Quality Plan Administrators, Inc.
Provider Manual

202.722.2744

www.qualityplanadmin.com

Provider Manual
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Section A

Introduction

Under its Utilization Management Program, Quality Plan Administrators, Inc. considers only necessity, appropriateness, and covered status of care requested. QPA, Inc. has no incentive to deny or reduce coverage or a request for service. QPA, Inc. has no financial incentive to underutilize covered services to participating members.

Introduction

A-1 Historical Summary of Quality Plan Administrators Inc. (QPA)

Quality Plan Administrators Inc. was established in 1986 and has successfully administered Dental and Vision care plans in both correctional institutions, as well as municipal governments since 1989. QPA has successfully administered the dental and vision care plans for the DC Government non-union employees for the period 1993 to 1996 after which the program was curtailed due to the lack of finding. More importantly, QPA has successfully administered the dental and vision plans to MCO Medicaid organizations since 1996 when these plans were first implemented.

Both principals in our company, Milton Bernard and Alphonzo Davidson are Dentists, Oral and Maxilofacial Surgeons (Board Certified), practicing in the community serving the Medicaid recipients, past presidents of the Robert T. Freeman Dental Society (the Local Organization of the National Dental Association), among other things. Almost every gain that has been made in respect to dental care *for* the indigenous population, as well as the dentists who have traditionally carried the burden for rendering care to the underprivileged (primarily Black and Latino) has been as a result of personal and organizational efforts promulgated by these two individuals.

QPA has hosted and significantly supported MAA in their efforts to increase the fees in order to expand the care to these long suffering communities who had never been accepted in the majority community of dentists or dental chains. Eventually, MAA was successful with increasing reimbursement to dentists rendering care to the poor.

QPA remains committed to providing a much needed support system to organizations who, in addition to making a reasonable honest profit share, maintains the commitment to providing comprehensive dental health care service to the poor, the homeless and the disenfranchised in a culturally competent manner.

A-2 Our Mission

Our mission is to provide a high level of quality dental and optical care while educating our patients. Our mission also embraces the concept of expanding the level of consciousness of not on only the recipients of care but also all agencies and organizations related to the provision of dental benefits regarding the significant impact that the lack of dental care has on the medical well being of patients. This is particularly true for patients of lower income levels who traditionally have increased risk factors.

A-2.1 Our Vision

Our vision is to assist in the formation of a cohesive amalgam of agencies and organizations that provide a unified front *of* Government, Corporations, private practices, hospitals and schools to combat the often neglected disease processes among the poor for the common good of our society. This would include expanded preventive and corrective care of pregnant women, obese diabetics, at risk cardiovascular diseased patients, immuno-suppressed patients all of whom are impacted by poor dental conditions and who require services above and beyond the norm.

A-3 Our Services and Providers

QPA has been associated with the positive growth of every MCO with which it has been associated over a span of eleven years. QPA's network of practitioners, provide a wide array of dental services, to include: preventive, interceptive, periodontal, general orthodontic, oral surgical and hospital care whenever necessary. There is no need for cumbersome referral policys, although the referral program exists, since a patient has the option to select a specialist at will from the network directory.

QPA maintains educational material and reporting systems that have consistently met MAA requirements. QPA has a high quality customer service support system and the most comprehensive network of providers for Medicaid and Alliance programs in the District of Columbia. QPA is currently involved in the process of expanding the Medicaid network into the adjacent states, i.e. Maryland and Virginia.

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

Section B

General Information

B-1 **Reference Contact Information**

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

Claims Customer Services	(202) 202-722-2744 or (800) 900-4112

QPA has expanded customer services for the convenience of not only providers but also members seeking information. Our hours for direct customer service contact extend from 8:00 a.m. to 6:00 p.m. Monday through Friday.

In addition our institutional providers, i.e. Children's hospital, Howard University Hospital and the Washington Hospital Center all have 24 hour emergency services which afford access to our members for after hour and weekend problems encountered by eligible members.

Our organization also honors encounter visits to George Washington University Hospital and other agencies outside of our network at the compensation levels that would be tendered to our in network providers when necessary.

With the advent of our conversion into a windows based electronic system on, electronic fax response programs, as well as an interactive voice response system have added to our customer/provider services program. These have significantly reduced the need for direct interaction with personnel to receive eligibility authorization as well as historical data for unlimited patients at a time.

B-2 Interpreter Services

Our organization has, and utilizes, employees who are fluent in English, Spanish, French, Haitian Creole and Amharic.

In the event that additional interpreter services are required, QPA will utilize the service currently utilized by the Medicaid Department, or the MCO's that we support.

Section C

Specialist Dental Providers

C-1 Becoming a QPA Provider

To become a participating QPA Provider, you must:

- Meet the credentialing requirements outlined below
- Be reviewed and approved by the QPA Credentialing Committee
- Have an executed contractual agreement with QPA
- Be willing to collaborate with QPA in coordinating and optimizing the delivery and quality of dental care to our patients
- . Provide proof of specialty training

C-2 Role of the Dental Network Practitioners

The dental network practitioner agrees to provide care to network enrollees within the scope of services and parameters of care afforded by individual plans administered by QPA. There may be variances in scope as well as compensation among the plans administered by QPA. It is advisable to study the protocols for each plan. It is understood that providers will provide in writing risk factors associated with all services they performed. This informed consent must be provided by either the patient or guardian by their signature on the form provided by the practitioner. It is the responsibility of the provider to be sure that the patient understands the risks and be given information about alternative care if it exist. The provider must also be qualified to treat the complications of the procedures performed by them by virtue of their training

C-2.1 Role of the Specialist Dental Provider

Every specialist dental provider on our network must meet the minimum credentialing requirements, specified by the DC Board of Dental Examiners and the American Dental Association. This generally means that an individual has graduated from a certified educational program and has met the requirement for Board Eligibility or Board Certification in a branch of dentistry recognized by the American dental association as a specialist. The provider will render specialized care that is designed to enhance the total care of an individual that exceeds the usual training afforded a general practitioner.

C-3 Provider Rights and Responsibilities

C-3.1 All Dental Practitioners

Practitioners and Providers shall facilitate advance directives for individuals as defined in 42 C.F.R 489.100, a written instruction, such as a living will or durable power of attorney for health care recognized under District of Columbia law (whether statutory or as recognized by the courts of the District) relating to the provision of health care when the individual is incapacitated. Practitioners and Providers can receive information about procedures for advance directives from Caring Connections, 1-800-658-889, www.caringinfo.org.

C-3.2 General Dentists

1. Examine patients and develop a treatment plan that falls within the scope of acceptable care as outlined by the ADA for his or her patients.

2. Although a procedure may fall outside of the benefit structure for the plan coverage, the provider should, nevertheless recommend the appropriate care to the patient.

3. At all times, recommend procedures that are appropriate and fall within the code of behavior advocated by the Board of Dental Examiners for the District of Columbia. Have the right to appeal denials to QPA and while doing so, inform the patient. Appeals also extend to credentialing denials.

C-3.3 Specialists

1. Specialists must be appropriately credentialed by the American Dental Association in order to promote themselves or limit their practices under this classification.

2. All the above criteria obtain to specialists

3. Have the right to appeal to a body consisting of their peers.

C-4 Health Insurance Portability and Accountability Act (HIPAA)

C-4.1 Medical Records HIPAA Issues

QPA is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects that its practitioners and providers are familiar with their responsibilities under the HIPAA and take all necessary action to fully comply. Any member record containing clinical, social, financial, or any other data on a QPA member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure. To maintain these standards, Practitioners should ensure that the following Standards for Availability, Confidentiality and Organization of Dental Records are met.

Practitioners' Dental records are to be maintained in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Practitioner offices are to have an organized dental record filing system that facilitates access and availability of records at all times.

The following elements should be in place:

- A designated staff-person qualified by training or experience, which has oversight of and access to the medical records storage system (paper or electronic system).
- The Office has a policy that includes the manner, in which the dental record is organized, the content of the medical record and the manner in which it is filed.
- If the practitioner has several offices, there is a system to obtain records from one office to another if a patient is seen at several office locations.
- Records for patients who have not been seen by the practitioner for a period of time may be stored off site and are easily accessible if the patient should return.
- The office implements and maintains procedures for maintaining and safeguarding the confidentiality of member dental records and treatment in accordance with applicable federal and state law.
- QPA and provider agree, that they will not divulge information, with an enrollee's employer or any outside agency without the members consent.
- Our providers must agree to act in accordance and comply with the provisions of HIPAA.
- . QPA reserves the right to inspect records on both announced and unannounced visits

C-4.2 Release of Dental Records

A member has the right to review a copy of his/her dental records. A written authorization from the member or responsible party is required for the release of dental records. The authorization should include the following:

- Name of the institution/Practitioner that is to release information
- Member's full name
- Member's address
- Member's date of birth
- Description of type of information to be released (including dates of services)
- Date consent is signed
- A statement with respect to the Patients rights with respect to the release of psychotherapy notes if applicable
- A statement advising the member that they can revoke their authorization at any time

Copies of dental records should be released promptly upon written request and reasonable notice from the member or their representative. After the authorized release of dental record copies, the written authorization should be retained in the member's original dental records.

C-4.3 Report suspected waste, fraud and abuse to the appropriate agency

Issues involving QPA patients can be reported to the Customer Service Department or Grievance Coordinators for initial review. The process for reporting to official agencies will be supervised by the Compliance Officer or Risk Manager. Additionally, QPA shall ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

C-4.4 Understand your billing practices

Be diligent in supervising and training your billing personnel. It is your responsibility to ensure compliance with billing guidelines and regulations. Upcoding, unbundling, billing for phantom patients, and billing for services that have not been performed could be found to be fraudulent practices and may be forwarded to the appropriate legal entity for review. Underutilization of services might constitute fraud in a capitated network. Each member should be seen by his or her Dental Care Practitioner at least once a year; if only for preventative screenings.

C-4.5 Report suspected child abuse or neglect

Suspected abuse and/or evidence of abuse or neglect must be reported to the Child Protection Services Division of the DC Department of Human Services and/or the Metropolitan Police department. The Child Abuse and Neglect Reporting Hotline – for District referrals is **(202) 671 SAFE (202) 671-7233**. Appropriate referrals for case management and other social agencies should also be initiated.

C-4.6 Implement HIPAA Practitioner provisions

QPA is a HIPAA compliant company. It is essential that you understand the impact of this act on your practice.

Section D

Eligibility Verification, Authorization and Referral Procedures

D-1 Eligibility Criteria

Member Eligibility — Who Is Eligible:

Any patient who has met the eligibility requirements of the three Medicaid MCO's, are eligible for QPA services (Chartered Health Plan and Health Right, HSCSN). In addition, QPA administrates the DC Healthy Smiles Medicaid plan. A patient's eligibility status may change frequently; therefore, verification of eligibility is mandatory at the time of the service.

D-2 Eligibility Verification Procedure

D-2.1 When to Check Eligibility

All participating providers are responsible for verifying a patient's eligibility at each visit. The presentation of a member's identification card is not sufficient proof that the member is still eligible.

QPA updates the list of active patients on a monthly basis; however, eligibility verification is still required at each visit

D-2.2 How to Check Eligibility

In order to verify a member's eligibility, you may contact the Customer Services department at (202) 722-2744 or 1(800) 900-4112. Such verification does not guarantee payment for services rendered because patient eligibility data is subject to change. Each MCO member has an identification card. Even with presentation of the card, other identification may be necessary to verify identity.

D-2.3 QPA eligibility Access System

QPA has established a rapid response fax system as well as an interactive voice response (EBVS 202 722 4215) system, both of which can be accessed via the segregated providers' selective access program. While the information gained from these automated response systems is the same as would be derived from customer service, the hours are extended and affords responses for unlimited eligibility requests.

D-2.4 FAX BACK ELIGIBILITY: For those busy offices that normally need three or more eligibility verifications per phone call, we strongly suggest that you fax a list of your patients directly to our office 202 291 5703 (Please include your tax id, each patients id, and which insurance they have presented to you. Our staff will process your request and fax the patient eligibility to your office in a timely fashion. Should your patient's service date change, the provider should request a new verification. Please see the example of our fax form, Exhibit VIII (page 91). To assure that payment is authorized, Providers should check eligibility on the service date that a patient visits their office.

D-2.5 INSTRUCTIONS: ENROLLEE BENEFITS VERIFICATION SYSTEM (EBVS)

EBVS DIRECT CALL: (202) 722 4215

Before accessing Quality Plan Administrators' telephone system benefits verification system, please make sure you have the following information:

1. Your PASSWORD which is your Tax ID Number

2. Member's MEDICAID NUMBER (please note that in order for EBVS to recognize the Medicaid number it should be prefixed by a "0" e.g. 77777777 should be entered as 077777777)

3. The list of GROUPS consist of:

   - 20 Managed PPO
   - 100 DC Vision
   - 2501 Chartered Medicaid (under 21)
   - 2502 Chartered Medicaid (adult)
   - 2590 Chartered Alliance *
   - 3306 HealthRight Medicaid (under 21)
   - 3307 HealthRight Medicaid (adult)
   - 3390 HealthRight Alliance *
   - 6220 DC Healthy Smiles (under 21)
   - 6221 DC Healthy Smiles (adult)
   - 8800 HSCSN (Children with Special Needs)

4. The CODE for the services to be provided are:

   1 = Dental

   2 = Vision

*** Alliance patients under age 19 yrs. will be treated under EPSDT**

D-2.6 Specialty referrals

Although referrals to specialists are usually done by the general dentist, patients can call customer service to be referred to a specialist close to their neighborhood or who is more readily accessible. A patient may also choose to refer directly to our directory of providers or access our web site to directly choose a specialist for appropriate care. Pediatric or adult patients who require specialty care for sedation technique, as opposed to restraints, should be referred to appropriate providers such as Children's Hospital, Howard University Hospital, or other network specialist or pediatric dentist.

D-2.7 General Referral Information

Participants may select any dentist on our network by:

(a) Accessing the brochure distributed by our MCO's

(b) Calling QPA (202) 722-2744 or (800) 900-4112

(c) Browsing our website or

(d) calling customer service of our MCO's.

QPA's customer service will assist in referring patients to appropriate dental service organizations based upon their needs and location. Emergency referrals are also available.

D-3 Sample ID Cards: Please see Section H

EXHIBIT I (page 61):
Chartered Member ID Card

EXHIBIT II (page 62):
DC HealthCare Alliance Member ID Card

D-3.1 DC Chartered Health Plan member ID cards are issued to DC Medicaid (TANF), DC Healthy Family Program (DCHF) and Chartered Alliance enrollees. The card includes the following information:

- The Chartered logo is in the top left-hand corner.
- The member's PCP name, practice or group name, the address and phone number of the Practitioner's office is in the top right hand corner.
- The member's Charter identification number and case number (that links family patients) are in the middle of the card.
- The group number (GP#), which is used by the pharmacist when a member needs a prescription, is the eight-digit (2740 ####) number located under the Chartered logo, above the member's Chartered identification number.
- The member's name (last, first, middle initial), date of birth, gender and medical assistance (Medicaid) number is in the lower left corner on the card.
- The member's co-payment for PCP (primary care Practitioner) visits, SPC (specialty care Practitioner) visits, and RX (prescription) scripts is shown as zeros. **There are no co-payments for Medicaid enrollees.**

EXHIBIT III (page 64)

Health Right Member ID card

EXHIBIT IV (page 65)

HSCSN Member ID Card

Health Services for Children with Special Needs, Inc.

EXHIBIT V (page 66)

DC Healthy Smiles ID card

D-4 General Referral Information

If the member indicates that a change in status has occurred, the Practitioner must immediately contact the Customer Service Department at (202) 722-2744 or toll free (800) 900-4112 to determine the status of coverage for services being rendered. The Customer Department is open Monday through Friday, 8:00 am. — 6:00 p.m.

The Customer Services Department is staffed to assist Practitioners and patients with any of the following:

- Choosing or changing a member's Primary Care Practitioners
- Educating patients on how to access their QPA's benefits
- Changing a member's demographic information

D-5 Dental Treatment Requiring Prior Authorization

D-5.1 Preauthorization/Pre-Certification

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

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

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

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

D-5.2 Objectives

The QPA preauthorization process is designed to:

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

Section E

Claims Submission Procedures

E-1 Required Data Elements

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

Patient name

Patient date of birth

Patient demographic information

Member identification number

Rendering provider name

Payee name and address

Provider Signature

Provider Federal Tax Identification Number

Date of Service

All appropriate CDT codes

Amount billed for each procedure

Place of service code

Type of service

Anesthesia/sedation time in minutes (O.S.)

Replacement of previous prosthodontic appliance

Date of previous service

Pre authorization request

Actual Service

Pre and/or post operative radiographs as outlined in protocols

Additional information as outlined under the “by report” sections outlined on protocols

E-2 Paper Claims Submission

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

Quality Plan Administrators
7824 Eastern Avenue, N.W.
Suite 100
Washington, DC 20011

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

E-3 Electronic Claims Submission

QPA accepts electronic claims submissions effective January 2008.

QPA electronic claims payor id is: CX077

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

E-3.1 Fax response and interactive voice response (IVR) system

QPA has acquired response systems designed to rapidly address your eligibility and procedural history needs, and you may utilize these functions. Please see section D-2.4 (pg. 17) for fax back instructions, and section D-2.5 (pg 18) of this manual for instructions to use our telephone Enrollee Benefits Verification System.

E-4 Coordination of Benefits

Occasionally a member will have another insurance carrier who is the primary source of coverage. In such an instance the primary carrier's explanation of benefits and payment made must be submitted to QPA with the claim, and appropriate adjustments will then be made by QPA.

E-5 Claims Filing Limits

Each MCO has developed a claim filing limit within which QPA holds the provider responsible for filing claims. Strict adherence to this policy is strongly advised since deviation from this policy which states 180 days will result in non payment. Additionally there is no recourse against the patient for the collection of these fees due to a lack of timely filing.

E-5.1 CLAIM SUBMISSION TIPS

1. For prompt payment we recommend submission within 30 days of the date of service.
2. **Claim forms must indicate the treating dentist's name, address, NPI# and signature. This will ensure that your claim will be processed using the correct practitioner record in our system**
3. **Please ensure that claims are signed by treating dentist even in group practices**
4. Claim forms should be legible. Typed or computer generated.
5. Every visit, ask the patient or guardian if there have been any changes in insurance coverage.
6. Verify eligibility prior to treatment and include eligibility number on the claim form.
7. Avoid unnecessary claim denials and the need for resubmission by using current ADA procedure codes provided in our desk top manuals.
8. The claim form's Record of Services section should be completed using your Usual and Customary Rates even though the plan payment will reflect the fee schedule provided.
9. If radiographs are required for processing, the following guidelines should be followed:

    - Radiographs should be as recent as possible.
    - Radiographs must be labeled with the exposure date.
    - Duplicate and panoramic radiographs must be labeled R/L.
    - When a radio graph does not demonstrate a clinical condition well, an intra-oral photograph is suggested as an additional diagnostic aide.
    - A radiograph should be stapled to the corresponding claim, especially when sending multiple claims in one envelope.
    - Periapical x-ray must be appropriately mounted.

10. Fill out all blocks on the claim forms especially information regarding replacement of an existing denture or fabrication of new prosthesis.
11. Be sure to label and list all teeth to be replaced.
12. Remember to identify if there are multiple providers treating our members. If so, they must be credentialed through Quality Plan Administrators, Inc. They must also provide the NPI# as the treating dentist on the claim.

E-6 Prompt Payment Act of 2002

QPA Plan shall pay all clean claims within 30 days after the receipt in accordance with the District of Columbia Prompt Payment Act of 2002. A clean claim is a claim that has no material defect or impropriety, include any lack of reasonably required substantiating documentation, which substantially prevents timely payment being made on the claim. There shall be a reputable presumption that QPA has received a claim within 5 business days from the date the Practitioner or person entitled to reimbursement placed the claims in the United States mail. This presumption is 24 hours for electronic submission, if not returned by the clearinghouse.

All claims without the necessary information required to ensure timely processing will be denied or returned with an explanation.

Vital information required for claims processing includes:

- Member/Patients name and identification number
- Member's date of birth and address
- Diagnosis code(s) (oral surgery, hospitals: CPT & ICD-9) and corresponding CDT codes.
- Dental CDT Codes
- Date(s) of service
- Place of service codes
- Charges per line and total (Your UCR)
- Practitioner's federal tax identification number or social security number
- Practitioner's name
- Practitioner's PIN number and group number if applicable
- National Provider Identifier (NPI#) and taxonomy #
- Vendor name and billing address
- Name and address of facility where services were rendered
- Signature: The treating provider must sign the claim form or indicate signature on file (with the QPA Credentials record of each provider). All providers must include his/her NPI# and taxonomy# on claim forms. Claims without these numbers cannot be paid and will be denied and returned to you.

E-7 Claims Inquiries

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

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

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

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

E-8 Claims Denials

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

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

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

E-8.1 Appeals

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

Quality Plan Administrators, Inc
Attn: Appeals Coordinator
7824 Eastern Avenue, N.W.
Suite 100
Washington, DC 20012

OR

Fax: (202) 291-5703

E-8.2 Claims Payment Review

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

E-9 Balance Billing Patients

Participating providers are prohibited from balance billing QPA patients unless specifically stated in that plan design including, but not limited to, situations involving non-payment by QPA or insolvency of the MCO. The Practitioner shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against the involved MCO. The practitioner is not, however, prohibited from collecting co-payments, co-insurance or deductibles for non-covered services in accordance with the specific terms of the applicable members benefit plan.

In the event a practitioner refers a patient to a non-participating practitioner without prior-authorization, or provides excluded services to a patient, the practitioner must inform the patient in advance, in writing: (i) of the service(s) to be provided; (ii) that QPA will not pay for or be liable for said services; and (iii) that patient will be financially liable for such services. In the event the practitioner does not comply with the requirements of this section, the practitioner shall be required to hold the patient harmless as described above.

Section F

Quality and Risk Management

F-1 Quality Management Program Description

QPA's Quality Management (QM) Program is a comprehensive, integrated and widely deployed approach to planning, designing, measuring, assessing, and improving quality, patient safety, health outcomes, utilization, risk management, affiliated care, and service performance. All plans, goals, and initiatives are congruent with the District of Columbia Medical Assistance Administration (MAA) strategy, but aligned with, and guided by, QPA's mission and vision. Assessing group and patient needs, responding to the voice of the customer, and monitoring quality of care and service are integrated into QPA's QM Program.

There is no Health Care Program in the United States which provides Carte Blanche access to unlimited care irrespective of cost.

The provision of services under most, if not all, Medicaid programs, is tailored to meet the financial limitations based upon the overall budget while affording basic care to provide function and reasonable esthetics to the patient. The patients, are not required to contribute to their care.

QPA has been given the responsibility to construct viable management protocols which strike a balance between the provider's needs and finding while assuring reasonable cost containment.

It is generally understood that the cost containment is not unlike that of a commercial carrier, thus does not limit access to care or reduce the quality of services.

F-2 Credentialing/Recredentialing Criteria

F-2.1 Initial Credentialing

A Practitioner is eligible to be credentialed if they:

- Hold a current unrestricted license to practice dentistry in the District of Columbia or jurisdiction serviced by QPA.
- Hold a current Federal Drug Enforcement Agency (DEA) Certificate or Controlled Dangerous Substance (CDS) certificate, if applicable
- Hold the current malpractice insurance limits for their specific discipline as required by QPA
- Agree to provide information on sanctions and/or disciplinary action imposed by any other health institution, professional health care organization, licensing authority and/or regulatory body, including voluntary or involuntary limitation, reduction, or loss of clinical and/or technical skills, and current competence
- Demonstrate a degree of professional competence comparable to other network Practitioners in their specialty, as well as the ability to deliver cost effective health care and meet the geographic, specialty and business needs of QPA
- Agree to participate in all quality management activities required by QPA. Provide information, which pertains to all education, training, and board certification.
- Provide professional work history to include the beginning and ending month for each position listed. A gap in work history that exceeds one year must be clarified in writing

The credentialing process begins when the Practitioner submits a completed, signed and dated credentialing application, a Consent and Release Form accompanied by copies of their state license, DEA or CDS, malpractice face sheet, and curriculum vitae. The Credentialing staff will then complete Primary Source Verification (PSV). In addition, site reviews will be conducted for all Practitioners utilizing the Office Site Review Tool. The application, PSV and site review results are forwarded to the Credentialing Committee for a decision. The Credentialing Committee consists of participating dental network Practitioners. All Practitioners are sent written notification of initial credentialing/recredentialing decisions.

F-2.2 Recredentialing

All Practitioners must be recredentialed within two years of their last credentialing date. QPA re-verifies the information that is subject to change over time. You will be contacted approximately six months prior to the expiration of your current credentialing period to update your information for recredentialing reviews.

Static historical elements such as education are not re-verified. The intent of the recredentialing process is to identify any changes in the practitioner's licensure, sanctions, certification, clinical privileges, competence, or health status that may affect the Practitioner's ability to perform the services that they are under contract to provide.

QPA collects and conducts primary source verification on all recredentialing information and documentation. In addition, the recredentialing process incorporates an assessment of the practitioner's performance with QPA, which includes dental record review, access and site reviews, patient complaints, patient satisfaction, and information from quality improvement activities.

F-2.3 Quality Improvement program

QPA has met with consultants whose expertise is the implementation of NCQA standards relating to managed care. This model developed by the national committee for quality assurance is utilized by our organization.

The following are some of the standards being utilized by QP:

(a) Initial and periodic site inspections, practices, chart reviews and facility access.

(b) Provider re credentialing after initial credentialing

(c) Claims review and practice trends

(d) Member and provider satisfaction surveys

(e) Office visitation based upon member complaints e.g. regarding perceived deviations from infection control like washing gloves etc.

F-3 Complaints and Grievances

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

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

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

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

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

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

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

Please report complaints to:

Quality Plan Administrators
Attention: Grievance Coordinator
7824 Eastern Avenue, N.W.
Suite 100
Washington, DC 20012

202-722-2744 or 1-800-900-4112
Or
Compliance Hotline at: (202) 291-2974

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

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

F-4 Patient Rights and Responsibilities

A QPA Plan patient has the right to:

- Be treated with dignity and respect.
- Receive all covered services listed in the handbook.
- Good quality care.
- Have access to dental care services 24 hours a day, 365 days a year.
- Choose a Dentist from QPA's list of providers.
- Change a Dentist and choose another one from QPA's list of practitioners/providers.
- Receive dental care in the comfort and convenience of a practitioner's or provider's office.
- To be sure that others cannot hear or see them when receiving care
- Make his/her own doctor appointments.
- Be a part of dental education programs offered by QPA.
- Have your dental records remain private, according to HIPAA rules.
- Have access to dental records in accordance with applicable federal and state laws.
- Receive prompt and polite responses to questions and concerns.
- Be told of any changes that have something to do with dental services or how to get them.
- Receive information about QPA, our services, our practitioners and providers and other dental care workers, our facilities, and his/her rights and responsibilities as a patient.
- Make recommendations about the patients' rights and responsibilities.
- Have a discussion about the dental care needed, regardless of cost and regardless if QPA covers it.
- Have access to case management services.
- Request information regarding advance directives and receive assistance in preparing them.
- Participate in making dental decisions, including the right to refuse treatment.
- To be told if a dental care practitioner is a student and to be able to refuse his/her care
- Receive authorization policies and procedures.
- Be aware of incentive plans for QPA's practitioners and providers.

- Receive a summary of the most recent patient satisfaction survey.
- Receive information on alternative medically necessary treatment options and alternatives, presented in a manner appropriate to your condition and easy to understand.
- Seek a second opinion from a qualified dental care professional within the network or out-of-network.
- Receive free interpreter services as needed, including help with sign language, if hearing impaired
- File a complaint or appeal orally or in writing.
- Have someone assist with getting information regarding the qualifications and titles of those responsible for providing care.
- Refuse the care of the practitioner or provider.

F-5 Patient Record Keeping Guidelines

QPA is committed to partnering with our contracted practitioners and providers in providing our patients with the highest possible quality of care. Consistent, current and complete documentation is an essential component of quality patient care. The dental record must “tell the story” of the patient as determined by the dentist in the circumstances in which he or she saw the patient.

The record is not just a personal memory aid for the individual dentist who creates it. It must allow other health care practitioners and providers to read quickly and understand the patient’s past and current health concerns.

Efficient dental record keeping facilitates current and future treatment of individuals by recording which treatments have and which have not been effective, and the degree to which they have been effective as well as preventing harmful interactions attributable to different treatments.

In recognition of the key role that dental records play in providing clinical care, and to promote best-practice dental record keeping, we have adopted the components identified by the ADA as our standard for dental record keeping.

These guidelines have been incorporated into our ongoing quality oversight of contracted practitioners and providers and are available upon request.

Practitioners should have a patient’s dental record available and accessible at all times for patient care.

F-6 Provider Advisory Committee

The QPA Dental and Optical Advisory Committee provides a forum for the QPA practitioners to participate with QPA leadership on issues related to the clinical and operational facets of QPA. Committee members represent generalist and specialist in each discipline.

The Committee provides QPA with a mechanism to involve practitioners in the development of policies and procedures affecting patient care, clinical practice trends, and evidence-based guidelines. Committee members provide support and participate on other QPA Quality Committees including grievance and fraud activities.

F-6.1 Responsibilities:

1) Enhance QPA's ability to provide quality health care and services.

2) Provide strategies to improve patient satisfaction.

3) Participate as advisors in patient complaint resolution.

4) Participate in a forum to discuss and resolve practitioner and provider satisfaction issues.

5) Provide input in the development of educational and training sessions for QPA's practitioners, providers and patients.

6) Participate as advisors in the discussions about the development of policies and procedures that affect clinical care and service.

F-7 Risk Management Program Description

QPA, Inc. has developed a philosophy of Risk Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist's treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the "community practice patterns" of local dentists and their peers. With this mind, QPA, Inc.'s Risk Management Program is designed to ensure the fair and appropriate distribution of healthcare dollars as defined by the regionally based community practice patterns of local dentists and their peers. The ultimate basis for evaluation is predicated on standards developed by the American Dental Association and the Washington, DC Board of Dental Examiners. All risk management analysis, evaluations and outcomes are related to these patterns. QPA, Inc.'s Risk Management Program recognizes that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

QPA, Inc.'s Risk Management Program evaluates claims submissions in such areas as:

1. Diagnostic and preventive treatment;
2. Patient treatment planning and sequencing;
3. Types of treatment (appropriateness of treatment);
4. Treatment outcomes;
5. Treatment cost effectiveness; and
6. Sentinel events.

F-8 Identifying and Reporting Fraud and Abuse

Report suspected waste, fraud and abuse to the appropriate agency

Issues involving QPA patients can be reported to the Customer Service Department (202 722-2744) for initial review. The process for reporting to official agencies will be supervised by the Compliance Officer or Risk Manager.

QPA is obligated to report suspected cases of waste, fraud and abuse usually manifested by inappropriate billing to the appropriate agency. These include but are not limited to MCO's we serve the Medicaid Department of the District of Columbia and the D.C. Board of Dental Examiners.

QPA ensures that no individual who reports plan violations or suspected fraud and abuse will be subject to retaliation.

QPA is committed to fair adjudication that at the same time assures prudent financial management.

Fraud: is the intentional misrepresentation of a provider or individual supporting a provider, of services that will eventuate in excessive benefits to themselves.

This results in unnecessary and illegal costs to the overall program.

Abuse: Is the intentional harm to a patient caused by acts of omissions, negligence, sexual abuse or assault and other criminal acts.

Member Fraud: QPA requires that providers insist upon members presenting not only Identification cards, but also picture ID whenever possible in order to reduce the incidence of member fraud e.g. loaning an I.D. card to a non member, so that they can derive unauthorized benefits. Any suspected attempts should be reported to QPA.

QPA is in agreement with guidelines set forth by the District of Columbia Office of Inspector General. When reporting information concerning Waste, Fraud, and Abuse, be as specific and provide as much detail as possible. The more information you provide, the more thorough an investigation can be. Please indicate if possible:

- The specific nature of the wrongful or inappropriate act
- The name of the person or persons who committed the act
- The place where the person works
- The date and time the act occurred
- The place where the act occurred
- The reason you believe the act is wrongful or inappropriate
- The name, telephone number, and address of any person who can corroborate or supplement your information.
- Waster, Fraud, and Abuse can also be reported directly to the District of Columbia Office of Inspector General hotline: (202) 724 8477 or (800) 521 1639

F-9 The Americans with Disabilities Act of 1990 and Rehabilitation Act

F-9.1Section 504 of the Rehabilitation Act ("Rehab Act") and Title III of the Americans with Disabilities Act (ABA) Specific Requirements

Section 504 of the Rehabilitation Act ("Rehab Act") and Title III of the Americans with Disabilities Act (ADA) prohibit discrimination against individuals with disabilities and require QPA's network of providers to make their services and facilities accessible to such individuals. QPA expects all providers in its network to comply with the requirements of these statutes. The requirements of the ADA and the Rehab Act regarding accessibility are lengthy and complex. QPA's policy on access summarizes the main requirements and sets forth QPA's minimum expectations of its providers. Providers should consult with their own legal counsel about their obligations under these statutes.

F-9.2 Non-Discrimination

The ADA and Rehab Act prohibit discrimination by public accommodations and recipients of federal assistance, respectively, against individuals with disabilities. QPA providers fall into both of these categories. Accordingly, they may not, on the basis of an individual's disability or an individual's association with someone with a disability, (1) deny that individual goods, services, facilities, privileges, advantages, or accommodations; (2) provide that individual goods, services, facilities, privileges, advantages, or accommodations that are not equal to that afforded to other individuals; (3) provide that individual goods, services, facilities, privileges, advantages, or accommodations that are different than or separate from that afforded to other individuals; or (4) provide goods, services, facilities, privileges, advantages, or accommodations in a segregated setting.

In addition, QPA providers must not use eligibility criteria that would screen out or tend to screen out individuals with disabilities from fully and equally enjoying any of their goods, services, facilities, privileges, advantages or accommodations.

F-9.3 Modifications in Policies, Practices and Procedures

QPA providers have an affirmative obligation to make reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages or accommodations to individuals with disabilities, unless they can demonstrate that making the modification would fundamentally alter the nature of the goods, services, facilities, privileges, advantages or accommodations or pose an undue burden.

In other words, unless providing the modification would change the fundamental nature of a provider's service, or pose an undue burden, the modification must be made. The undue burden analysis takes into account the resources of the provider, which means that small doctors' offices, for example, will be more likely to be able to demonstrate an undue burden than a hospital.

The nature of the reasonable modification will vary depending on the circumstances of each case. However, QPA providers should always consider a request for a modification carefully. It is never appropriate to reject a request without giving meaningful consideration to the request or possible alternatives if the request cannot be accommodated. Requests for a reasonable modification and responses to such requests should be documented.

The following are some examples of reasonable modifications in policies, practices and procedures:

> **Example 1:** A medical facility has a policy of not allowing animals into any part of the building. This facility is required to modify this policy to allow a person with a disability to bring a service animal into the building, unless doing so would result in a fundamental alteration or jeopardize the safe operation of the medical facility. If there are facts showing that the presence or use of a service animal would pose a significant health risk in certain designated areas of a hospital, for example, may serve as a basis for excluding service animals in those areas.
>
> The provider has no obligation to care for or supervise a service animal. In addition, if the service being provided by the service animal is not apparent, a provider may ask what the animal performs for the person with a disability.
>
> **Example 2:** A health clinic has an evacuation plan for use during a fire or other emergency under which elevators will be shut off. The clinic must modify this evacuation procedure to provide alternative means for mobility-impaired patients to be evacuated from the building.
>
> **Example 3:** A doctor's office is located in a building that has an entrance that cannot be made accessible to a patient who uses a wheelchair. Normally, the doctor does not see patients off-site. The doctor may have to modify this policy to see this patient at an alternate location that is accessible.

F-9.4 Auxiliary Aids and Services

The ADA and Rehab Act require providers to provide auxiliary aids and services to individuals with disabilities that are necessary to ensure their equal access to the goods, services, facilities, privileges, or accommodations that they offer, unless an undue burden or a fundamental alteration would result. **Providers may not charge extra for these auxiliary aids and services.**

Auxiliary aids and services can take many forms, depending on the needs of the individual with a disability. A good way to approach the situation is to have a dialogue with the individual with a disability about what auxiliary aid or service he or she needs. Although the decision of what auxiliary aid or service to offer is ultimately the provider's, a dialogue between the patient and provider is usually very productive and resolves most issues.

One of the greatest challenges that providers face is how to provide "effective communication" with patients who are vision or hearing impaired. The ADA and Rehab Act both require that providers provide auxiliary aids and services to their vision or hearing impaired patients to

ensure that there is "effective communication." Depending on the length, importance and complexity of the communication at issue, a provider may have to provide a deaf patient with a qualified sign language interpreter, at no charge. In other cases, written materials or the exchange of written notes may suffice.

> **Example 1:** An oncologist meets with a deaf patient for an hour to discuss treatment options for her leukemia. A qualified sign language interpreter must be present to provide "effective communication."

> **Example 2:** A deaf patient goes to his doctor for a bi-weekly check-up, during which the nurse records the patient's blood pressure and weight. Exchanging notes and using gestures are likely to provide an effective means of communication at this type of check-up.

If the circumstances require a qualified interpreter, a provider may not rely on the family members or friends of the individual with a disability to provide interpretation services.

To provide effective communication with vision impaired patients, a provider may have to provide a reader, brailed materials, or large print materials, depending on the circumstances.

> **Example:** A blind patient cannot read and fill out the patient intake forms that must be completed for new patients. The provider should have someone read the form to the patient and help the patient complete the form.

Providers should also be aware that they may also have to provide a means for effective communication to family members and friends with vision or hearing impairments to the extent that those persons play an important role in the care of the patient, even if the patient does not have a vision or hearing impairment.

> **Example:** A patient receiving chemotherapy in the hospital is very sick and her mother, who is deaf, is at the hospital virtually all the time to assist in her care and communicate with hospital staff about her daughter's needs. The hospital must provide effective communication with the mother.

F-9.5 Direct Threat

A provider may exclude an individual from participating in or benefiting from its goods, services, facilities, privileges, advantages and accommodations if the individual poses a direct threat to others that cannot be mitigated with reasonable modifications of policies, practices, or procedures, or by providing auxiliary aids or services. This determination must be based on an individualized assessment of the facts, not generalizations or stereotypes about the effects of a particular disability. Exclusions based on a "direct threat" determination should be carefully documented.

F-9.6 Accessible Facilities

QPA's providers must have physical facilities that are accessible to individuals with disabilities. The level of accessibility that is required depends on when the facility was constructed. Facilities constructed for first occupancy after January 26, 1993, must meet the highest level of accessibility set forth in the ADA regulations at 28 C.F.R. part 36, Appendix A (the "ADA Standards"). Facilities constructed for first occupancy prior to January 26, 1993 (Pre-1993 Facilities) are not required to meet the ADA Standards but must still remove structural barriers to

the extent the removal is "readily achievable" (is, can be carried out without much difficulty and expense). In addition, any alterations to a Pre-1993 facility made after January 26, 1992, must comply with the ADA Standards to the maximum extent feasible. QPA recommends that its providers conduct a self-evaluation of their facilities to determine if they are in compliance with these requirements. More information concerning the ADA Standards can be found at www.ada.gov.

QPA will conduct periodic reviews of its providers to ensure compliance with this and other policies. With regard to physical accessibility, QPA will focus primarily on the following aspects of each facility in its reviews:

a. **Accessible parking.** If parking is provided at a provider's facility, there must be accessible parking spaces located as close to the accessible entrance as possible marked with the international symbol of accessibility (ISA). For a lot with up to 100 spaces, one in every 25 spaces must be accessible. (A provider with more than 100 spaces should consult the ADA Standards for the required number). An accessible parking space for a car must be located on level ground and at least 8' wide; with an adjacent access aisle that is at least 5' wide. There must be one van accessible space for every eight accessible spaces (with a minimum of one in all parking lots). Van accessible spaces must have 8' wide access aisles.

b. **Accessible Entrance.** There must be at least one accessible public entrance for every two at the facility. An accessible entrance must meet the following minimum requirements:

   I. Have no abrupt change in level greater than ¼" (e.g., no steps). Thresholds must be beveled with a maximum 1:2 slope and no higher than '/2";

   2. Provide 32" of clear width when the door is open at 90 degrees; and

   3. Have door hardware that can be used with a closed fist or flail hand (~g, lever hardware).

   Note: If the facility has public entrances that are not accessible, there must be signage at those entrances indicating the location of the accessible entrance(s)
   .

c. **Accessible Route**. Individuals with mobility impairments who use wheelchairs or scooters must have accessible routes that they can use to access provider facilities.

   There must be an accessible route from the accessible parking, public sidewalk, passenger loading zone, and public transportation stop to the building entrance.

   There must be an accessible route connecting (a) the accessible entrance, (b) accessible restrooms, and (c) and all locations within the facility where goods and services are provided to the public (e.g. reception area, exam rooms, treatment rooms, hospital rooms).

As a general matter, an accessible route is a clear unobstructed path that is at least 36" wide with (1) a maximum primary slope of *5%;* (2) a maximum cross slope of 2%; (3) a firm, stable, and slip resistant surface; (4) no abrupt change in level more than ¼" (e.g. steps), although thresholds can be up to ¼" high if they are beveled with a 1:2 slope. An accessible route can narrow to 32" clear width at doorways. An accessible route can also include curb ramps and ramps, for which there are specific standards, set forth in the ADA Standards. One of the basic requirements for ramps is that the slope cannot exceed 8.33%.

d. **Accessible Restrooms.** Every facility must have at least one accessible male and female restroom that is on an accessible route. As a general rule, an accessible restroom must have the following features:

1. A door that provides a 32" clear width when open at 90 degrees;

2. A door that can be open with less than *5* lbs of force;

3. Entrance door hardware that can be used with a closed fist or flail hand;

4. Have maneuvering space on both sides of the door that is level (i.e., maximum 2% cross slope in both directions) and at least 24" of clear space next to the latch side of the door;

5. A 5'x 5' stall ("Accessible Stall") with an out-swinging door with the following features:

    i. A toilet that has a centerline at 18" from the adjacent side wall with a seat that is no higher than 17" to 19" from the floor to the top of the seat;

    ii. A hook in the Accessible Stall that is no higher than 48" from the floor;

    iii. A horizontal grab bar behind the toilet that is at least 36" long and mounted between 33"-36" above the floor; and

    iv. A horizontal grab bar along one side of the toilet (the side closest to the toilet) that is at least 40 inches long and mounted between 33"-36" above the floor.

6. At least one sink that has (I) a bottom edge located at between 29" and 34" above the floor; (2) insulated pipes; (3) hardware that can be operated with a closed fist or flail hand; and (4) a 30" x 48" clear floor space to allow someone to approach the sink from the front.

7. Soap and towel dispensers that are no higher than 48" from the floor.

8. Either a full-length mirror. Or a mirror mounted no more than 40" above the floor.

e. **Restroom Signage.**

1. If there are restrooms that do not have an Accessible Stall, there must be signage at those restrooms indicating the location of the restrooms that have an Accessible Stall.

2. Signs designating restrooms must be mounted on the wall next to the latch side of the door, 60” from the floor to the centerline of the sign with raised lettering and Braille.

Practitioners should be aware that this is not a complete list of requirements under the ADA Standards and is only intended to provide guidance to providers about what accessibility features will be the focus of QPA’s reviews. QPA also recognizes that some Pre-1993 Facilities may not be able to meet all of these requirements due to technical or structural issues or expense (for small providers) and will take those factors into consideration.

Section G

Regulatory Requirements And Clinical Criteria

G-1 AAPD/ADA/AAP Periodicity & Anticipatory Guidance Recommendations: (Exhibit V page 52)

G-2 Clinical Criteria

QPA has developed convenient "Table Top" summaries of benefits covered and related limitations for each program we administer. These "Table Top" summaries are available to our providers via our web site www.qualityplanadmin.com or by contacting customer service.

Special Instructions

G-2.1 Infection control

Infection control is not considered a separate billable dental procedure or service and can not be billed to the patient or the plan.

G-2.2 Material and Laboratory costs

When biopsies are performed, a pathology report is required. QPA may be invoiced by the laboratory. Eligibility (confirmed) is a requirement.

G-2.3 Removal of fixed space maintainer (D1555)

Procedure delivered by dentist who did not originally place the appliance or by the practice where the application was originally delivered to the patient.

G-2.4 Dental Claim review

In certain circumstances, radiographs and other diagnostic information relevant to claims and pre-treatment estimates are reviewed by licensed dentists who provide consulting services to QPA. Based on the documentation submitted, these dentists may make recommendations to QPA claims staff to assist the claim staff in making benefit determination recommendations. For example they may advise if there is less expensive treatment that meets generally accepted dental standards of care that could be considered for benefit determination purposes.

Diagnostic documentation is required for review by our dental consultant staff and should be included with initial claim submission and pre treatment estimates involving services listed below.

Required diagnostics are:

- Most recent dated and labeled radiographs of diagnostic quality are required for individual teeth receiving extensive restorative procedures such as crowns, pulpotomies, endodontics (pre & Post), four surface restorations, space maintainers.
- Most recent dated and labeled radiographs of diagnostic quality, and mounted, of the respective upper and lower arch are required, for partial or full denture prosthetic pre-

authorization purposes.

- Most recent pre treatment periodontal charting (date) and, mounted, dated, and labeled full mouth radiographs, or as completed a series as is available, are required for periodontal services. Procedure codes D4270, D4271, D4273, D4275 and D 4276 only require a narrative report indicating the location, nature and extent of the mucogingival problem. Procedure code D4249 requires a recent pre operative radiograph of the tooth or teeth involved.

Occasionally, radiographs will be requested for procedures other than the ones specified above. All radiographs submitted should be of good diagnostic quality, labeled clearly, mounted, and dated. Duplicate radiographs should be labeled indicating the right and left side.

G-2.5 Claims review appeal process

A participating QPA dentist may, on a QPA participant's behalf, submit an appeal of benefit recommendation rendered by our dental consultant by following these guidelines, which will expedite the appeal process:

- Submit a copy of the original explanation of Dental benefits
- Submit original and any additional diagnostic information
- Submit a narrative report clearly identifying the reason for the appeal

G-2.6 Prosthodontics

For initial removable partial or full dentures, please indicate extraction dates on the submitted claim. For replacement dentures, please indicate the initial date of placement of original denture.

Preventive (D1000 — D1999)

Prophylaxis/fluoride treatment

QPA does not process combination codes Dl201 and D1205; if submitted, it will be broken down for benefit determination. The age limit for child vs. adult prophylaxis is group plan specific, but QPA standard plan design provides that the age limit for a child is up to age 14.

G-2.7 Evaluations (D0120 — D0150)

QPA considers this code to include a non emergency oral evaluation performed on eligible members participating, as a periodic oral evaluation. This had been preceded by a comprehensive evaluation.

Oral evaluation for a patient under three years of age and counseling with primary caregiver (D0145)

Diagnostic and preventative services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

G-2.8 Comprehensive oral evaluation (D0150)

Our plan considers this evaluation to include the elements contained in the ADA descriptor. It will be allowed for the initial evaluation of a QPA participant by either a general dentist or an appropriate specialist. QPA will regard subsequent evaluations as a periodic oral evaluation procedure (D0120)

Comprehensive periodontal evaluation (new or established patient) (D0180)

This procedure is indicated for patient showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.

G-2.9 Intraoral complete series of x rays

For benefit determination purposes, QPA considers a completer series of x rays (D0210) as: nine or more periapical x rays (D0220 -D0230) with or bitewings x-rays (D0270 — D0274); or, vertical bitewings (D0277) with four or more periapical x-rays, or with three or more additional bitewings x-rays; or, a combination of panoramic film (D0330) and bitewing x-rays, or periapical x-rays.

Restorative (D2000— D2999)

G-2.10 Surface combinations

QPA will combine surfaces for restorations performed on the same tooth and same date of service. The dentist can only bill QPA for the approved code based upon current CDT code description.

G-2.11 Sedative filling (D2940)

Procedure D2940 cannot be billed to QPA when performed in conjunction with any restorative procedure or root canal therapy on the same tooth during the same participant visit.

G-2.12 Core buildup, including any pins (D2950)

A core buildup should be submitted with a pre-treatment estimate for the crown or with the service date of the final crown to ensure accurate determination of benefits. Core buildups may be payable when the permanent crown is inserted or as long as we have an approved pre-treatment estimate.

G-2.13 Diagnostic documentation requirements

Most recent dated and labeled pre operative radiographs are required for crowns, and should be included with pre treatment estimates.

Endodontics (D3000— D3999)

G-2.14 Root canal therapy

The following procedures(s) can not be billed as a separate charge to QPA participant when performed in conjunction with root canal therapy on the same tooth:

- Intra-operative treatment radiographs (D0220/D0230)
- Pulp Testing (D0460)
- Pulpotomy (D3222)
- Canal Preparation (D3950)
- Palliative treatment (D9110)
- Surgical procedure for isolation of a tooth with rubber dam (D3910)

G-2.15 Apexification/recalcification (D3351 — D3353)

This procedure is performed in three stages consisting of an initial visit, interim visit(s) and a final visit, which includes completed root canal therapy. It is important to submit all visits along with your fee for each stage to ensure accurate claim processing.

G-2.16 Canal preparation and fitting of preformed dowel or post (D3950)

Procedure D3950 can not be billed as a separate charge to QPA when performed in conjunction with a post and core (D2952/D2954) or root canal therapy on the same tooth.

Periodontics (D4000 — D4999)

G-2.17 Per quadrant scaling/root planning (Requires Pre-Authorization)

QPA defines a full quadrant as four or more teeth for scaling/root planning. Procedures involving one to three teeth per quadrant will have their own CDT codes and fees. Quadrant indicator (UR, UL, LL, LR) are required on claim submissions. QPA will determine the benefit on a quadrant related procedure for scaling/root planning based upon the number of teeth, which require that procedure. This is based on our dental consultant's review of submitted documentation. If the benefit determination is for a partial quadrant procedure, you will be limited to bill the fee for the lower of your submitted charge, or allowance, for partial quadrant. QPA is only responsible for the partial quadrant scheduled amount if that is the final benefit determination.

G-2.18 Per quadrant periodontal surgical procedures (Requires Pre-Authorization)

QPA defines a full quadrant as four or more teeth, or bounded spaces for surgical procedures. Procedures involving one to three teeth, or bounded spaces, per quadrant will have their own CDT codes and fees. Quadrant indicators (UL, UR, LL, LR) are required on claim submissions. QPA will determine the benefit on a quadrant related procedure for surgical procedures based on the number of teeth, or bounded spaces, which require that procedure. This is based on our dental consultant procedure; you will be limited to bill QPA the fee for the lower of your submitted charge, or QPA allowance, for a partial quadrant.

G-2.19 Periodontal Charting

QPA considers periodontal charting part of the evaluation process

Benefit determination guidelines for full mouth debridement (04355)

For benefit determination purpose, QPA will reimburse claims for full mouth debridement as outlined in each plans fee schedule.

G-2.20 Diagnostic documentation requirements

Most recent periodontal charting (dated) and, dated, mounted, and labeled full mouth radiographs, or as complete a series as is available, should be included in the initial claim submission and pre determination of periodontal procedures.

For procedures D4270, D4272, D4273, D4275, and D4276 include a narrative report indicating the location, nature and extent of the mucogingival problem. For procedure D4249, include a recent dated and labeled pre operative radiograph.

Irrigation

Irrigation is not included in the descriptor for code D9630 and cannot be submitted for payment under this code, irrigation is normally included within other services rendered to the QPA participant and can not be billed as a separate charge.

Prosthodontics, removable (D5000— D5899)

G-2.21 Initial and replacement of dentures

For initial dentures, please indicate extraction dates on the submitted claim. For replacement dentures, please .indicate date of fabrication of the original dentures on submitted claim.

Complete denture adjustments (D5410 —D5411)

For benefit determination purposes, QPA considers all adjustments performed on complete/immediate dentures within the first six months of the total treatment of inserting the denture. When reline is performed on an immediate denture within the first six months of placement, QPA will consider payment based upon written justification.

Partial dentures (D5211 —D5281)

The QPA fee for partial dentures includes an allowance for all teeth and all clasps.

G-2.22 Material and laboratory costs

QPA can not be billed a separate charge for material and laboratory costs since they are included in the services provided.

G-2.23 Diagnostic documentation requirements

Most recent dated and labeled, preoperative radiographs of the remaining teeth in the respective upper and lower arch are required for fixed bridgework and should be included on initial claim submission and pre treatment estimates.

Oral and Maxillofacial surgery (D7000 — D7999)

G-2.24 Diagnostic documentation required

Although pre authorization is not required when submitting claims for all OMS codes beyond D7l40 please attach clear and legible pre-surgical radiographs to the claim.

Orthodontics (D8000— D8999)

G-2.25 Full course of orthodontic treatment

The allowance represents the maximum amount that a dentist can collect for each full course of orthodontic treatment rendered to a QPA participant. This fee includes all appliances, office visits and follow-up visits, (including retention). There is no limitation on the total number of months necessary for orthodontic treatment. If a pre paid plan, the retentive appliance fee is included.

The QPA fee in effect at the time active treatment is started applies for the entire treatment time based on the appropriate QPA allowance, regardless of any change in the participant's status as a QPA eligible participant and regardless of any change in the provider's status.

This QPA allowance does not include charges for cosmetic banding, broken appliances due to participant neglect and/or missed appointments.

To ensure quicker processing when submitting a claim for a full course of orthodontic treatment, submit the following information: appropriate CDT code, your fee for the total treatment, and the total projected treatment time.

All orthodontic procedure require pre-authorization. A cephalometric radiograph and models must be submitted to QPA with a treatment plan to be evaluated by our consultant who will determine medical necessity. If required our consultant will perform the cephalometric tracing in order to complete the analysis.

Adjunctive general services (D9000 — D9999)

G-2.26 Palliative (emergency) treatment of dental pain

Palliative treatment (D9110) can not be billed to QPA as a separate charge when performed during the same visit with definitive treatment.

G-2.27 Local anesthesia D9215)

Local anesthesia (D9215) done in conjunction with definitive treatment is not a covered service when billed as a separate charge.

Occlusal adjustment — Limited/complete (D9951 — D9952)

Procedures D9951 and D9952 can not be billed to QPA in conjunction with the placement of restoration or prostheses. QPA consider on occlusal adjustment as part of the restorative process when performed during the same participant visit.

G-2.28 Patient/Member Notification of Risk Factors

All providers of services must list the known risk factors associated with the use of the papoose, restraints, Nitrous Oxide, general and local anesthesia, and sedation techniques on your informed consent form, even if their expected occurrence rate is low.

The consent form should be multi-lingual, i.e. English and Spanish. If your office identifies that a patient speaks a language other than one of these two and if no staff member is able to communicate with that patient, translation services must be requested from QPA, which will arrange for services with the appropriate payer.

Where an individual is unable to read or comprehend what they are reading, and if no staff member is able to communicate, then translation services must be requested from QPA, which will arrange for interpretive services with the appropriate payer.

Where the use of behavior modification procedures including restraints is necessary, the organization must verify that the dentist providing such services has been trained and is currently qualified to perform them. Such dentist's expertise must include the ability to manage possible complications as specified by either the specialty Association Board, or the DC Board of Dental Examiners. The provider must maintain auditable documentation in the dentist's personnel file that the dentist has the proper training and certification.

G-2.29 Provider Monitoring by QPA

QPA may make periodic visits, both announced and unannounced, to a providers office as a monitoring measure that will serve to lend support to the contention of their outstanding ongoing care.

SECTION H

EXHIBITS

The Chartered Member ID Cards

Chartered Health Plan Member ID card

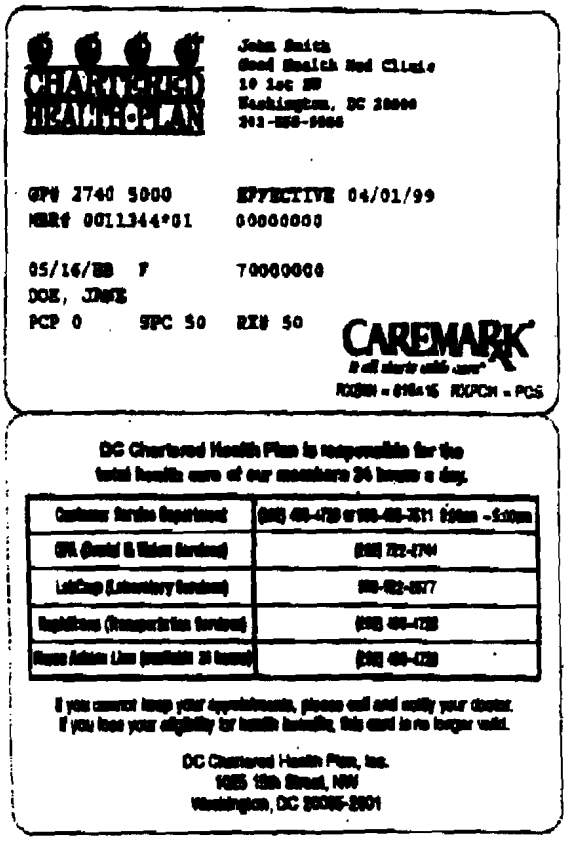


EXHIBIT I

DC HealthCare Alliance Member ID card

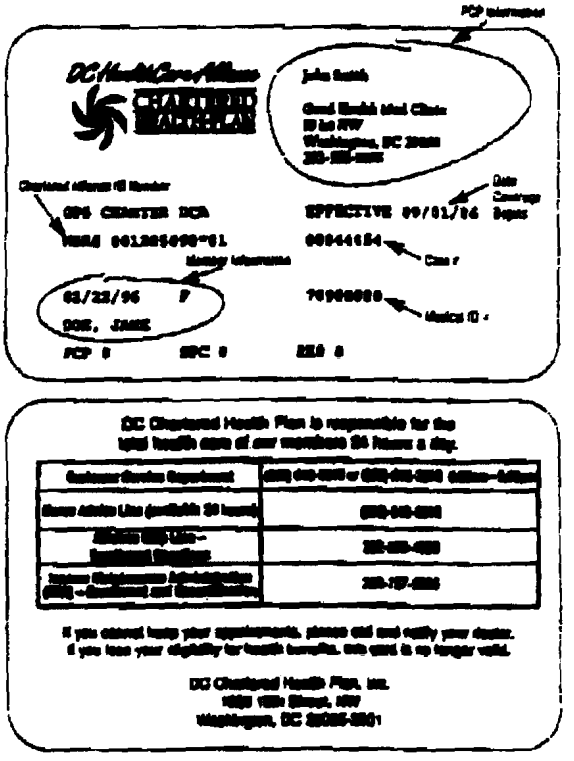


EXHIBIT II

Health Right Member ID card

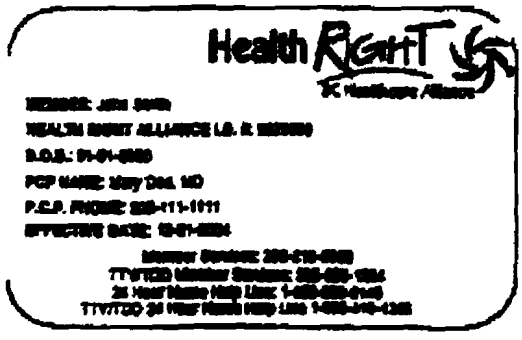
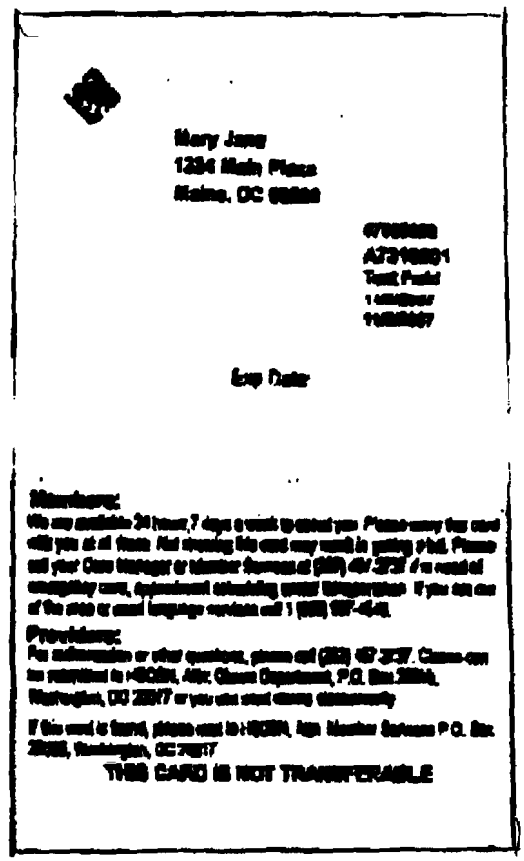


EXHIBIT III



Health Services for Children with Special Needs, Inc

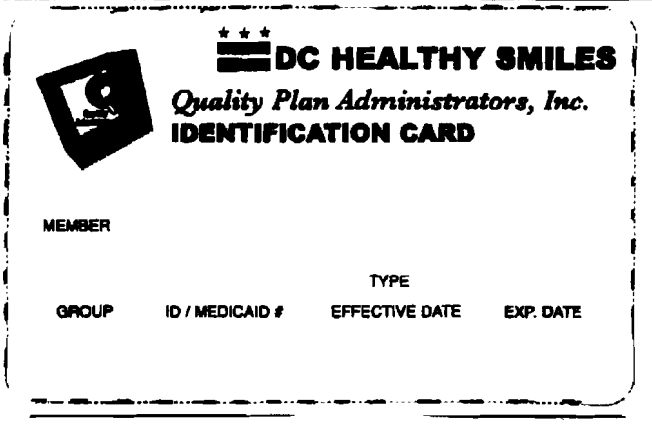
(HSCSN)

1731 Bunker Hill Road, NE
Washington, DC 20017

Customer Service: (202) 467 2737

EXHIBIT IV

DC Healthy Smiles Member ID card



PROGRAM ADMINISTERED BY:
Quality Plan Administrators, Inc.
7824 Eastern Avenue, N.W., Suite 100
Washington, DC 20012 (202) 722-2744

IMPORTANT: The enrollee named on this card, and any eligible dependent, has qualified for benefits under a plan provided by Quality Plan Administrators, Inc. Please communicate with the Administrator to confirm eligibility.

Signature of Enrollee _____

EXHIBIT V

District of Columbia Department of Health
Medical Assistance Administration
Dental Periodicity Schedule

The District of Columbia Department of Health Medical Assistance Administration (DC DOH MAA) Dental Health Periodicity Schedule follows the American Academy of Pediatric Dentistry Periodicity Schedule oral health recommendations in consultation with local medical communities. This schedule is designed for the care of children who have no contributing medical conditions and are developing normally. The DC DOH MAA Dental periodicity schedule will be modified for children with special health care needs or if disease or trauma manifests variations from normal.

Age	Birth - 12 months	12 - 24 months	24 months – 3 years	3 - 6 years	6 - 12 years	12 years & Older
Clinical Oral screening[1]	•	•	•	•		
Assess oral growth and development[2]	•	•	•	•	•	•
Referral for Regular & Periodic Dental care[3]		If at risk	•	•	•	•
Counseling for nonnutritive Habits[4]	•	•	•	•	•	•
Oral hygiene counseling[5]	•	•	•	•	•	•
Dietary Counseling[6] Injury prevention counseling[7]	•	•	•	•	•	•
Fluoride Supplementation[8]		•	•	•	•	•
Radiographic Assessment[9]			•	•	•	•
Pit & Fissure Sealants[10]			•	•	•	•
Assessment & Treatment of Developing Malocclusion				•	•	•
Assessment and Removal of 3rd molars						•
Substance Abuse Counseling					•	•
Anticipatory Guidance[11]	•	•	•	•	•	•

See Footnotes on Back

EXHIBIT VI

1. The Primary Care Physician/Pediatrician should perform the first/initial oral health screening following AAP guidelines.
2. An oral assessment can be done by the Primary Care Physician/Pediatrician up to age 3. Every infant should receive an oral health risk assessment from his/her primary health care provider or qualified health care professional by 6 months of age that includes: (1) assessing the patient' s risk of developing oral disease using the AAPD Caries-risk assessment tool; (2) providing education on infant oral health; and (3) evaluating and optimizing fluoride exposure.
3. All children should be referred to a dentist for the establishment of a dental home no later than age 3. Children determined by the PCP/Pediatrician to be at risk for dental caries should be referred to a dentist as early as 6 months after the first tooth erupts, or 12 months of a (whichever comes first) for establishment of a dental home. Children at risk are defined as:
    - Children with Special Health Care Needs
    - Children of mothers with a high caries rate
    - Children with demonstrable caries, plaque, demineralization, and or staining
    - Children who sleep with a bottle or breastfeed throughout the night
    - Later-order offspring
    - Children in families of low socioeconomic status

    Once dental care is established with a dental professional, it is recommended and is the right of every child enrolled in Medicaid to see the Dentist every six months.
4. At first discussion of the need for additional sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysphasia occurs.
5. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism. Counseling is given to parents/guardians/caregivers up to age 2. At age 2, the provider should include the patient/child in the counseling. For children 12 years and older, counseling need only be done with the child/patient if the dentist feels this is appropriate – Otherwise include the parents.
6. At every screening discuss the role of refined carbohydrates, frequency of snacking, etc.
7. Initial discussions should include play objects, pacifiers, and car seats; when learning to walk, include injury prevention. For school-age children and adolescent patients, counsel regarding sports and routine playing.
8. Fluoride supplementation as indicated including a topical fluoride varnish, as indicated by the child' s risk for caries and periodontal disease and the water source. (Performed by dental professional only)
9. As per AAPD "Clinical guideline on prescribing dental radiographs." (Performed by dental professional only)
10. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/ or fissures; placed as soon as possible after eruption. (Performed by dental professional only)
11. Appropriate oral health discussion and counseling should be an integral part of each visit for care. (Performed by dental professional only)

REFERENCES FOR DENTAL PERIODICITY SCHEDULE

1. American Academy of Pediatrics, "Policy Statement on Oral Health Risk Assessment Timing and Establishment of the Dental Home", Pediatrics, 111(5):1113-16 (2003).
2. *Guide to Children's Dental Care in Medicaid,* U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (Oct. 2004)
3. Cruz GG, Rozier RG, and Slade G, "Dental Screening and Referral of Young Children by Pediatric Primary Care Providers," Pediatrics, 114(5):642-52 (Nov. 2004)
4. Seale NS and Casamassimo PS, "Access to dental care for children in the United States: a survey of general practitioners," JADA, 134:1630-1640 (dec. 2003)
5. American Academy of Pediatric Dentistry, *Policy on Use of a Caries-risk Assessment Tool (CAT) for Infants, Children and Adolescents* Originating Council, Council on Clinical Affairs, Adopted 2002

Complete and fax to QPA: 202-291-5703

*Date:*_____

*Provider :*_____

*Tax ID # :*_____

*Fax #:*_____

Patient Name	*ID # and ins.*	*History*	*-Auth #*

Notes:

EXHIBIT VII

EXHIBIT VIII

Quality Plan Administrators, Inc.
7324 Eastern Avenue, NW, Suite 100
Washington, DC 20012-1305

VOID VOID

EMPLOYEE'S RESPONSIBILITY

VOID

TOTAL AMOUNT CHARGED
TOTAL NOT COVERED
TOTAL ELIGIBLE CHARGES
BENEFITS PAID AT 100%
OTHER BENEFITS PAID
DEDUCTIBLE APPLIED
CO-PAY APPLIED

BENEFITS PAYABLE TO

VOID

TOTAL PAID BY PLAN

Quality Plan Administrators, Inc.
7324 Eastern Avenue, NW, Suite 100
Washington, DC 20012-1305

DATE
PATIENT

0245

DATE

PAY TO THE ORDER OF

VOID

VOID

THE HSC HEALTH CARE SYSTEM

SIGNATURE

OLD LINE BANK

EXHIBIT VIII

SIGNATURE

VOID

VOID

WASHINGTON DC 20010-4386

DC Healthcare Alliance/CHP (02590)

Payment Employee: 2

Check Date: 10/31/2007 Check #: 7488 Check Amount: $19,693.00

Claim Number / Incurred Date	Employee Name / Dependent	Cvrg Cd	Proc Cd	Charge Amt	Discount Amt	Deductible Amt	Not Covered	Co Amt	Paid Amt
9/5/2007	9/5/2007	DEMR	D9110/	$54.00	$19.00	$0.00	$0.00	$0.00	$35.00
			PPO BENEFIT APPLIED					Surcharge Held:	$0.00
9/24/2007	9/24/2007	DPRV	D1110/	$52.00	$4.00	$0.00	$0.00	$0.00	$48.00
			PPO BENEFIT APPLIED					Surcharge Held:	$0.00
9/24/2007	9/24/2007	DRES	D2140/	$59.00	$4.00	$0.00	$0.00	$0.00	$55.00
			PPO BENEFIT APPLIED					Surcharge Held:	$0.00
9/28/2007	9/28/2007	DPRR	D5213/	$1,740.00	$1,065.00	$0.00	$0.00	$0.00	$675.00
			PPO BENEFIT APPLIED					Surcharge Held:	$0.00

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EXHIBIT IX