



ODS Community Dental Provider Handbook

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Welcome to our network of Medicaid (Oregon Health Plan) dentists

Thank you for your participation in the ODS Community Dental Provider network. The services you provide improve members' health and help them to have healthy mouths and bodies.

The information in this handbook will help answer many of your questions about the ODS Community Dental Plan. We welcome your comments and suggestions to improve the handbook and make it your one-stop resource for provider information.

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

Baker	Grant	Marion	Washington
Benton	Gilliam	Multnomah	Wallowa
Clackamas	Harney	Morrow	Wasco
Clatsop	Hood River	Polk	Wheeler
Coos	Lake	Sherman	Yamhill
Crook	Lane	Tillamook	
Deschutes	Linn	Umatilla	
Douglas	Malheur	Union	

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

ODS Community Dental conducts dental workshops to bring you information on updates and changes. These workshops also provide an opportunity for you to ask questions and meet our team members.

We are always looking for dentists to participate in the ODS Community Dental network. If you know of a dentist who is interested, please contact us.

Again, thank you for your support and participation.

Sincerely,

Dr. Teri Barichello, DMD
VP, Chief Dental Officer

ODS Community Dental mission

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

Rules for participating dentists

Participating dentists agree to abide by the following rules of ODS Community Dental, in addition to the Oregon Administrative Rules (OARs) that govern the Oregon Health Plan (OHP). You can locate the following OAR rule books online at:

<https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-OHP.aspx>

[Oregon Administrative Rules](#)

[Oregon Health Plan \(MCO and CCO\) Program \(division 141\)](#)

[OHP Dental Services](#)

[OHP General Rules](#)

Participating ODS Community dentists also agree:

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

Credentialing

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

We credential dentists when they join the ODS Community Dental provider network and every three years after that. Our process includes verifying credentials as well as reviewing and monitoring malpractice claims, state licensing disciplinary activity, and adverse outcomes.

We keep information provided during this process confidential. If we do not have your current credentials on file, we will pay the claim at the out-of-network level or may return it to your office.

Application elements that may be subject to verification:

- Current and past state license/s
- DEA certificate
- Malpractice insurance coverage; ODS Community Dental requires a \$1 million minimum per claim and a \$3 million minimum aggregate amount for participation in our network
- Current practice information
- Work history, gaps in work history of two (2) months or more require explanation
- Dental or undergraduate education from an accredited school
- Malpractice claim history of last five (5) years, three (3) years for recredentialing
- Medicare/Medicaid sanctions/exclusions
- State license sanctions of last five (5) years, three (3) years for recredentialing
- Additional administrative data relating to a provider's ability to provide care and service to ODS Community Dental members
- National Provider Identifier, type 1- Individual

Discrepancy in credentialing information

When we find information that differs substantially from the information you submitted, we may require an explanation.

- We will notify you in writing of the discrepancy and request a written explanation within seven (7) calendar days. Our dental director or the peer review committee will review the explanation.
- If you do not respond within seven (7) calendar days, our credentialing supervisor will contact you by telephone to request a written response within seven (7) calendar days.
- If we do not receive a response, your application will be terminated and you will be notified via certified letter.

Our Credentialing staff will process your application by verifying the information and will contact your office if additional information is needed. Once the verification is complete, the supervisor, dental director and/or peer review committee will review the application for any concerns, and will determine if you will be credentialed as a participating dentist.

While participating with ODS Community Dental, dentists must maintain all licenses, registrations, certifications and accreditations required by law. You must promptly notify ODS Community Dental in writing of any formal action against your licenses or, if applicable, against any certifications by certifying boards or organizations. You must notify ODS Community Dental of any changes in practice ownership or business address, along with any other facts that may impair your ability to provide services to ODS Community Dental members.

You have the right to:

- Appeal an ODS Community Dental decision to restrict, suspend or take other adverse action against your participation status.
- Not be discriminated against based on your race, ethnic/national identity, gender, age, sexual orientation or types of procedures performed, legal under U.S. law, or patients in whom the provider specializes.
- Review information obtained by ODS Community Dental to evaluate the credentialing application. We will not share information that is peer-protected and protected by law.
- Correct erroneous information discovered during the verification process.
- Request, from the credentialing department, the credentialing application status via telephone, email or correspondence.
- Withdraw the application, in writing, at any time.
- Have the confidentiality of the application and supporting documents protected, and the information used for the sole purpose of application verification, peer review and panel participation decisions.
- Be notified of these rights.

To find an electronic version of the dental credentialing and credentialing applications visit our website:

https://www.modahealth.com/dental/contracting_credentiaing.shtml

You can send your application and materials by:

Mail: Moda Health Attn:

Provider Credentialing – 8th Floor,

601 S.W. 2nd Avenue, Portland, OR 97204

Fax: 503-265-5707

Email: credentialing@modahealth.com

Services covered by ODS Community Dental

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

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

- Pregnant women
- Non-pregnant women and adults 21 and over
- Children under 21

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

Diagnostic
Clinical oral evaluations
Radiographs

Preventive
Prophylaxis
Fluoride treatment
Sealants

Prosthodontics (Removable)
Complete and partial dentures
Repairs to complete and partial dentures
Denture rebase and reline procedures

Restorative
Amalgam
Build-ups
Composite resin restorations
Crowns

Endodontics
Root Canal Therapy

Oral Surgery
Extractions
Surgical extractions

Periodontics
Non-surgical services

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

Service limitations and exclusions

In addition to service limitations listed in the [OHP coverage list](#) the following limitations and exclusions apply:

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

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

Billing the member for non-covered services

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

The following are examples of when members cannot be billed:

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

When a member chooses to receive a specific service that is not covered by ODS Community Dental, you must document this using the Oregon Health Authority/Oregon Health Plan Client Agreement to Pay for Health Services (OHP 3165 form), and the agreement must be physically signed by both the member and provider (stamped

signatures are considered invalid) prior to rendering non-covered services. This agreement is valid only if the estimated fees do not change and the service is scheduled within 30 days of the member's signature. A sample of this OHA approved form has been included in the back of this handbook for your convenience. A copy of this form can also be downloaded [here](#) from our website. You are required to:

- Inform the member that the service is not covered
- Provide an estimate of the cost of the service
- Explain to the member their financial responsibility for the service
- Complete the OHA OHP Client Agreement to Pay for Health Services (OHP 3165 form) located in the back of this handbook.
- Make arrangements with the member prior to rendering the service
- Complete the agreement in the primary language of the member

A brief listing of non-covered ODS Community Dental services includes the following:

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

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

You may bill a member if the member did not advise you that they had Medicaid insurance and you made attempts to obtain insurance information.

- You must document attempts to obtain information on insurance or document a member's statement of non-insurance.
- Merely billing or sending a statement to a member does not constitute an attempt to obtain insurance information.

For a complete description of the rules, please refer to the [General Rules, 410-120-1280](#)

Overpayments

When your office determines that you have received an overpayment on one of your patients, please include a copy of the refund request letter, a check for remittance of overpayment and the following information:

- Patient name
- Member identification number
- Date of service
- Claim number (if known)
- Reason for refund

You may also use the “Provider Refund Submission Form” located under “Provider Resources” on the ODS Community Dental site. Simply print the form, fill in the appropriate information and mail the form with your refund to the address shown on the bottom of the form.

Recovery of overpayments to providers

If ODS Community Dental does not receive payment within 90 days of a written request, then we may deduct the amount you owe from the amount that is due to you on your next claim(s).

The Prioritized List of Health Services

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

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

ODS Community Dental covers all funded services for dental.

Resources

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

To find the [Prioritized List](#)

You may also [Search the list](#)

To see ODS Community Dental list of [covered and non-covered services](#):

Important to know

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

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

Member transportation

Transportation to dental appointments is available to patients who have no other means to get to the dental appointment. Non-urgent transportation is a benefit provided to the member by the member’s coordinated care organization (CCO). Members should contact their CCO for transportation assistance by calling the transportation phone number listed in the following CCO section.

Coordinated care organizations (CCOs)

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

ODS Community Dental began partnering with the CCOs in October 2013. There are a total of 15 CCOs in Oregon. ODS Community Dental has partnered with the following 9 CCOs:

CCO	General Contact	Transportation Contact	Counties Served
Columbia Pacific CCO	800-224-4840	888-585-4221	Clatsop, Columbia, Tillamook
Eastern Oregon CCO	888-788-9821	877-875-4657	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler
Health Share of Oregon	888-519-3845	866-336-2906	Clackamas, Multnomah, Washington
InterCommunity Health Network CCO	800-832-4580	866-724-2975	Benton, Lincoln, Linn
Jackson Care Connect	800-224-4840	888-518-8160	Jackson

PacificSource Community Solutions – Columbia Gorge	800-431-4135	877-875-4657	Hood River, Wasco
PacificSource Community Solutions – Central Oregon	800-431-4135	866-385-8680	Crook, Deschutes, Jefferson, Klamath,
PacificSource Community Solutions – Marion and Polk	800-431-4135	800-431-4135	Marion and Polk
PacificSource Community Solutions – Lane County	800-431-4135	800-431-4135	Lane County
Trillium Community Health Plan	877-600-5472	877-800-9899	Benton, Lane, Linn, Clackamas, Multnomah, Washington, Douglas

Qualified interpreter services

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

To arrange for interpreter services, complete the ODS Community Dental Interpreter Request form, which is available in the back of this handbook and on our website, and fax it to our customer service department at 503-952-5259 no less than 48 hours prior to the appointment.

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

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

ODS Community Dental OHP providers can choose to coordinate interpreter services themselves rather than coordinating them through ODS Community Dental; however, the provider will be responsible for paying for the interpreter services.

Second opinions

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

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

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

The requesting provider may call 800-342-0526 or fax the completed referral request form to 503-952-5259.

Dental Case Management

The ODS Community Dental Case Management team works closely with members, providers, and coordinated care organizations (CCOs) to ensure that our members who need additional support in accessing dental services receive the care they need.

We do this by:

- Coordinating specialty dental services for members with special needs
- Providing educational materials, follow-up, and reminder letters that are culturally and linguistically appropriate and specific to members' medical conditions
- Working with providers and CCO case management to coordinate care for members
- Making sure children newly placed in foster care receive an oral health assessment
- Addressing the need for ongoing preventive dental services for members of all ages
- Generating and distributing reports to providers that list children that meet the age criteria for dental sealants

For more information on our dental case management services, please refer to our dental case management policy on the ODS Community Dental website. If you have a patient who needs additional support, please contact ODS Community Dental Customer Service at 800-342-0526.

The referral process

For general dentists

You do not need a written referral to make a referral to a specialist. If you are requesting a referral for oral surgery, endodontics, pediatric dentistry, or denturists please have your office contact ODS Community Dental Customer Service at 800-342-0526 for names of specialty providers. You can also search Find Care on our website for a specialist in your area.

For patients with special needs, periodontal needs or when a second opinion is needed you do need to submit a written referral form request. You can fax the completed request to 503-952-5259 (see form in the back of this handbook).

For capitated providers

If you are requesting a referral for oral surgery, endodontics, pediatric dentistry, or denturists please have your office contact our ODS Community Dental Customer Service at 800-342-0526. Your office must send a referral request to ensure appropriate claims processes for the specialty office.

Referral requests must include:

- All pertinent patient information (name, ID number, birth date, medical concerns, etc.)
- Procedure that is being requested.
- Provider contact information, including mailing address and a return fax number, when applicable.

ODS Community Dental notifies the general dentist within 10 working days of receiving the request if the referral is approved, denied or pending for further review. Urgent referrals are processed within 1–2 working days.

Once the referral is approved, ODS Community Dental documents in the member record the specialist the member was referred to.

If the referral request is denied, a formal written denial is mailed to the member and to the general dentist providing reason for denial. The notification includes the reason for denial and the member's right to appeal the denial. Referrals are not a guarantee of payment.

Referral process for specialists

- Specialists must check eligibility before seeing a patient, regardless of the origin of the referral. The patient must be eligible with ODS Community Dental on the date of service.
- Specialists requesting additional follow-up visits or wishing to send a patient to another specialist for consultation or treatment must consult with the patient's general dentist.
- Referrals are not a guarantee of payment.

Eligibility

The Oregon Health Authority reviews eligibility requirements for all OHP members, and once the member is enrolled they can choose a dental carrier or may be assigned to a carrier through their coordinated care organization. The provider must verify that the individual receiving dental services is an eligible individual on the date of service for the service provided and that ODS Community Dental is the dental plan responsible for

reimbursement. The provider assumes full financial risk of serving a person who isn't eligible for the service provided on the date of service. (OAR 410-141-3565)

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

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

Verifying member eligibility — online

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

Medicaid Management Information System (MMIS)

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

ODS Community Dental providers who are not contracted directly with the State for fee-for-service reimbursement should confirm MMIS access with Health Systems.

Verifying member eligibility — telephone

ODS Community Dental Customer Service staff uses Health Systems' MMIS system and Benefit Tracker to provide up-to-date information and policies so you can be confident you will receive the most current information available. You can reach us at 800-342-0526 from 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday, excluding holidays.

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

Office information:

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

Member information:

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

*If you don't know the member ID, please be prepared to provide the member Social Security Number (SSN) and member address.

Verifying member eligibility — email and fax

Email: You can email ODS Community Dental Customer Service at dentalcasemanagement@modahealth.com.

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

Fax: You can fax ODS Community Dental Customer Service at 503-952-5259. You can fax a list of ODS Community Dental members including the member's first and last name, member ID and the member's date of birth. ODS Customer Service will use Health Systems' MMIS system, CCO web portals and Benefit Tracker to verify the member's eligibility. Faxes received by 3 p.m. will be returned no later than 9 a.m. on the following business day.

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

Benefit Tracker (BT)

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

There are many benefits to using Benefit Tracker.

- Locate benefit information, including determining the type of plan a member is enrolled in.
- Access the most up-to-date information at the most convenient times for you, whether it's during office hours or after hours.
- Quickly determine the best treatment plan for your patient bases on benefit information.
- Keep track of the latest claims status of a patient or use the search filters to find the status of older claims.
- Print hard copies for patient files, treatment plan presentations and easy updates to plan benefit software.
- Common preventive services box. Displays whether or not a member is eligible for cleaning (prophylaxis), exam, bitewing radiographs, and full mouth series or panoramic radiographs. If the benefit is currently not available Benefit Tracker will display the next available date for the service.

Benefit Tracker contact information

To register contact our Benefit Tracker Administrator:

Mail: Benefit Tracker Administrator

601 SW Second Ave.

Portland OR 97204

877-337-0651 (choose option 1)

Email: ebt@modahealth.com

For more information [see our website](#).

ODS Community Dental ID cards

In addition to an OHP ID card, members enrolled through a coordinated care organization (CCO) will also receive an ID card from the CCO. ODS Community Dental will be listed on the card as their dental plan if they have been assigned to ODS Community Dental.

Assigned dentists

ODS members who are assigned to a specific dentist or office must seek treatment from that dentist for their benefits to be paid. If a patient seeks treatment from you, and you are not their assigned dentist, please direct the member to seek treatment from their assigned dentist. You can identify members who are assigned to a specific dental office on the Benefit Tracker under “Group Limitations.”

Exceptions

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

In non-emergency cases, members need a referral to a specialist or an out-of-network provider before we will issue payment to that provider. If you need to refer a patient to a specialist or another provider, please call our customer service department at 800-342-0526 or email dentalcasemanagement@modahealth.com.

Capitation List

Arrow Dental LLC — Astoria 433 30th St Astoria, OR 97103 (503) 338-6000	Arrow Dental LLC — Salem 1880 Lancaster Drive NE, Suite 121 Salem OR 97305 971-600-3498	Arrow Dental LLC — Milwaukie 10505 SE 17 th Ave Milwaukie, OR 97222 (503) 653-4093
Arrow Dental LLC — Eugene 890 Seneca Rd Suite 100 Eugene, OR 97402 (541) 653-8610	Arrow Dental LLC — Clatskanie 400 SW Bel Air Drive Clatskanie, OR 97016 (503) 728-2114	OHSU Dental Clinics 2730 SW Moody Ave Portland OR 97201 503-494-8867
James Klusmier 165 NW 1 st Ave John Day, OR 97845 541-575-0363	Elisha B Mayes 1400 Division Street Elgin, OR 97827 541-437-6321	Family Dental Care Inc. Locations may vary Please contact 503-644-2663 or 888-350-0996 for member assignment
Winding Waters Medical Clinic 603 Medical Parkway Enterprise, OR 97828 541-426-4502	Eastern Oregon Dental Group 1831 First St Baker City, OR 97814 541-523-2144	Gentle Dental Locations may vary Please contact 503-644-2663 or 888-350-0996 for member assignment
Capitol Dental Locations may vary Please contact 503-644-2663 or 888-350-0996 for member assignment	Mosaic Medical Locations may vary Please call 541-383-3005 for member assignment	

Health through Oral Wellness program

When it comes to oral health, we know some people need more care than others. ODS Community Dental’s Health through Oral Wellness program offers extra benefits to members who have a greater risk for oral diseases.

To help your high-risk patients get the extra dental benefits and related care they need, you must be signed up for PreViser™, a third-party dental risk and periodontal disease application. Just follow these steps to get started:

1. Sign up at my.previser.com/signup/ddor
2. Complete the request fields and click Register
3. You will receive an email from PreViser asking you to validate and complete your registration by going to previser.com and selecting ‘My Account’

By registering for PreViser, you will be able to conduct clinical risk assessments on ODS Community Dental (OHP) patients. ODS Community Dental members may now qualify for additional benefits if they score 3+ on their clinical risk assessment. Below is the enhanced benefits grid that details what benefits your patients will be eligible for based on their risk scores.

Enhanced plan	Risk levels	Enhanced benefit	CDT codes	Frequency
High-risk: caries/periodontitis	Caries risk (3+) or Periodontitis risk (3+) or Periodontal disease severity (4+)	Prophy or periodontal maintenance	D1110, D1120, D4346, D4910	Combination up to 1 per 3 months
		Fluoride varnish or topical fluoride	D1206, D1206	Combination up to 1 per 3 months
		Sealants	D1351	Once per 2 years
		Oral hygiene instruction or nutritional counseling	D1330, D1310	Once per 12 months
		Drugs or medicaments dispensed in the office for home use	D9630	Once per 6 months

ODS Community Dental members already receive benefits for all levels of oral cancer risk. We encourage you to assess oral cancer risk as an educational opportunity for patients.

After completing the assessment and receiving your patient’s scores from PreViser, you may confirm their eligibility in Benefit Tracker and inform them about their enhanced benefits.

Billing reminder: a caries risk assessment is covered once every 12 months. Submit risk assessment code D0601, D0602, or D0603 on claim to receive reimbursement.

Timely access

To ensure that ODS Community Dental members have access to high-quality service and dental care in a timely manner, we are required to follow Oregon Administrative Rule standards. We use the ODS Community Dental, third next available appointment survey, after-hour's access survey and member complaints to assess how well we are complying with the standards.

A. Telephone triage for appointment scheduling

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

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

B. Walk-in triage

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

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

C. Appointment scheduling

1. **Emergent dental care:** The member is seen or treated within **24 hours**. Members calling or walking into the office with emergent problems are put in immediate contact with a clinical staff member. If the dental condition requires treatment not available in the office, the member is sent to the appropriate facility or specialty dentist immediately. Referrals are provided if necessary.
2. **Urgent dental care:** Urgent care is made available within **one week** depending on the member's condition.
3. **Routine care:** A member with routine care needs is scheduled for an appointment within an average of **eight weeks** unless there is a documented special clinical reason, which would make access longer than 8 weeks appropriate.

Monitoring access

ODS Community Dental uses the following methods to monitor contracted providers to ensure timely access to care. Dentists who do not meet the criteria outlined are notified that they must comply with the rules in order to continue as a participating provider with ODS Community Dental.

1) ODS Community Dental conducts a weekly Third Next Available Appointment (TNAA) survey to assess timely access for emergent, urgent, routine care and routine care for pregnant women in accordance with Oregon Administrative Rule 410-141-3515 (11)(b) and 410-141-1510.

- Providers must report their TNAA for each appointment type (emergent, urgent, routine, and routine for pregnant women).
- This must be completed for each provider at every clinic (provider in multiple locations must report the TNAA for every location)
- If a provider is not meeting access standards, they must report special circumstances or reason that is temporarily limiting their availability (provide out of office, illness, staffing changes, etc.)

2) ODS Community Dental conducts an after-hour telephone survey to assess timely access of our members for appointments and 24-hour access, 7 days a week for dental emergencies in accordance with the following rules:

- Oregon Administrative Rule 410-141-3840 and 410-141-3515 (11)(b)(A) for the Oregon Health Plan
- Board of Dentistry's rule 818-012-0010 under "Unacceptable Patient Care"

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

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

- An answering service that is able to reach the patient's primary dentist or an on-call dentist; or
- The patient's primary dentist office message will instruct an established patient to call a listed after-hours telephone number to reach the primary dentist or an on-call dentist. We also call this after-hours number to determine whether the patient can leave a message.
- If a provider is not meeting the standard, they are notified by ODS and must provide a plan to gain compliance. A follow-up survey is conducted within 2 months. If non-compliance continues, it is reported to Dental Quality Improvement Committee, which may recommend removal from ODS Community Panel.

3) ODS Community Dental audits contracted provider dental records on an annual basis to ensure compliance with the Oregon Board of Dentistry Oregon Administrative Rule (OAR) 818-012-0070 standards of practice for patient records, and to evaluate quality of care, access to care and ongoing performance improvement.

- ODS will select a random sample of records to review and will submit request to providers.
- The list of items to be reviewed during each chart audit is evaluated annually by ODS' Dental Director to ensure it meets current standards of practice of dental records. To assess timely access to care, providers must submit appointment scheduling proof.
- Each dental record is reviewed by a qualified reviewer and scored for completeness.
- Providers are notified of the results. Any charts that fall below the passing score are reported to the Dental Quality Committee for appropriate interventions.

Member rights and responsibilities

Members can find a copy of these rights and responsibilities in the Dental Member Handbook they receive upon enrollment.

Members have the right to:

1. Be treated with dignity and respect.
2. Be treated by participating providers the same as other people seeking dental care benefits to which they are entitled.
3. Select or change primary care dentists (PCD).
4. Have a friend, family member or advocate present during appointments and at other times as needed within clinical guidelines.
5. Be actively involved in creating treatment plans.
6. Be given information about conditions, covered services and non-covered services in order to make an informed decision about proposed treatment(s).
7. Consent to treatment or refuse services and be told the consequences of the decision, except for court-ordered services.
8. Receive written materials describing rights, responsibilities, benefits available, how to access services and what to do in an emergency.
9. Have written materials explained in a manner that is understandable.
10. Receive necessary and reasonable services to diagnose the presenting condition.
11. Receive covered services under the Oregon Health Plan that meet generally accepted standards of practice and are medically appropriate.
12. Receive covered preventive services.
13. Have access to urgent and emergency services 24 hours a day, seven days a week.
14. Receive a referral to specialty providers for dentally appropriate covered services.
15. Have a clinical record maintained that documents conditions, services received and referrals made.
16. Have access to one's own clinical record, unless restricted by law, and request and receive a copy of their records and request that they be amended or corrected.
17. Transfer a copy of their clinical record to another provider.
18. Execute a statement of wishes for treatment (Advanced Directive), including the right to accept or refuse dental treatment and the right to obtain a power of attorney for healthcare.
19. Receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations.
20. Know how to make a complaint or appeal about any aspect of care or the plan.
21. Request an Administrative Hearing with Health Systems.
22. Receive interpreter services.
23. Receive a notice of an appointment cancellation in a timely manner.

24. Receive covered services under OHP, which meet generally accepted standards of practice, as is dentally appropriate.
25. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation and to report any violations to ODS Community Dental or to the Oregon Health Plan.
26. Post-stabilization services after an emergency department visit.
27. A second dental opinion.
28. Be free from retaliation or dismissal due to the filing or resolution of a grievance, appeal or hearing request.

Members have the responsibility to:

1. Choose, or help with, assignment to a provider or clinic, once enrolled.
2. Treat all providers and their staff with respect.
3. Be on time for appointments made with providers and call in advance either to cancel if unable to keep the appointment or if expected to be late.
4. Seek periodic dental exams, check-ups and preventive care from the member's dentist.
5. Use the member's dentist or clinic for diagnostic and other care except in an emergency.
6. Obtain a referral to a specialist from the general dentist before seeking care from a specialist.
7. Use urgent and emergency services appropriately and notify ODS Community Dental within 72 hours of an emergency.
8. Give accurate information for the clinical record.
9. Help the provider obtain clinical records from other providers. This may include signing a release of information form.
10. Ask questions about conditions, treatments and other issues related to their care that they do not understand.
11. Use information to decide about treatment before it is given.
12. Help in the creation of a treatment plan with the provider.
13. Follow prescribed, agreed-upon treatment plans.
14. Tell providers that the member's dental care is covered under the Oregon Health Plan before services are received and, if requested, show the provider the Division Medical Care identification form.
15. Tell the authority worker of a change of address or phone number.
16. Tell the Authority worker if she becomes pregnant and notify the Authority worker of the birth of the child.
17. Tell the Authority worker if any family members move in or out of the household.
18. Tell the Authority worker if there is any other insurance available.
19. Pay for non-covered services received under the provisions described in OAR 410-120-1200 and 410-120-1280.
20. Pay the monthly OHP premium on time if so required.

21. Assist in pursuing any third-party resources available and to pay ODS Community Dental the amount of benefits paid from an injury from any recovery received from that injury.
22. Bring issues, complaints or grievances to the attention of ODS Community Dental.
23. Sign an authorization for release of dental information so that ODS Community Dental can get information pertinent and needed to respond to an administrative hearing request in an effective and efficient manner.

Seclusion and restraint policy

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

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

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

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

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

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

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

Member dismissal and disenrollment guidelines

Definitions:

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

Requirements:

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

Key points when considering member dismissal:

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

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

When can a member be dismissed?

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

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

When you decide to dismiss a member:

When you and your clinic decide to dismiss a member you must send a letter to the member informing them of the dismissal, with a copy to ODS Community Dental. Dentists are asked to provide urgent care for the dismissed member for 30 days following this notification. ODS Community Dental customer service representatives work with the member to establish a new dentist.

When a member cannot be dismissed:

Oregon Administrative Rule 410-141-3810 (4)© states that members shall not be dismissed from a dentist or disenrolled from ODS Community Dental solely because:

- The member has a physical, intellectual, developmental, or mental disability.
- There is an adverse change in the member's health.
- The provider or ODS Community Dental believes the member's utilization of services is either excessive or lacking.
- The member requests a hearing against a provider or ODS Community Dental.
- The member exercises their option to make decisions regarding their dental care, with which the provider or the plan disagrees.
- The member engages in uncooperative or disruptive behavior as a result of their special needs.

Causes for requesting member disenrollment:

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

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

Send copies of relevant documentation, including chart notes and a police report, to ODS Community Dental. ODS Community Dental will contact Health Systems to request immediate disenrollment.

Missed appointment policy

We ask that you establish an office policy for the number of appointments you will allow a member to miss before dismissing them from your practice. This policy should apply equally for all patients. You must notify members of this policy on their first visit, and have them sign an acknowledgement of the policy.

When a member misses an appointment, you should contact the member to reschedule and notify ODS Community Dental Customer Service of the missed appointment. We will then contact the member and educate them on the importance of keeping appointments and let them know that they need to give advance notice if they need to cancel.

If the member continues to miss appointments and you decide to dismiss the member, you must send a letter to the member informing them of the dismissal and provide a copy to ODS Community Dental Customer Service. Please include other relevant documents including chart notes, correspondence sent to the member, signed contracts and/or documentation of case conferences. We will ask the member to select a new provider. After a member has been dismissed from two providers within a 12-month period for missing appointments, we will request that the member be disenrolled from ODS Community Dental.

Member complaints and appeals

Complaints

A complaint is an expression of dissatisfaction to ODS Community Dental or a provider about any matter that does not involve a denial, limitation, reduction or termination of a requested covered service. Examples of complaints include, but are not limited to: access to providers, waiting times, demeanor of dental care personnel, quality of care and adequacy of facilities.

We encourage you to try to resolve member complaints on your own. If you cannot resolve a complaint, please inform the member that ODS Community Dental does have a formal complaint procedure. Members can contact our customer service department to make a complaint. If a member isn't satisfied with the way we handle a complaint the member can file a complaint with the Oregon Health Authority's Ombudsman's Office. There is no time limit for filing a complaint.

A member may also file a complaint directly with the state of Oregon:

Oregon Health Authority Ombudsperson
500 NE Summer St. NE, E17
Salem, OR 97310-1097

Phone: 503-947-2346 or 877-642-0450 (TTY: 711)

Members have the right to have a representative (including their provider) file a complaint on their behalf. The member's written consent is required in order to file a grievance or appeal on the member's behalf.

Appeals

An appeal is a request to review an ODS Community Dental decision to deny, limit, reduce or terminate a requested covered service or to deny a claim payment. It can be made by a member, the member's representative or a provider as long as the person appealing has the member's permission. Member appeals must be made in writing within 60 days of the decision to deny or limit services.

If the person making the appeal calls our customer service office, they must also follow up with a written appeal. They also have the right to file a request for an administrative hearing with the Oregon Health Authority. The member has the right to request that the benefits continue while the case is being decided, however if the decision to terminate or limit benefits is upheld the member will be required to pay for services performed during the appeal.

Resolving Complaints and Appeals

The ODS Community Dental appeals staff makes decisions about member complaints and appeals, seeking input from appropriate parties, such as the provider, dental consultant or care coordination staff. Most complaints are resolved within five days, and most appeals are resolved within 16 days, but for more complicated complaints and appeals it may take up to 30 days to resolve.

If a member is experiencing an emergency and cannot wait for a review, they may call or write to ODS and ask for an expedited appeal. If the appeal is an emergency, we will respond to the request within 72 hours.

If ODS fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe, the member may initiate a contested case hearing.

Contested care hearing process

OHA has an appeal process for members who are dissatisfied with our response to an appeal of a denial, limitation, reduction or termination of a requested covered service or denial of claims payment. This process is outlined in the ODS Notice of Adverse Benefit Determination letter.

If a provider filed an appeal on behalf of a member, the provider may subsequently request a contested case hearing on behalf of the member with the member's written consent, in accordance with the procedures in OAR 410-141-3900.

Members may obtain more information about this process by contacting their OHP caseworker or by contacting the ODS Community Dental customer service department at 800-342-0526.

Members can submit a complaint or appeal in one of the following ways:

Write
Member Appeal Unit

Fax
503-412-4003

ODS P.O. Box 40384
Portland, OR 97240

Attention: Appeals Unit

Call
800-342-0526

OHP Complaint Form

A member may file a complaint using an OHP Complaint Form 3001 and an appeal using a Request for Administrative Hearing (MSC 443) or Appeal and Hearing Request for Medical Service Denials (OHP 3302). These forms can be [found online](#). [Complaint forms](#) are also available on the ODS website.

Denials

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

The notice of action includes the following information:

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

Appeals

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

An appeal may be requested as follows:

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

Fax
503-412-4003

Telephone
ODS Community Dental OHP: 503-243-2987 or 800-342-0526 (TTY 711)

Submitting claims

Acceptable Claim Form

Please file all claims using the most recent American Dental Association Dental Claim form. If you would like information on billing claims electronically, contact our Dental PR department at 888-374-8905 or 503-265-5720.

Timely filing guidelines

ODS Community Dental requests that you submit all eligible claims within four months from the date of service. We will consider claims received after this invalid and won't pay them. There are exceptions, you must submit claims that meet the criteria outlined in OAR 410-141-3564 within 12 months of the date of service or we will consider them invalid and won't pay them.

Use your proper provider identifiers

In order for claims to be processed correctly, each claim must include the correct Tax ID Number (TIN), license number and National Provider Identifier (NPI). If your clinic has multiple dentists or providers, the name of the individual who provided the service must also be noted. If this information is not provided, the claim may be returned for resubmission with the missing information

If you do not receive an explanation of payment (EOP) within 45 days after you submit the claim, your billing office should contact ODS Community Dental Customer Service or check Benefit Tracker to verify that we have received the claim. Please verify that we have received your initial claim before you submit a duplicate. When submitting a claim electronically, please check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing.

You must submit all information to process a claim in a timely manner (e.g., radiographs, chart notes). You must identify adjustments and make those requests within 12 months of the date of service.

Corrected Billings

To make corrections to a previously submitted claim, please write “corrected billing” in the remarks section of a paper claim or note “corrected billing” on an electronic claim. In addition, please include dental records if the change involves a change in procedure or the addition of procedure codes.

Electronic claims submission

You can reduce administrative time and shorten turnaround time by submitting claims electronically.

We can accept claims from the following electronic connections:

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

Our EDI Department will work with your office to advise you of the options available. For information on setting up this process, please call or write:

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

Members with other insurance coverage

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

Calculating coordination of benefits

As secondary payer, ODS Community Dental issues benefits when the primary carrier paid less than our allowed amount for each procedure. We pay the difference between the amount we allow and the primary carrier's total payment.

If the primary plan pays more than our allowed amount, we will not issue a benefit. All remaining balances, including primary plan deductibles and/or co-insurances, are to be included in the provider discount.

Predetermination of benefits

Predeterminations are always optional and never required for any dental services and are not guarantee of payment. For a complete list of services that are eligible for predeterminations, please refer to our comprehensive list of covered and non-covered services. This list includes detailed CDT code benefit information including any age or frequency limitations, as well as predetermination option availability. You can find this list on the Moda website at www.odscommunitydental.com. Select dental provider, resources, forms and then OHP forms.

Predeterminations are an option for partials, dentures, and third molar extractions. A current ADA form may be submitted with the following information:

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

Care coordination is important to us. If you have a Medicaid patient with a healthcare need or comorbid condition that requires them to have additional dental treatments please send a letter and supporting chart notes to our dental team at 601 SW 2nd Ave Portland, OR 97204, attention Dental Correspondence.

Professional review

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

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

We handle your re-evaluation requests in the same manner; however, we do not re-evaluate claims without additional, pertinent information.

Procedure codes that ALWAYS require professional review

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

To expedite the processing of your claim, please submit the clinical information with your initial claims submission using the clinical review requirements on the following pages:

Restorative	Endodontics	Periodontics	Prosthodontics	Oral & Maxillofacial Surgery	Adjunctive General Services
D2751	D3331	D4920	D5211	D7287	D9212
D2752	D3351		D5212	D7340	D9630
D2980	D3352			D7350	D9920
				D7540	
				D7550	
				D7560	
				D7670	
				D7911	
				D7912	
				D7980	
				D7981	
				D7982	
				D7983	

Clinical Information requirements

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

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

DIAGNOSTIC SERVICES: D0100-D0999		
Code	Description of service	Submission request
D0140	Limited Oral Evaluation – Problem Focused	Chart notes outlining the necessity of the treatment rendered, including the diagnosis for the below dates of service(s). Include any additional diagnostic information available to assist in determining benefits.
D0220, D0230	Periapical Radiographs	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D0310	Sialography	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D0320	Temporomandibular Joint Arthrogram	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D0321	Temporomandibular Joint Films	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D0472, D0473, D0474, D0480, D0486, D0502	Accession of tissue, gross examination, preparation and transmission of written report, other oral pathology procedures, by report	Pathology report and/or chart notes outlining necessity and specific location of the issue being removed. Services performed on the lip, cheeks or tongue are not covered.

CROWNS D2390 - D2799		
Code	Description of Service	Submission Request
D2390	Resin-based composite crown, anterior	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photograph. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
D2710, D2712, D2751, D2752	Crowns – single restorations only	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photograph. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
D2980	Crown Repair	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photograph. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
BUILDUP/POSTS: D2950 - D2957		
Code	Description of Service	Submission Request
D2950, D2951, D2954, D2955, D2957	Core buildup for single restorations	<p>Current periapical radiographs with detailed chart notes regarding the necessity of the treatment and preoperative photograph. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.</p> <p>If replacement crown, periapical radiographs and/or photos after existing crown removed, Per the ADA, buildups should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.</p>

ENDODONTICS: APEXIFICATION D3351-D3353		
Code	Description of Service	Submission Request
D3310, D3320, D3330	Endodontic Therapy	Current periapical radiographs with chart notes. Please also indicate the type of final restoration being placed after completion of the endodontic treatment.
D3331, D3333	Obstruction and root repair	Pre-operative and post-operative periapical radiographs, if applicable, with chart notes regarding the necessity of the endodontic procedure.
D3332	Incomplete root canal	Please provide chart notes indicating why this tooth is inoperable or unrestorable.
D3346	Retreatment of Previous Root Canal Therapy – anterior	Current periapical radiographs and chart notes. Please also indicate the type of final restoration being placed after completion of the endodontic treatment.
D3351, D3352, D3353	Apexification/recalcification procedures	Current periapical radiographs and chart notes. Please also indicate the reason for treatment and if apexification/ recalcification procedure is the first step of root canal therapy.
D3410, D3430	Retrograde Filling	Pre-operative and post-operative periapical radiographs, if applicable, and chart notes regarding the necessity of the endodontic procedure.
PERIODONTAL PROCEDURES: D4211-D4268		
Code	Description of Service	Submission Request
D4210, D4211	Gingivectomy	Periodontal charting (probing done within past 12 months), diagnosis, bitewing radiographs, and chart notes regarding the necessity of the periodontal treatment, and date of last active periodontal therapy, if applicable.
D4341, D4342	Periodontal scaling and root planing	
D4910	Periodontal maintenance	
D4355	Full-mouth debridement to enable comprehensive evaluation and diagnosis	Chart notes regarding necessity, and any additional diagnostic information to assist in determining benefits.
D4920	Unscheduled dressing change	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.

PROSTHETICS: D5213 - D5214		
Code	Description of Service	Submission Request
D5211, D5212, D5221 D5222	Removable prosthetic services	Current periapical radiographs, periodontal charting done within past 12 months and definitive treatment plan for entire mouth. Please indicate missing teeth to be replaced and teeth to be clasped, as well as any additional teeth that will be extracted.
D5820, D5821	Interim Partial Denture	Current periapical radiographs, periodontal charting done within past 12 months, definitive treatment plan for entire mouth and chart notes.
BIOPSY: D7285-D7410		
Code	Description of Service	Submission Request
D7285, D7286, D7287, D7288, D7410, D7440, D7450, D7460, D7465	Surgical procedures	Pathology report indicating specific location of tissue. Services performed on the lip, cheeks or tongue are not covered.
ORAL AND MAXILLOFACIAL SURGERY: D7111- D7997 (EXCLUDING BIOPSY)		
Code	Description of Service	Submission Request
D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7490, D7510, D7530, D7540, D7550, D7560, D7960, D7963, D7971	Oral and maxillofacial surgery	Current periapical radiographs and chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D7320, D7340, D7350, D7471, D7520, D7670, D7770, D7910, D7911, D7912, D7970, D7980, D7981, D7982, D7983, D7990, D7997	Oral and maxillofacial surgery	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Please include any additional diagnostic information available to assist in determining benefits.

ADJUNCTIVE PROCEDURES: D9910- D9940		
Code	Description of Service	Submission Request
D9211, D9212, D9310, D9440, D9610, D9612, D9630, D9920, D9930	Adjunctive procedures	Chart notes outlining the necessity of the treatment rendered, including the diagnosis. Please include any additional diagnostic information available to assist in determining benefits.

Information required only when clinical is requested.

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

Dental Records Standards

The provider is required to:

- Have all active dental records available for ODS Community Dental.
- Have a filing system that provides retrievable dental records.
- Maintain dental records for seven years after the date of service for which claims are made.
- Participating providers are required to release requested information to ODS Community Dental according to OAR 410-141-3520.

Fraud and abuse

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

Two common types of healthcare fraud include member and provider fraud.

Examples of member fraud include:

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

Examples of provider fraud include:

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

To ensure that you are not the victim of healthcare fraud:

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

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

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

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

Information obtained as part of a suspected fraud, waste or abuse investigation may be considered confidential. Any information used and/or developed by participants in the investigation of a potential fraud, waste and abuse occurrence is maintained solely for this specific purpose. ODS Community Dental assures the anonymity of complainants to the extent permitted by law.

Federal laws

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

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

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

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

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

Federal Program Fraud Civil Remedies Act: The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against people who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. Any person who makes, presents or submits, or causes to be made, presented or submitted, a claim that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil money penalties of up to \$5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

State laws

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

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

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

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

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

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

Confidentiality

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

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

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

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

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

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

ODS Community Dental staff adheres to HIPAA-mandated confidentiality standards. This is a summary of how we protect members' health information:

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

Release of information

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

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

For your convenience, a sample authorization form has been included at the back of this provider manual. A current authorization form and instructions on how to complete the form can be downloaded from the [ODS website](#).

Quality improvement

Program goal

At ODS Community Dental, the goal of our quality improvement (QI) program is to ensure delivery of appropriate, cost-effective and high-quality oral healthcare to our members.

Program objectives

- Implement review processes to evaluate dental aspects of care, such as:
 - Use of services
 - Adequacy of dental record keeping
 - Operation and outcome of referral process
 - Access (the appointment system, after-hours call-in system, etc.)
 - Grievance system
 - Encounter data management
- Continuously evaluate and identify opportunities for improving:
 - The quality of dental care and service delivery
 - Barriers to services at the plan and practitioner level
 - Communication within the organization, and between the organization and its practitioners and members
 - Member care through communication of QI activities to members and practitioners
- Identify and address education needs of practitioners and members
- Ensure compliance with regulatory requirements

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

QI committee

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

Scope of service

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

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

Dental health promotion and education

ODS Community Dental provides health promotion and education information for ODS Community Dental members and their families. The brochures listed below are available for your patients on the ODS website. You may print copies of these brochures for your patients or contact the ODS Community Dental Healthcare Services department at 503-948-5548, 877-277-7281 or by email at dentalcasemanagement@modahealth.com for a supply.

Tobacco cessation

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

We ask that you take an active part in helping members who are ready to quit tobacco to find the resources available to them. OHP members have benefits for tobacco cessation services through their OHP medical plan. Please help your patients who use tobacco by doing the following and documenting it in the chartnotes:

Ask, Advise, Assess, Assist, Refer

ASK about tobacco use at every visit.

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

ADVISE all tobacco users to quit.

Use clear, strong and personalized language. For example "Quitting tobacco is the most important thing you can do to protect your health."

ASSESS readiness to quit.

Ask every tobacco user if they are willing to quit at this time.

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

ASSIST tobacco users with a quit plan:

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

REFER OHP members:

- To their medical plan to arrange for quitting
- To the Oregon Tobacco Quit Line
 - Call these numbers for free from anywhere in Oregon:
1-800-QUIT-NOW (1-800-784-8669)
Español: 1-877-2NO-FUME (1-877-266-3863)
TTY: 1-877-777-6534
Or register online at: www.quitnow.net/oregon/ Español: www.quitnow.net/orwwegonsp/
The Quit Line is open seven days a week, 4 a.m. to 12 a.m. (Pacific Time)

ODS Community Dental referral request form

When submitting a referral request, please follow these instructions and submit all requested information via our website:

<https://www.odscommunitydental.com/providers/resources/referral-form>

Incomplete request forms and/or information may result in a denial of the referral. Detailed instructions by specialty, including information required for each referral type, is available below.

General instructions for the referral form:

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

Pediatric

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

Endodontic

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

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

Oral surgery

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

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

Periodontal

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

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

Please submit referral forms via our website:

<https://www.odscommunitydental.com/providers/resources/referral-form>

Forms, brochures and document links

Member Authorization

https://www.modahealth.com/pdfs/auth_phi.pdf

Missed appointment form

The number of missed appointments is to be established by the provider or PHP. The number must be the same for commercial members or patients. The provider must document they have attempted to determine the reason(s) for the missed appointments and to assist the OHP member in receiving services.

<https://www.odscommunitydental.com/providers/resources/missed-appointment-form>

Dental hospital referral

<https://www.odscommunitydental.com/providers/resources/referral-form>

OHA Financial Waiver

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

<https://www.odscommunitydental.com/odscommunitydental/-/media/odscommunitydental/pdfs/provider-resources/patient-responsibility-waiver-in-english.pdf>

Interpreter request form

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

<https://www.odscommunitydental.com/providers/resources/interpreter-request-form>

Contact information

Send dental claims to:

ODS Dental Claims
PO Box 40384
Portland, OR 97204

Send complaints and appeals to:

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

ODS Community dental customer service:

Provides information regarding benefits, eligibility, claim status, etc.
800-342-0526
Fax: 503-765-3297
dentalcasemanagement@modahealth.com

Dental professional relations:

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

Benefit Tracker (BT):

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

Electronic data interchange:

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

Health Systems MMIS System and AVR

(Provides information for OHP and eligibility requirements)
MMIS: <https://www.or-medicaid.gov/ProdPortal/Default.aspx>
Automated Voice Response: 866-692-3864

The most recent version of this handbook is available online at
<https://www.odscommunitydental.com/providers/resources>



Questions? Visit [ODSCommunityDental.com](https://www.odscommunitydental.com) or contact Customer Service at 800-342-0526 or Dental Provider Relations at 888-374-8905.