once the office is paid for the 24 months of treatment, the office is responsible to complete the treatment.

Please respond to all verification requests expeditiously in order to minimize delays in claims processing and/or payment. Any inquiries regarding this process may be directed to the Verification Unit via mail, fax: 516-228-5026, or email: Verifications@Healthplex.com

D. MEMBER RIGHTS & RESPONSIBILITIES

Member Rights

- All members have the right to receive pertinent written and up-to-date information about Healthplex, the managed care services Healthplex provides, the participating dentists and dental offices, as well as member rights and responsibilities.
- All members have the right to privacy under federal law that protects health information and to be treated with dignity when receiving dental care, which is a private and personal service. Personal information is to be used as part of its regular business, such as payment for services.
- Members cannot be treated differently because of their race, color, national origin, age, religion, disability sex or sexual orientation.
- All members have the right to have decisions pertaining to their treatment based solely upon the appropriateness of care, service and existence of coverage.
- All members have the right to fully participate with caregivers in the decision making process surrounding their health care and to learn all the treatment choices in a clear language they understand.
- All members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
- All members have the right to voice a complaint against Healthplex, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the member's expectations.
  - Members can call Healthplex Customer Service at 1-800-468-9868.
- All members have the right to appeal any decisions related to patient care and treatment.
- All members have the right to get health care services in a language they can understand in a culturally sensitive way.
- All members have the right to receive emergency care when and where it is needed.

Member Responsibilities

- All members have the responsibility to provide, to the best of their abilities, accurate information that Healthplex and its participating dentists need in order to provide the highest quality of health care services.
- All members have the responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.

E. HIPAA & PRIVACY REGULATIONS

HIPAA & Privacy Regulations

Healthplex providers must comply with all requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information, and agree to cooperate with Healthplex in its efforts to ensure compliance with the privacy regulations put forth under HIPAA and other related privacy laws.

HIPAA and related privacy laws require that providers safeguard member Protected Health Information (PHI) in such administrative activities as claim submission, record keeping, and sharing of member information. Providers must take care to share member information only with entities who have the authority to receive such information, and only with those individuals who need access to such information in order to conduct processes such as treatment, payment, and health care operations.

Please refer to your Healthplex Provider Agreement for detailed HIPAA and privacy information and related requirements.

F. PROVIDER RIGHTS & RESPONSIBILITIES

Provider Rights & Responsibilities

- Establish a "dental home" for enrollees beginning at age one.
- Communicate with patients regarding existing oral conditions and dental treatment options.
- Recommend a course of treatment to a patient, even if the course of treatment is not a covered benefit.
- Supply accurate, relevant, factual information to a patient and Healthplex in connection with an appeal or complaint filed by the member.
- Object to policies, procedures, or decisions made by Healthplex, Inc. that are in conflict with their own opinions or beliefs.
- Expect reimbursement for services rendered and approved within 45 days of submission of all clean claims (Fee for Service Providers - paper claims) and within 30 days (Fee for Service Providers – electronic claims).
- Expect capitation payments by the 15th of the subsequent month. (Capitation Providers)
- Notify the member in writing and obtain member's signature if the dentist intends to charge the patient for such services not approved by Healthplex or covered by the program.

G. APPOINTMENT AVAILABILITY

Purpose & Goal

Purpose - To insure that all subscribers are seen by participating providers in a timely manner.

Goal – Members are to have reasonable access to a panel provider.

Patient wait time in the office should be less than 45 minutes.

Standards

Patient Situation	Examples	Timeframe for Appointment
Urgent/Emergency Care	Pain, swelling, bleeding	Within 24 hours of request
Routine	Routine exam, cleaning	Within four weeks of request (or 28 calendar days)

Survey Procedure

Healthplex Provider Relations staff annually calls provider offices as if they are members making an appointment.

If the appointment given meets the above standards, the provider office has passed the survey.

If the appointment given is outside the above standards, the provider office has failed the survey.

Survey Failures

A written notification regarding the failure is sent to the provider office. The notification may require the provider to submit a written Corrective Action Plan (CAP).

Subsequent failures may result in the following actions:

- An office may need to submit a Corrective Action Plan outlining the steps the office will take to ensure timely appointments are given;
- An office may be closed to new patients until the office is able to accommodate new patients in the timeframe established;
- A Healthplex-initiated Corrective Action Plan may be implemented;
- The office could be terminated from participation with Plan(s).

H. AFTER HOURS SURVEY & PLAN PARTICIPATION CALLS

After Hours Survey

Purpose – To ensure members have access to care 24 hours a day, 7 days a week.

Survey calls are made annually after normal business hours to verify that providers are either available to take patient calls or have a mechanism in place to direct patients appropriately on how to obtain emergency care 24 hours a day, 7 days a week.

Acceptable mechanisms include an answering machine with an outgoing message giving a telephone number and/or directions on how to reach the provider, or an answering service that will contact the provider in an emergency, or direct the patient to call the Healthplex Customer Service number 1-800-468-9868.

After Hours Survey Failures

A written notification regarding the failure is sent to the provider office. The notification may require the provider to submit a written Corrective Action Plan (CAP).

Subsequent failures may result in the following actions:

- An office may need to submit a Corrective Action Plan outlining the steps the office will take to ensure members have access to care 24 hours a day, 7 days a week;
- An office may be closed to new patients until the office is able to have acceptable mechanisms in place;
- A Healthplex-initiated Corrective Action Plan may be implemented;
- The office could be terminated from participation with Plan(s).

Plan Participation Calls

Purpose – To ensure provider office staff is knowledgeable about the Healthplex Plans for which they participate.

Calls are made to ascertain whether the provider office staff answering the phone recognize the Plan(s) with which they participate.

Education on Plan participation and follow up information is provided when necessary. Provider education calls or site visit orientations may be scheduled on a periodic basis to further promote an understanding of the Plans.

I. PANEL PARTICIPATION

Information Requests

Providers request information regarding Healthplex Plans.

If there is a network need, the following information is sent in response:

- Dentist Personal Profile (Credentialing Application)
- Fee Schedules/Rates
- Office Update Form
- W-9 Information
- Contracts/Agreement

All paperwork is to be filled out, signed, and returned to Healthplex promptly for processing.

If there is no network need at the time of the Information Request, written notification will be sent to the provider. The provider's information and interest will be kept on file for future reference.

Credentialing Summary

Purpose – To maintain a provider panel that meets NCQA Guidelines

- All dentists treating Healthplex patients as participating providers must be credentialed.
- Providers must be credentialed prior to panel placement.
- At a minimum of every three years, every participating dentist must be recredentialed and continue to meet guidelines.
- Additionally, the office must pass the on-site visit by a Healthplex Field Representative.

Providers will be notified of the credentialing outcome in writing.

Panel Placement

Panel Placement will occur when the provider is successfully credentialed and a favorable site visit is completed. Providers will receive a Welcome Packet including the necessary information for their office, such as:

- Plan information
- Reimbursement information
- Encounter/Claim Forms
- Specialty Referral Forms, as applicable

J. TERMINATION FROM PLAN PARTICIPATION

Panel Participation Terminations

Participation terminations initiated by Healthplex conform to the applicable contracts and state insurance laws.

Types of Terminations

Automatic terminations include, but are not limited to:

- Loss of license
- Final disciplinary action by a governmental agency or licensing board that impairs the practitioner's ability to practice
- Conviction of fraud
- Insolvency or Dissolution
- Practitioner's death
- Determination of imminent harm to patient

No hearings are required to be offered for automatic terminations.

Terminations for cause include, but are not limited to:

- Failure to comply with Healthplex Quality Assurance Program
- Failure to comply with credentialing criteria
- Unsatisfactory site visit
- Consistent below-average utilization reporting
- Failure to comply with Healthplex and/or State access and availability requirements

Hearings are offered for terminations for cause.

Non-renewal of Practitioner Agreement:

- All contracts are effective either from the date specified on Page 1 of the Agreement and continue in effect until the first anniversary or the date listed on the Welcome Letter.
- The Agreement is automatically extended for successive one-year periods unless either party notifies the other that it elects not to renew upon 60 days' written notice prior to the renewal date.

No hearings are required to be offered for non-renewals.

Transition Period

Transition care is used to assist members and to provide continuity of care for patients who are currently undergoing treatment. Practitioners are advised in the termination notice that they must complete any dental work in progress before the termination date. Any exceptions must be approved, in advanced, by

Healthplex.

K. SITE VISITS

Purpose & Goal

Purpose: To maintain and ensure safe patient dental care for Healthplex members.

Goal: To minimize medical liability issues for participating panel providers.

Policy

Routine site visits for participating offices will be performed.

The visit provides the office with an independent objective assessment of how the office is adhering to state and federal (ADA, OSHA) guidelines.

Site Visits

Visits will generally be scheduled in advanced.

The office will be inspected for cleanliness, sterilization techniques, safety and overall office features using the Facility Review Tool.

Selected charts will be reviewed using the Record Review Tool.

Prior to leaving the participating provider's office, the site visit representative will review with the provider or office manager the results of the site visit. A follow up letter will be sent to the office covering any quality improvement findings as appropriate.

Follow up visits and visits due to complaints or quality issues may be unannounced.

Site Visit Deficiencies

When deficiencies are reported, the office is again notified through written correspondence of these deficiencies. A timeline will be given for the participating provider's office to perform corrective action to remedy the deficiencies. A follow up site visit will be done to verify remediation of the deficiencies. The site visit could be either scheduled or unannounced.

Immediate panel termination will occur if serious deficiencies are found that are deemed imminent harm to patient care, e.g., sterilization.

For one or more less serious deficiencies or for repeated non-corrective action on the part of the participating provider, panel termination is at the discretion of Healthplex management.

L. PROVIDER COMPLAINTS AND GRIEVANCES

Purpose & Goal

Purpose: To respond to provider complaints and grievances in a timely and fair manner.

Goal: To resolve provider complaints and grievances fairly and in a manner consistent with Healthplex policies.

Procedure

Providers can file complaints and grievances in writing:

- ProviderRelations@healthplex.com

- Healthplex
  333 Earle Ovington Boulevard; Suite 300
  Uniondale, NY 11533-3608
  Attention: Director, Provider Relations
  Provider Grievance

Please include all pertinent information and supporting documentation. Missing information will extend the time period in which complaints and grievances can be resolved.

Provider complaints and grievances will be acknowledged within 15 calendar days.

Determination letters will be sent within 45 calendar days from date of receipt of complaint or grievance, or from date of receipt of all pertinent information and supporting documentation.

Providers are not penalized for filing complaints and grievances.