Subpart 3. Managed Care for Physical and Basic Behavioral Health

Chapter 21. Dental Benefits Prepaid Ambulatory Health Plan

§2101. General Provisions

A. Effective May 1, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing shall adopt provisions to establish a comprehensive system of delivery for dental services covered under the Medicaid Program. The dental benefits plan shall be administered under the authority of a 1915(b) waiver by implementing a prepaid ambulatory health plan (PAHP) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. All Medicaid recipients that are receiving dental services through the fee-for-service system will receive dental services administered by a dental benefit plan manager (DBPM).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:784 (April 2014).

§2103. Participation Requirements

A. In order to participate in the Medicaid Program, a DBPM must be a successful bidder, be awarded a contract with the department, and complete the readiness review.

B. A DBPM must:

1. meet the federal definition of a PAHP as defined in 42 CFR §438.2;

2. have a license or certificate of authority issued by the Louisiana Department of Insurance to operate as a Medicaid risk bearing "prepaid entity" pursuant to R.S. 22:1016 and submit with the proposal response;

3. have a certificate from the Louisiana Secretary of State, to conduct business in the state;

4. meet solvency standards as specified in federal regulations and title 22 of the *Louisiana Revised Statutes*;

5. have a network capacity to enroll a minimum of 1,288,625 Medicaid members into the network;

6. is without an actual or perceived conflict of interest that would interfere or give the appearance of impropriety or of interfering with the contractual duties and obligations under this contract or any other contract with DHH, and any and all applicable DHH written policies. Conflict of interest shall include, but is not limited to, the contractor serving, as the Medicaid fiscal intermediary contractor for DHH;

7. is awarded a contract with DHH, and successfully completed the readiness review prior to the start date of operations; and

8. have the ability to provide core dental benefits and services to all assigned members on the day the Dental Benefits Program is implemented.

C. A DBPM shall ensure the provision of core dental benefits and services to all eligible enrollees when the Dental Benefit Program is implemented.

D. Upon request by the Centers for Medicare and Medicaid Services, the Office of Inspector General, the Government Accounting Office, the department or its designee, a DBPM shall make all of its records pertaining to its contract (services provided thereunder and payment for services) with the department available for review, evaluation and audit. The records shall include, but are not limited to the following:

1. pertinent books and documents;

2. financial records;

3. dental records and documents; and

4. provider records and documents involving financial transactions related to the contract.

E. A DBPM shall maintain an automated management information system that collects, analyzes, integrates, and reports data that complies with department and federal reporting requirements.

F. A DBPM shall obtain insurance coverage(s) as specified in the terms of the contract. Subcontractors, if any, shall be covered under these policies or have insurance comparable to the DBPM's required coverage.

G. A DBPM shall provide all financial reporting as specified in the terms of the contract.

H. A DBPM shall be subject to a retainage of 10 percent from all billings under the contract as surety for performance as specified in the terms of the contract during the life of the contract.

I. In the event of noncompliance with the contract and the department's guidelines, a DBPM shall be subject to the sanctions specified in the terms of the contract including, but not limited to:

1. corrective action plans;

2. monetary penalties; or

3. suspension and/or termination of the DBPM's contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:784 (April 2014).

§2105. Prepaid Ambulatory Health Plan Responsibilities

A. The DBPM shall be responsible for the administration and management of its requirements and responsibilities under the contract with the department and any and all department issued guidance. This includes all subcontracts,

employees, agents and anyone acting for or on behalf of the DBPM.

1. No subcontract or delegation of responsibility shall terminate the legal obligation of the DBPM to the department to ensure that all requirements are carried out.

B. A DBPM shall possess the expertise and resources to ensure the delivery of dental benefits and services to members and to assist in the coordination of covered dental services, as specified in the terms of the contract.

C. A DBPM shall have written policies and procedures governing its operation as specified in the contract and department issued guidance.

D. A DBPM shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status or need for dental services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

E. A DBPM shall be required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered dental services as specified in the terms of the contract.

F. The DBPM shall establish and implement a quality assessment and performance improvement program as specified in the terms of the contract and department issued guidance.

G. A DBPM shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract and department issued guides.

H. The DBPM must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The DBPM shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid programs as well all requirements set forth in the contract and department issued guidance.

I. A DBPM shall collect data on enrollees and provider characteristics and on services furnished to members through an encounter data system as specified in the contract and all department issued guidance.

J. A DBPM shall be responsible for conducting routine provider monitoring to ensure:

1. continued access to dental care for eligible Medicaid recipients; and

2. compliance with departmental and contract requirements.

K. A DBPM shall not engage the services of a provider who is in non-payment status with the department or is excluded from participation in federal health care programs (i.e., Medicare, Medicaid, CHIP, etc.).

L. Dental records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

M. The DBPM shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The DBPM shall submit provider manuals and provider directory to the department for approval prior to distribution, annually and subsequent to any revisions.

a. The DBPM must provide a minimum of 60 days' notice to the department of any proposed material changes to the member handbooks and/or provider manuals.

b. After approval has been received from the department, the DBPM must provide a minimum of 30 days' notice to the members and/or providers of any proposed material changes to the required member education materials and/or provider manuals.

N. Member education materials shall include, but not be limited to:

1. a welcome packet including, but not limited to:

a. a welcome letter highlighting major program features and contact information for the DBPM; and

b. a provider directory when specifically requested by the member (also must be available in searchable format on-line);

2. member rights and protections as specified in 42 CFR §438.100 and the DBPM's contract with the department including, but not limited to:

a. a member's right to change providers within the DBPM;

b. any restrictions on the member's freedom of choice among DBPM providers; and

c. a member's right to refuse to undergo any dental service, diagnoses, or treatment or to accept any service provided by the DBPM if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

3. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the DBPM or the department including, but not limited to reporting to the department's Medicaid Customer Service Unit if the member has or obtains another health insurance policy, including employer sponsored insurance; and

4. the amount, duration, and scope of benefits available under the DBPM's contract with the department in sufficient detail to ensure that members understand the benefits to which they are entitled, including, but not limited to:

a. information about oral health education and promotion programs;

b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

c. how members may obtain benefits, including emergency services, from out-of-network providers;

d. the policy on referrals for specialty care; and

e. the extent to which, and how, after-hour services are provided;

5. information to call the Medicaid Customer Service Unit toll free telephone number or visit a local Medicaid eligibility office to report changes in parish of residence, mailing address or family size changes;

6. a description of the DBPM's member services and the toll-free telephone number, fax telephone number, e-mail address and mailing address to contact DBPM's member services department;

7. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English, Spanish and Vietnamese; and

8. grievance, appeal and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and in the DBPM's contract with the department.

O. The provider manual shall include but not be limited to:

1. description of the DBPM;

2. core dental benefits and services the DBPM must provide;

3. emergency dental service responsibilities;

4. policies and procedures that cover the provider complaint system. This information shall include, but not be limited to:

a. specific instructions regarding how to contact the DBPM to file a provider complaint; and

b. which individual(s) has the authority to review a provider complaint;

5. information about the DBPM's grievance system, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;

6. medical necessity standards as defined by DHH and practice guidelines;

7. practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

8. primary care dentist responsibilities;

9. other provider responsibilities under the subcontract with the DBPM;

10. prior authorization and referral procedures;

11. dental records standards;

12. claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;

13. DBPM prompt pay requirements;

14. notice that provider complaints regarding claims payment shall be sent to the DBPM;

15. quality performance requirements; and

16. provider rights and responsibilities.

P. The provider directory for members shall be developed in two formats:

1. a hard copy directory for members and, upon request, potential members; and

2. a web-based online directory for members and the public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:784 (April 2014).

§2109. Benefits and Services

A. Core benefits and services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to enrollees under the Louisiana Medicaid state plan.

1. *Core benefits and services* shall be defined as those oral health care services and benefits required to be provided to Medicaid eligible individuals as specified under the terms of the contract and department-issued guides.

B. The following is a summary listing of the core dental benefits and services that a DBPM is required to provide:

1. diagnostic services which include oral examinations, radiographs and oral/facial images, diagnostic casts and accession of tissue—gross and microscopic examinations;

2. preventive services which include:

a. prophylaxis;

b. topical fluoride treatments;

c. sealants;

d. fixed space maintainers; and

e. re-cementation of space maintainers;

3. restorative services which include:

a. amalgam restorations;

b. composite restorations;

c. stainless steel and polycarbonate crowns;

d. stainless steel crowns with resin window;

e. pins, core build-ups, pre-fabricated posts and cores;

f. resin-based composite restorations;

g. appliance removal;

h. unspecified restorative procedures; and

i. ancillary medical services;

4. endodontic services which include:

a. pulp capping;

b. pulpotomy;

c. endodontic therapy on primary and permanent teeth (including treatment plan, clinical procedures, and follow-up care);

d. apexification/recalcification;

e. apicoectomy/periradicular services;

f. unspecified endodontic procedures; and

g. organ transplant-related services;

5. periodontal services which include:

a. gingivectomy;

b. periodontal scaling and root planning;

c. full mouth debridement; and

d. unspecified periodontal procedures;

6. removable prosthodontics services which include:

a. complete dentures;

b. partial dentures;

c. denture repairs;

d. denture relines; and

e. unspecified prosthodontics procedures;

7. maxillofacial prosthetics services which include fluoride gel carrier;

8. fixed prosthodontics services which include:

a. fixed partial denture pontic;

b. fixed partial denture retainer; and

c. other unspecified fixed partial denture services;

9. oral and maxillofacial surgery services which include:

a. non-surgical extractions;

b. surgical extractions;

c. coronal remnants extractions;

d. other surgical procedures;

e. alveoloplasty;

f. surgical incision;

g. temporomandibular joint (TMJ) procedure;

h. other unspecified repair procedures;

i. durable medical equipment and certain supplies;

10. orthodontic services which include:

a. interceptive and comprehensive orthodontic treatments;

b. minor treatment to control harmful habits; and

c. other orthodontic services; and

11. adjunctive general services which include:

a. palliative (emergency) treatment;

b. anesthesia;

c. professional visits;

d. miscellaneous services; and

e. unspecified adjunctive procedures.

NOTE: This overview is not all inclusive. The contract, policy transmittals, approved Medicaid State Plan, regulations, provider bulletins, provider manuals, published fee schedules, and guides issued by the department are the final authority regarding services.

C. The core benefits and services provided to the members shall include, but are not limited to, those services specified in the contract policy transmittals, approved Medicaid state plan, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

D. Excluded Services. The DBPM is not obligated to provide for services that are experimental, non-FDA approved, investigational, or cosmetic and are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid director, in consultation with the Medicaid dental director, may consider authorizing services at his/her discretion on a case-by-case basis.

E. Utilization Management

1. The DBPM shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review and service authorization, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM shall submit an electronic copy of the UM policies and procedures to DHH for written approval within thirty calendar days from the date the contract is signed by the DBPM, but no later than prior to the readiness review, annually thereafter, and prior to any revisions.

2. The UM Program policies and procedures shall meet all Utilization Review Accreditation Commission (URAC) standards or equivalent and include medical management criteria and practice guidelines that:

a. are adopted in consultation with a contracting dental care professionals;

b. are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field;

c. are considering the needs of the members; and

d. are reviewed annually and updated periodically as appropriate.

3. The policies and procedures shall include, but not be limited to:

a. the methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services;

b. the data sources and clinical review criteria used in decision making;

c. the appropriateness of clinical review shall be fully documented;

d. the process for conducting informal reconsiderations for adverse determinations;

e. mechanisms to ensure consistent application of review criteria and compatible decisions;

f. data collection processes and analytical methods used in assessing utilization of dental care services; and

g. provisions for assuring confidentiality of clinical and proprietary information.

4. The DBPM shall disseminate the practice guidelines to all affected providers and, upon request, to members. The DBPM shall take steps to encourage adoption of the guidelines.

5. The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:

a. the vendor must be identified if the criteria were purchased;

b. the association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;

c. the guideline source must be identified if the criteria are based on national best practice guidelines; and

d. the individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the DBPM dental director or other qualified and trained professionals.

6. UM Program dental management criteria and practice guidelines shall be disseminated to all affected providers and members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

7. The DBPM shall have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or healthcare provider when requested. The procedures shall outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.

8. The DBPM shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the DBPM may deny authorization of the requested service(s).

9. The DBPM shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.

10. The DBPM shall use the department's definition of medical necessity for medical necessity determinations. The DBPM shall make medical necessity determinations that are consistent with the department's definition.

11. The DBPM shall submit written policies and processes for DHH approval, within thirty calendar days, but no later than prior to the readiness review, of the contract signed by the DBPM, on how the core dental benefits and services the DBPM provides ensure:

a. the prevention, diagnosis, and treatment of health impairments;

b. the ability to achieve age-appropriate growth and development; and

c. the ability to attain, maintain, or regain functional capacity.

12. The DBPM must identify the qualification of staff who will determine medical necessity. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

13. The DBPM shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

14. The individual(s) making these determinations shall have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

15. The individual making these determinations is required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.

16. The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The DBPM shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR 438.210.

17. The DBPM shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

18. The DBPM shall report fraud and abuse information identified through the UM program to DHH's Program Integrity Unit.

19. In accordance with 42 CFR §456.111 and 456.211, the DBPM utilization review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this Section. This information must include, at least, the following:

a. identification of the enrollee;

b. the name of the enrollee's dentist;

c. date of admission and dates of application for, and authorization of, Medicaid benefits if application is made after admission;

d. the plan of care required under 42 CFR 456.80 and 456.180;

e. initial and subsequent continued stay review dates described under 42 CFR 456.128, 456.133; 456.233 and 456.234;

f. date of operating room reservation, if applicable; and

g. justification of emergency admission, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:786 (April 2014).