# Horizon NJ Health Dental Provider Manual, November 2014

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Dental Services: General Provisions

This manual describes the policies and procedures of Horizon NJ Health, a program of Horizon Blue Cross Blue Shield of New Jersey, that pertain to the provision of and reimbursement for medically necessary dental services to eligible individuals covered by Horizon NJ Health. In addition to the private office, dental services may be provided in the home, hospital and approved independent clinic.

Horizon NJ Health offers a full range of dental services to its members. These services include preventative, diagnostic, specialty and major restorative dental services. When necessary, orthodontics are also covered. Please refer to the Dental Benefit Grid on page 46.

Scion Dental administers dental services for Horizon NJ Health members.

For members eligible for dental benefits, services include the initial exam and any required dental services determined to be necessary. Horizon NJ Health coordinates all prior authorizations for the provision of inpatient dental services. Please contact Horizon NJ Health at the telephone number below to obtain more information about covered dental benefits:

Horizon NJ Health
1-855-878-5368

All claims for dental services should be mailed to:

Horizon NJ Health
PO Box 299
Milwaukee, WI 53201

Please contact the Horizon NJ Health Physician and Health Care Hotline at the telephone number below for information regarding Horizon NJ Health benefits and member eligibility:

Horizon NJ Health Physician and Health Care Hotline
1-800-682-9091

Policies and Procedures

Dental policies applicable to Horizon NJ Health members are contained in this manual and our website. To view the policies and procedures of this manual, and any changes, please refer to www.HorizonNJHealth.com. Click onto the For Providers tab and link to the Provider Resource Information, Clinical and Preventative Guidelines and Policies, Medical Policies then Dental Services.

Please be advised that Horizon NJ Health, under New Jersey law, has the right to make any changes to policies and procedures, including this Manual, which become effective 30 days after any changes are posted.

Glossary

The following words and terms, when used in this manual, will have the following meanings, unless the context clearly indicates otherwise.

Clinical laboratory services – Professional and technical laboratory services ordered by a dentist within the scope of practice as defined by the laws of the state in which the dentist practices and which are provided by a laboratory.

Concurrent care – A type of service rendered to a member by practitioners in which the dictates of dental necessity require the service of dentists of different specialties, in addition to the Primary Care Dentist, so that needed care can be provided.

Consultation – a service rendered by a qualified dentist, upon the request of another practitioner, in order to evaluate through personal examination of the member, history, physical finding and other ancillary means, the nature and progress of a dental or related disease, illness or condition and/ or to establish or confirm a diagnosis, and/ or to determine the prognosis, and/or suggest treatment. A consultation should not be confused with “referral for treatment” when one practitioner refers a member to another practitioner for treatment, either specific or general for example “Endodontic treatment on teeth Nos. 3 and 5,” or “Extract teeth Nos. 7, 8, 9 and 10,” or “Extract tooth or teeth causing pain.”

Dental review – the current, ongoing review of the degree of quality in the delivery of continuing dental services and health care, which is constantly monitored and maintained by the provision of direction, coordination and regulation.
Dental services – any diagnostic, preventative or corrective procedures administered by or under the direct personal supervision of a dentist in the practice or the practitioner’s profession, i.e., specialty. Such services include treatment of the teeth, associated structures of the oral cavity and contiguous tissues, and the treatment of disease, injury or impairment which may affect the oral or general health of the individual. Such services will maintain a high standard for quality and will be within the reasonable limits of those services which are customarily available, accepted by and provided to most persons in the community within the limitations and exclusions here in after specified.

Direct personal supervision – the actual physical presence of the dentist on the premises.

Emergency dental – a specific condition of the oral cavity and/or contiguous tissues which causes severe and/or intractable pain and/ or could compromise the life, health or safety of the member unless treated immediately. For example:

1. Pain or acute infection from a restorable or not restorable tooth.
2. Pain resulting from injuries to the oral cavity and related structures.
3. Extensive, abnormal bleeding.
4. Fractures of the maxilla or mandible or related structures or dislocation of the mandible.

General dentist or Primary Care Dentist – one who assumes responsibility for the primary and continuing dental care of the member.

Horizon NJ Health – a Medicaid managed care organization and a product of Horizon HMO.

Member – anyone enrolled and eligible to receive services provided by Horizon NJ Health.

Non-routine dental service – any dental service that requires prior authorization by a Horizon NJ Health dental consultant in order to be reimbursed by Horizon NJ Health.

Participating dentist – any dentist licensed to and currently registered to practice dentistry by the licensing agency of the state where the dental services are rendered, who accepts the promulgated requirements of the New Jersey Division of Medical Assistance and Health Services, and signs an agreement with Horizon NJ Health for the purpose of treating Horizon NJ Health members.

Peer Review – the evaluation by practicing dentists and other health care providers as to the quality and efficiency of services ordered and/or performed by other practicing dentists; also, the all-inclusive term for dental review efforts including dental practice analysis, inpatient hospital and extended care utilization review, and dental claims audit and review.

Prior authorization – approval by a Horizon NJ Health dental consultant before a service is rendered.

Program – the Horizon NJ Health Managed Dental Program.

Quality – the standard of dental care or degree of excellence generally prevailing throughout the profession by those who provide similar service, not related to any geographical area or population group, as judged by competent practitioners who are qualified to perform those procedures.

Referral – directing a member from one participating dentist to another for diagnosis and/or treatment. Referrals are not required for the purpose of claim payments.

Routine dental service – any dental service that is reimbursable by the program without authorization by a Horizon NJ Health dental consultant.

Short Procedure Unit number (SPU number) – a number required for all impatient procedures performed. The Utilization Management Department of Horizon NJ Health supplies this number.

Specialist – one who is licensed to practice dentistry in the state where treatment is rendered, who limits his or her practice solely to his or her specialty, which is recognized by the American Dental Association and is registered as such with the licensing agency in the state where the treatment is rendered.
Transfer – the relinquishing of responsibility for the continuing care of the member by one dentist and the assumption of such responsibility by another dentist.

Urgent dental care – care for a specific condition of the oral cavity and or contiguous tissues, which would not compromise the life, health or safety of the member if not treated immediately. For example:
- Fractured tooth with no pulpal involvement.
- Broken denture.
- Denture adjustments
- Recementation of a crown.

Utilization – that service, procedure, or item provided to a member by a qualified physician or health care professional, in a setting, at a time and in an amount which is appropriate and acceptable to the standards of the profession.

Utilization Review – the retrospective analysis of the performance of a dentist for evaluation of the efficient provision of dental services.
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Provisions for Participation

(a) Any Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS), authorized to provide dental and surgical services by the state of New Jersey, and approved by Horizon NJ Health in accordance with section (b) below, and who complies with the policies and procedures of Horizon NJ Health and Horizon NJ Health, will be eligible to provide dental and surgical dental services to Horizon NJ Health members.

Any out-of-state dentist may provide dental and surgical services under this Program if he or she meets the documentation and licensing requirements in the state in which he or she is practicing and is a Horizon NJ Health participating dentist.

(b) In order to participate in the Horizon NJ Health dental program, a dental practitioner will apply to and be credentialed by Horizon NJ Health. An applicant will complete and submit the Application and the “Horizon NJ Health Provider Agreement” (Horizon NJ Health Amendment) and other related documents by sending them to the following address or fax:

Horizon NJ Health
Attn: Credentialing
N92W 14612 Anthony Ave
Menomonee Falls, WI 53051
Fax: 866-396-5686
Email: credentialing@sciondental.com

Credentialing application process may be completed on our website www.credentialingportal.com.

(c) Upon signing and returning the Provider Application, the Provider Agreement and other enrollment documents to Horizon NJ Health, the dentist will receive written notification of approval or disapproval.

Credentialing

Horizon NJ Health considers the use of effective screening and credentialing criteria an important tool for maintaining the quality of its provider network. Horizon NJ Health complies with state, regulatory and accrediting body standards for credentialing of its physician and health care professional network. Participants must provide information on:

- Education/ training
- Current state licensure
- For oral surgeons, full admitting privileges at Horizon NJ Health participating hospitals
- New Jersey Controlled Drug Substance (CDS) and Drug Enforcement Agency (DEA) Certificates
- Information regarding breaks in practice/training
- Current adequate professional liability insurance (malpractice)
- Satisfactory history of malpractice claims and settlements
- Satisfactory National Practitioner Data Bank inquiry
- Satisfactory inquiry of New Jersey Treasury and federal Office of Inspector General (OIG) Web sites
- Copy of a written certification to perform anesthesia, intravenous sedation and analgesia, if applicable
- Work history
- Any sanctions imposed by Medicare and/or Medicaid
- Any censure by the State Board of Dental Examiners
- Physical/mental health, history of chemical dependency/substance abuse, loss of license and/or felony convictions, loss or limitation of hospital privileges or disciplinary activity, and an attestation to the correctness and completeness of the information submitted

Horizon NJ Health may utilize the services of an external Credentialing Verification Organization to meet State requirements. Cooperation with such services is required of all dentists applying for participation in the program. Failure to do so will result in the application being denied by the Horizon NJ Health Credentialing Committee.

In addition, your cooperation is required in connection with site reviews which are conducted on all primary and specialty care offices to ensure that our members are receiving treatment in an appropriate, clean, and safe environment that respects our members’ privacy. An initial site visit is required in conjunction with credentialing and every three years thereafter. Reviews of dental records may be conducted after six months’ participation with Horizon NJ Health to ensure that all records are in compliance with our dental record-keeping standards.
Recredentialing

Recredentialing of participating dentists is required by Horizon NJ Health every three years. This process will include a review and update of all credentialing information as well as the following:

- Correspondence between the dental program and the dentist or health care professional
- Utilization management and quality reviews
- Compliance with Horizon NJ Health and Horizon NJ Health policies and procedures
- Patient satisfaction or complaint response information
- Other pertinent data

Cultural Competency

Dentists and other health care professionals will demonstrate cultural competency in the following ways:

- Assess members and document in the medical record the presence of cultural and/or language barriers to care
- Seek information from members, families and/or community resources to assist in servicing and responding to the needs and preferences of culturally and ethnically diverse members and families

- Display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of members and families
- Provide magazines, brochures and other printed materials that reflect diverse cultures in waiting areas
- Understand that folk and religious beliefs may influence how families respond to illness, disease, death and their reaction and approach to a child born differently-abled
- Understand that the family unit can be defined differently by different cultures
- Whenever possible, seek to employ bilingual staff or trained personnel to serve as interpreters
- Understand that a member and/or family’s limitation in English proficiency is in no way a reflection of their level of intellectual functioning
Provider Services website

Horizon NJ Health Provider Services website allows participating providers direct access to our Enterprise System benefits administration software. Taking advantage of the online services offered through the provider website lowers program administration and participation costs for providers.

All that’s required is online access to the Internet Explorer web browser and a valid user ID and password. From Internet Explorer, providers and authorized office staff can log in for secured access to the system anytime from anywhere and handle a variety of day-to-day tasks, including:

- Verify member eligibility
- Set up office appointment schedules that automatically verify eligibility and prepopulate claim forms for online submission
- Submit claims for services rendered by simply entering procedure codes, relevant tooth numbers, etc.
- Submit authorization requests, using interactive clinical algorithms when appropriate
- Check the status of submitted claims and authorizations
- Review provider clinical profiling data relative to peers
- Download and print provider manuals
- Send electronic attachments, such as digital X-rays, EOBs and treatment plans
- Check patient treatment history for specific services
- Upload and download documents using a secure encryption protocol
The Horizon NJ Health provider web portal services allow us to maintain our commitment of helping you keep your office costs low, access information efficiently, get paid quicker and submit claims and authorizations electronically.

Registration

To register for our provider web portal, visit www.horizonnjhealth.com and click on the provider login link; once at the login page, click on the Register Now link.

You do not need to download or purchase software.

To obtain electronic use of our provider web portal, you only need Internet access and a unique user name and password.

- Register as a payee so you will have the option to view remittances and be paid electronically. (Horizon NJ Health will provide you with your unique payee ID.)

Contact Customer Service at 1-855-878-5368 to obtain your payee ID number.
**Introduction**

Once registered, you can navigate through the web portal and use the available resources and features to help streamline data entry.

**Verify Member Eligibility**

- One-step member eligibility verification
- Verification of dental treatment history

**Navigate to Manage Rosters**

- Verify multiple members at one time
- Create member rosters to help organize member information
Manage Claims

- Submit claims for services performed
- Review and print or save a list of claims submitted today for your records before they are sent on for processing
- Check the status of previously submitted claims
- Enter additional information such as NEA number under the Notes tab

![Claim Entry Screen](image1)

![Claims Screen](image2)
Manage Authorizations

- Submit authorizations for approval before performing services
- Attach electronic files, including X-rays and review authorizations submitted today – before they are sent on for processing
- Enter additional information such as NEA number under the Notes tab
- Check the status of previously submitted authorizations
From an authorization summary, you can:

- Run any applicable authorization guidelines
- Review a list of documentation required for each covered service
- Attach electronic files to the authorization record
- Attach clearinghouse reference information to the authorization record
- See the authorizations that have been submitted and may review and edit these authorizations
- Print a copy of the authorization summary for your records

Authorization Status:

- Auth Status search can be done by the following information:
  - Service Date or Entered Date
  - Auth State (Open or Finalized)
  - Member ID # or Name & DOB
Electronic Funds Transfers

The Horizon NJ Health provider web portal services allow us to give you faster payments by Electronic Funds Transfers (EFTs). The electronic payment offers a direct deposit into your account and allows you to obtain remittances faster on your online account.

To obtain your online remittances, navigate to the Manage My Documents page from the documents tab on the toolbar or by the link on the main page.

To enroll in EFT payment, please complete the following page and return to Horizon NJ Health via:

- Fax: 262.721.0722; e-mail: providerservices@sciondental.com;
  or mail: Provider Services, PO Box 170 Milwaukee, WI 53201
- Register for Electronic Funds Transfer to receive paper checks and online remittance statements
# Electronic Funds Transfer Authorization Agreement

To enroll in Horizon NJ Health Electronic Funds Transfer payment program, please fill out this form and return via:

**Mail:** Horizon NJ Health  
PO Box 170  
Milwaukee, WI 53201  

**Fax:** 262-721-0722

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### Part I - Reason for Submission

- [ ] New EFT Authorization  
- [ ] Revision to current EFT setup (i.e. account/bank change)

### Part II - Provider or Supplier Information

**Name of Payee:**

**Tax Identification Number:**  
- SSN  
- EIN

**Address of Payee:**

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### Part III - Depository Information (Financial Institution)

**Bank/Depository Name:**  
- Checking  
- Savings

**Depository Routing Number (nine digits - include any leading zeros):**

**Depository Account Number (include any leading zeros):**

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### Part IV - Billing Contact Information

**Name:**

**Phone Number:**

**E-mail Address:**

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### Part V - Authorization

I hereby authorize Horizon NJ Health to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTRACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

**Signature of Authorized Billing Contact**  
**Date**
**Dental Program Effective Date**

Horizon NJ Health offers a full range of dental services to its membership, in accordance with the provisions of dental benefit package. These services begin on the member’s effective date.

**Determining Eligibility**

The Horizon NJ Health member identification (ID) card cannot be accepted as sole verification of a member’s eligibility to receive benefits. ID cards do not list an expiration date and are not always returned when a member’s coverage terminates. A member must present his/her Horizon NJ Health ID card and the New Jersey Medicaid Health Benefit ID card (HBID).

At the time of a member’s visit, follow the steps below to verify eligibility:

1. Ask for the member’s Horizon NJ Health Member ID card and his/her HBID.
2. Make a copy of both sides of the cards for the member’s patient file.
3. Call the Horizon NJ Health Physician and Health Care Hotline to verify eligibility. Failure to check eligibility may result in claim denials if the member was not eligible for benefits on the date of service.

**Horizon NJ Health Physician and Health Care Hotline**

1-800-682-9091

**Member Identification Card**

Members enrolled with Horizon NJ Health will receive a blue and white Horizon NJ Health ID card, in addition to the HBID card provided by the state. Patients should be asked to present the Horizon NJ Health ID card to aid you in:

- Checking eligibility.
- Coordinating admissions.
- Delivery of service(s).
- Filing claims for final billing.
- Collecting copayments (NJ FamilyCare C and D only).

Be sure to make a copy of both sides of the member’s ID card when it is presented by the member.

Horizon NJ Health member identification cards contain the following information:

- Member name
- Member identification number
- Primary Care Physician’s (PCP) name and phone number
- Coverage effective date
- Copayment amounts (NJ FamilyCare only)
- Status of member dental coverage (covered/not covered)
- Mailing address for dental claims appears on the back of the card

Samples of the Horizon NJ Health Medicaid, NJ FamilyCare and MLTSS (Managed Long Term Services and Support) membership cards are shown. Please note that Horizon NJ Health codes 280/780 and YHZ before the member ID number should be disregarded. Horizon NJ Health dentists are not required to include a prefix.
Always carry this ID card. You must use your selected Primary Care Provider (PCP) for medical care. Members with Medicare Advantage or other insurance must see that plan’s PCP. If you need to see a Specialty doctor, you must get a referral from your PCP. You do not need a referral to see a Horizon NJ Health Eye Doctor, Dentist, OB/GYN provider, get ER care or a mammogram. Refer to the member handbook for specific coverage information.

**EMERGENCIES** - If you are having an emergency, call 911. If you get emergency care, you should follow up with your PCP within 24 hours or as soon as possible.

www.horizonNJhealth.com

**NJ FamilyCare**

Always carry this ID card. You must use your selected Primary Care Provider (PCP) for medical care. Members with Medicare Advantage or other insurance must see that plan’s PCP. If you need to see a Specialty doctor, you must get a referral from your PCP. You do not need a referral to see a Horizon NJ Health Eye Doctor, Dentist, OB/GYN provider, get ER care or a mammogram. Refer to the member handbook for specific coverage information.

**EMERGENCIES** - If you are having an emergency, call 911. If you get emergency care, you should follow up with your PCP within 24 hours or as soon as possible.

www.horizonNJhealth.com

**MLTSS**

Always carry this ID card. You must use your selected Primary Care Provider (PCP) for medical care. Members with Medicare Advantage or other insurance must see that plan’s PCP. If you need to see a Specialty doctor, you must get a referral from your PCP. You do not need a referral to see a Horizon NJ Health Eye Doctor, Dentist, OB/GYN provider, get ER care or a mammogram. Refer to the member handbook for specific coverage information.

**EMERGENCIES** - If you are having an emergency, call 911. If you get emergency care, you should follow up with your PCP within 24 hours or as soon as possible.

www.horizonNJhealth.com
General Dentistry Services

The general dentist is responsible for the provision of primary dental services. The general dentist agrees to make himself/herself available on a 24-hour, seven day per week basis via the use of:

- Answering service
- Covering dentist

Routine appointments will be made available within four weeks of the member’s call. Appointments for urgently needed care will be made available within 72 hours.

Emergency Care

Emergency care should be made available immediately and is to be given to any member in acute distress or pain at any time of the day or night. See definition of “Emergency Dental” on page 2.

After-Hours Calls

All after-hours calls for dental emergencies are received by the Horizon NJ Health Provider Services department at 1-800-682-9091, which communicates the requested need(s) to the appropriate After-Hours Horizon NJ Health Nurse via the after-hours cell phone. The After-Hours Nurse will triage the member and determine if a true emergency exists based on the following criteria:

- Severe pain
- Swelling
- Bleeding

If the After-Hours Nurse determines a true emergency exists, the nurse will place a call to the After-Hours Dentist who is on call. The on-call After-Hours Dentist will obtain all pertinent information from the After-Hours Nurse and contact the member to provide clinical instructions. After-hour responsibilities may include, but are not limited to, authorization of emergent/urgent care and/or other program-specific case management activities. After-hours staff will document all authorizations and track the activities of all related parties via the dental case management system.

Urgent Care

Urgent care patients must be seen within 72 hours. See definition of “urgent dental care” on page 3.

Corrective Action

Horizon NJ Health is committed to working cooperatively with participating physicians, dentists and other health care professionals to resolve any identified areas of noncompliance with administrative standards, quality improvement activities and/or state-mandated reviews. When a compliance problem is identified, the Dental Director or designee will contact the provider to discuss the situation and confirm the provider’s awareness of the appropriate policies and procedures.

Appointment Scheduling Standards

State-mandated appointment scheduling standards help ensure timely access to quality dental care. Compliance with these standards will be audited using periodic onsite reviews of offices and chart sampling, member satisfaction surveys and random telephone surveys of participating offices.

These are the standards for optimal scheduling of appointments:

- Appointments for routine dental care will be provided within four weeks
- Appointments for urgent care will be provided within 72 hours
- Emergency care will be provided immediately
Office Practice Standards for General Dentists

The state requires the following Office Practice Standards for Primary Care Dentists. Compliance with these standards will be audited by periodic onsite reviews of offices and chart sampling and member satisfaction surveys.

• General dentist will render dental care services within a reasonable amount of time from the time of scheduled appointment (45 minutes).
• General dentist will implement and document a policy to track missed appointments and to follow up for rescheduling and/or continuity of care issues.
• General dentist will render dental care in an office environment that meets OSHA and CDC standards.

Outpatient Procedures

When it has been determined by the physician, dentist or health care professional that a patient needs dental services performed at a surgical facility, a Short Procedure Unit (SPU) authorization number is needed.

The office should submit a prior authorization request listing the dental services that are planned to be performed in such a setting as well as code D9999. The completed General Anesthesia Checklist should accompany such requests as well. Please attach a letter of necessity including member’s name and Horizon NJ Health identification number, and, if the member is a minor, name of parent(s) or guardian(s). Please fax these requests to (866) 899-6186.

The physician, dentist or health care professional may be contacted to determine necessity. Once necessity is determined, a SPU number will be assigned to the patient. Upon completion of the dental treatment, the appropriate procedures should be billed to Horizon NJ Health using an ADA 2012 Claim Form.

Recordkeeping Requirements

Dentists are required to maintain individual records, which fully disclose the type and extent of services provided to the Horizon NJ Health member.

These records, which should include details of all services rendered for each encounter date, will be available and maintained in accordance with state law.

Such member records will be maintained in the dentist’s office regardless of the actual place of service (dental office, long-term care facility or hospital). These records will be available for a minimum of seven years following the last date of service, per state requirements.

The dentist will also document services in facility records as required below. Such information will be readily available to representatives of Horizon NJ Health or its agents as required.

The record will include, but not be limited to, the following:

1. The name, address and telephone number of the member, the member’s date of birth and Horizon NJ Health identification number, and, if the member is a minor, name of parent(s) or guardian(s).
2. Pertinent dental/medical history.
3. Detailed clinical examination data to include, where applicable:
   • Member’s chief complaint
   • Diagnosis
   • Cavities
   • Missing teeth (periodontal charting when necessary)
   • Abnormalities
4. Preoperative, progressive and postoperative radiographs retained in accordance with state law for a minimum of seven years following the last date of service. Professional liability insurance companies should be contacted for possible retention for longer periods. The number and type of radiographs should be entered on the member’s record. Postoperative radiographs should be taken only when dentally necessary and must have diagnostic value.
5. Treatment plan with description of treatment rendered to include:
   a. Tooth number
   b. Surfaces involved
   c. Site and size of treatment area
      (lesion, laceration, fracture, etc.)
d. Materials used  

e. Date(s) of service(s)  

f. Description of treatment or services rendered at each visit to include the name of the dentist or hygienist rendering it  

g. All medications  

h. Diagnostic laboratory and/or radiographic procedure(s) ordered, including result(s)  

i. Copy of the dental prosthetic work authorization(s) (prescription[s]), and dental prosthetic laboratory receipt(s)  

j. Explanation for any duplication of services within one year (Prosthetic services within seven and one-half years)  

k. Reasons for discontinuation of services (including attempts to complete treatment)  

l. Referral and consultation reports  

6. Any cultural or linguistic needs of the patient must be clearly documented.  

A complete description of treatment, as noted above, will also be entered into a hospital’s clinical records for any member treated at that facility. These entries must also satisfy that hospital’s specific regulations.  

A dentist who provides services for a nursing facility member (regardless of the place of service) will, in addition to maintaining his or her own office records, provide the nursing facility with an entry for the member’s clinical record that includes the following:  

- The results of an examination which will establish an admission record of the member’s dental status. If a current examination is required within six (6) months of a previous examination performed by the same physician or health care professional and billed to Horizon NJ Health, the results of the original examination will be entered into the clinical record as the current dental status.  

- A time frame, established on an individual basis, for the next periodic examination of the member. The time frame will be documented either at the time of examination or at the completion of treatment. For example, it may be entered on the clinical record for six months, one year, two years, three years or any other time period that the attending dentist has established per his/her knowledge of the member and the member’s dental status.  

• A record of dental treatment provided at each encounter. A photocopy of the completed and signed ADA 2012 Claim Form for examination and treatment will be accepted in lieu of a separate entry only if treatments (visits and description thereof) that preceded or followed the “dates of service” entered on the ADA 2012 Claim Form are listed separately on the member’s clinical record in addition to the record keeping requirements described in this section.  

Standards of Service  

The level of care specified in the dental treatment plan will be in accordance with the ethical and professional standards of the dental profession and meet the same high standard of quality provided to the community at large.  

All materials used, and all therapeutic agents used or prescribed, will meet the specifications established by the American Dental Association.  

Experimental procedures that are not approved by the New Jersey Board of Dental Examiners are not reimbursable by Horizon NJ Health.  

When an emergency arises and consultation with the attending practitioner is impossible, due consideration will be given to the preservation of those teeth that could be involved in the overall treatment plan of the attending practitioner.  

Special Standards of Services  

Dental services for which no specific provisions are made (or which are limited or prohibited in these policies and procedures) may be considered on an individual basis. Such a request should be forwarded to:  

Horizon NJ Health  
P.O. Box 362  
Milwaukee, WI 53201  

The request must be accompanied by all supporting documentation.
Place of Service

In addition to the private office, dental services may be provided in a hospital, approved independent clinic or other facility. Services performed in hospital and surgical center outpatient dental clinics require prior authorization and are subject to the same Horizon NJ Health policies, procedures and reimbursement schedule, as outlined in this manual, that apply to the dentist in “private” practice.

Services should be provided in any appropriate setting, governed by medical/dental necessity and not by the convenience or desires of the member or the provider(s) of service.

- Dental services performed on an inpatient basis in approved, licensed hospitals are reimbursable as long as these services require that level of care. This must be documented on the hospital records. Dental services are also reimbursable if the member is admitted for an eligible non-dental condition and the dental services are rendered as part of the prescribed treatment for such condition, or to alleviate the member’s discomfort during the period of hospitalization.

  1. Admission may be by the dentist or by a physician depending on the by-laws of the individual hospital.
  2. Authorization by a Horizon NJ Health dental consultant is for services only and does not authorize the place of service; thus, such authorization does not guarantee payment.

Visitation Policies

A physician, dentist or health care professional may be reimbursed for a house call (procedure code D9410) in addition to any other services provided on that day.

Reimbursement for hospital calls (procedure code D9420) can be billed for an inpatient or outpatient hospital visit, in addition to any other dental services provided on that day, and will be billed in accordance with the following:

1. Procedure code D9420 is not reimbursable if billed in conjunction with a consultation or other hospital calls on the same day.

2. For a dentist to be reimbursed for an initial hospital call or same day surgery, the hospital record must include, at minimum:
   a. The chief complaint(s).
   b. A complete history of the present illness and related systematic review including recording of pertinent negative findings.
   c. A complete pertinent past medical history.
   d. Pertinent family history.
   e. A description of a full examination pertaining to the history of the present condition, including the recording of pertinent negative findings.
   f. A record of a working diagnosis and treatment plan, and preparation of an “order sheet.”

3. If a history and examination required for reimbursement for procedure code D9420 is not personally performed by the billing practitioner, the dentist or health care professional should bill for procedure code D9420 (hospital call), provided the criteria for that code are met.

4. An initial hospital call or same-day surgery call (D9420) will not be reimbursed for the same member if the same practitioner, members of a same group, members of a shared health care facility or practitioner sharing a common record also bill for this procedure code.

5. An initial hospital call or same-day surgery call (D9420) will not be reimbursed in conjunction with a consultation (D9310) for same hospital admission and/or stay, if billed by the same practitioner, members of the same group, and members of a shared health care facility or practitioner sharing a common record.
Basis for Reimbursement

If a member receives care from more than one provider as part of a partnership or corporation in the same discipline for the same service, the total maximum payment allowance would be the same as that for a single attending dentist. The allowance fee for a given service will be considered full payment. No additional charge made by the dentist or on behalf of the covered Horizon NJ Health member will be accepted.

A fee will be paid only for eligible services rendered. If an eligible member does not complete the treatment plan, only those services already provided will be billed.

If a health care professional cannot complete a service and/or an authorized appliance for an eligible member, due to circumstances over which he or she has no control, Horizon NJ Health will reimburse the provider an amount consistent with the stage of completion of the authorized service and/or appliance. The stage of completion of the service should be detailed on the ADA 2012 Claim Form; in the case of an appliance, denture or crown, the case (to the point of completion) will be forwarded to a Horizon NJ Health dental consultant for proration. The case will be returned to the physician or health care professional and will be retained for at least one year pending possible return of the member.

Horizon NJ Health may authorize partial reimbursement for an appliance that is completed, but not delivered, to the member because of circumstances beyond the control of the physician or health care professional. An amount equivalent to the professional component for inserting and, adjusting the appliance will be deducted from the total reimbursement for such appliance. In the event the member returns and the service is completed, the physician or health care professional may request reimbursement for the deducted amount. Procedures as outlined above will apply.

Reimbursement is not made for (and members may not be asked to pay for) broken appointments.

Reimbursement for dental treatment can only be made during the period of member eligibility. Exception: The following treatments, if authorized and in the process of being rendered while the member is eligible, may be completed after the termination of the member’s eligibility.

Payment will be allowed if all services are completed within 60 calendar days after the termination of the member’s eligibility:

- Prostheses (including, for example, dentures, crowns, space maintainers and appliances) that are actually in the process of fabrication.
- Extractions and ancillary services such as general anesthesia and radiographs in conjunction with the insertion of an immediate denture when initial impressions have been taken during the period of eligibility.
- Endodontic treatment if pulp has been extirpated, as well as those services necessary to complete the restoration of that tooth, such as filling restoration(s) or post and core and crown, if authorized during a period of eligibility.

Despite what may be stated in other parts of this manual, payment may be made for dentures furnished after termination of eligibility where the last tooth in any specific arch is extracted during the period of eligibility.

- A denture, complete or partial, may be furnished in the opposing arch if it meets the guidelines of the program as specified in this chapter and is authorized in conjunction with the above denture.
- In order to obtain reimbursement for this denture(s), the primary impressions(s) must be initiated within 120 days and the denture(s) inserted within 180 days after the extraction of the last tooth. Authorization procedures set forth in this manual are applicable.

For immediate dentures, similar to provisions for dentures inserted subsequent to the healing period, prior authorization must have been obtained during the eligibility period, and all preliminary extractions completed during that same period. Authorized complete or partial dentures in conjunction with immediate replacement codes should be completed within 180 days of termination of eligibility.

- A denture, complete or partial, may be furnished in the opposing arch as described if it meets the guidelines of the program as specified in this manual and is authorized in conjunction with the above denture.
- In order to receive reimbursement for this denture(s), primary impression(s) must be initiated within 120 days and the denture inserted 180 days after the last preliminary extraction. Prior authorization procedures set forth in this manual are applicable as described.
Coordination of Benefits

Under the coordination of benefits policy, any service provided to a Horizon NJ Health member is reviewed against benefits provided for that same individual under other insurance carriers with whom the member has coverage.

The purpose of the coordination of benefits policy is to avoid duplication of benefit payments and to ensure that Medicaid and Horizon NJ Health are the payer of last resort.

Horizon NJ Health, as a Medicaid managed care company, is the “payer of last resort” on claims for services provided to those who have third-party insurance coverage including Medicare. In cases where another insurer is deemed responsible for payment, Horizon NJ Health will pay any applicable amounts up to the Horizon NJ Health fee allowance.

When you provide services to a member under these circumstances, you should bill the member’s primary insurance carrier directly. Make sure that you follow that insurer’s standard claim submission policies and forms. Upon receipt of payment, you should submit a claim form and the primary insurer’s explanation of benefits.

Coordination of benefits claims should be submitted to:

Horizon NJ Health
P.O. Box 299
Milwaukee, WI 53201

Non-covered Services

A non-covered service is any procedure that is done primarily for cosmetic purposes, for which dental necessity cannot be demonstrated, or is determined to be beyond the scope of the Program by our dental consultant as specified in the member’s benefit package.

Medical/dental supplies, equipment and other devices that are essential for the member’s medical/dental condition are allowable unless otherwise available at no charge from community services (such as the American Cancer Society or other service organizations).

Standard toothbrushes, dental floss and like items are considered personal hygiene items and are not covered by the Program.

Claim Form Submission (Fee-for-Service) Services

Submission of claims will be the responsibility of the individual dentist or group entity, whichever applies. Each Horizon NJ Health participating dentist is required to complete and submit a claim for each member treated. The ADA 2012 Claim Form provides a mechanism for Horizon NJ Health to monitor dental services rendered to its members and process claims from participating dentists.

A sample of the ADA Claim Form is on the following page. In the event that your ADA 2012 Claim Form supply is depleted, you can go online at www.adacatalog.org to obtain a printable form.
ADA American Dental Association® Dental Claim Form

**HEADER INFORMATION**
1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services  [ ] Request for Predetermination/Preauthorization
   - [ ] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)
- 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
- 13. Date of Birth (MM/DD/CCYY)
- 14. Gender
- 15. Policyholder/Subscriber ID (SSN or ID#)

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**
- 3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)
- 4. Dental?  [ ] Medical?  [ ] (If both, complete 5-11 for dental only.)
- 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
- 6. Date of Birth (MM/DD/CCYY)
- 7. Gender
- 8. Policyholder/Subscriber ID (SSN or ID#)

**PATIENT INFORMATION**
- 16. Plan/Group Number
- 17. Employee Name

**RECORD OF SERVICES PROVIDED**
- 21. Date of Birth (MM/DD/CCYY)
- 22. Gender
- 23. Patient ID/Account # (Assigned by Dentist)
- 24. Procedure Date (MM/DD/CCYY)
- 25. Area of Oral Cavity
- 26. Tooth Number(s) or Letter(s)
- 27. Tooth Surface
- 29. Procedure Name
- 30. Description
- 31. Fee

**AUTHORIZATIONS**
- 32. Total Fee

**ANCILLARY CLAIM/TREATMENT INFORMATION**
- 33. Missing Teeth Information (Place an "X" on each missing tooth.)
- 34. Diagnosis Code(s)
  - A _________________ C _________________ (ICD-9 = B; ICD-10 = AB)
  - B _________________ D _________________
- 34a. Diagnosis Code(s)
- 35. Remarks

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)
- 48. Name, Address, City, State, Zip Code

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**
- 49. NPI
- 50. License Number
- 51. SSN or TIN

**AUTHORIZATION INFORMATION**
- 52. Phone Number

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)
- 53. Date of Birth (MM/DD/CCYY)
- 54. Gender
- 55. Policyholder/Subscriber ID (SSN or ID#)

**POLICYHOLDER/SUBSCRIBER INFORMATION**
- 56. Plan/Group Number
- 57. Employee Name

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**
- 58. Phone Number

©2012 American Dental Association
J4300 (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

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Prior Authorization Procedure

All dental services requiring prior authorization should be submitted to:

Horizon NJ Health
P.O.Box 362
Milwaukee, WI 53201

Consideration for prior authorization will be based on the least costly appliance that fulfills the requirements of the specific situation or the extenuating circumstances. Those services that require prior authorization are defined as “non-routine services.” Prior authorization requests cannot be transferred from one dentist to another.

How to Submit Dental Claims Requiring Prior Authorization

Prior authorization request forms with applicable X-rays should be submitted to Horizon NJ Health. Do not staple X-rays to form. A copy of all dental prior authorization forms should be maintained by the dentist.

Prior authorization request forms received by Horizon NJ Health will be reviewed by the dental consultant. Upon completion of the review, the dentist will be notified of a decision in writing. All questions concerning prior authorizations may be directed to:

Horizon NJ Health
PO Box 362
Milwaukee, WI 53201

Or call:
1-855-878-5368
# Services Requiring Prior Authorization

(Subject to change, which will be updated on the Horizon NJ Health website).

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<td>Date of initial apexification visit, fill x-ray with claim</td>
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<tr>
<td>Code</td>
<td>Code Description</td>
<td>Required Documents</td>
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<td>Pre-op x-rays, peri charting, narrative of medical necessity, photo (optional)</td>
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<td>Pre-op x-rays, peri charting, narrative of medical necessity, photo (optional)</td>
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<td>Pre-op x-rays, peri charting, narrative of medical necessity, photo (optional)</td>
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<td>Provisional Splinting - Intracoronal</td>
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<td>Excision Of Malignant Lesion, Complicated</td>
<td>Copy of pathology report with claim</td>
</tr>
<tr>
<td>D7441</td>
<td>Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm</td>
<td>Copy of pathology report with claim</td>
</tr>
<tr>
<td>D7450</td>
<td>Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm</td>
<td>Copy of pathology report with claim</td>
</tr>
<tr>
<td>D7451</td>
<td>Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm</td>
<td>Copy of pathology report with claim</td>
</tr>
<tr>
<td>D7460</td>
<td>Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm</td>
<td>Copy of pathology report with claim</td>
</tr>
<tr>
<td>D7461</td>
<td>Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm</td>
<td>Copy of pathology report with claim</td>
</tr>
<tr>
<td>D7810</td>
<td>Open Reduction Of Dislocation</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7820</td>
<td>Closed Reduction Of Dislocation</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7830</td>
<td>Manipulation Under Anesthesia</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7840</td>
<td>Condylectomy</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7850</td>
<td>Surgical Disectomy, With/Without Implant</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7852</td>
<td>Disc Repair</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7854</td>
<td>Synovectomy</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7856</td>
<td>Myotomy</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7858</td>
<td>Joint Reconstruction</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7860</td>
<td>Arthroscopy</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7865</td>
<td>Arthroplasty</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7870</td>
<td>Arthrocentesis</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7871</td>
<td>Non-Arthroscopic Lysis And Lavage</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7872</td>
<td>Arthroscopy - Diagnosis, With Or Without Biopsy</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7873</td>
<td>Arthroscopy - Surgical: Lavage And Lysis Of Adhesions</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7874</td>
<td>Arthroscopy - Surgical: Disc Repositioning And Stabilization</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>Code</td>
<td>Code Description</td>
<td>Required Documents</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D7875</td>
<td>Arthroscopy - Surgical: Synovectomy</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7877</td>
<td>Arthroscopy - Surgical: Debridement</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7880</td>
<td>Occlusal Orthotic Device, By Report</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7910</td>
<td>Suture Of Recent Small Wounds Up To 5 Cm</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7911</td>
<td>Complicated Suture - Up To 5 Cm</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7912</td>
<td>Complicated Suture - Greater Than 5 Cm</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7920</td>
<td>Skin Graft (Identify Defect Covered, Location And Type Of Graft)</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7940</td>
<td>Osteoplasty - For Orthognathic Deformities</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7941</td>
<td>Osteotomy - Mandibular Rami</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7943</td>
<td>Osteotomy - Mandibular Rami With Bone Graft: Includes Obtaining The Graft</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7944</td>
<td>Osteotomy - Segmented Or Subapical</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7945</td>
<td>Osteotomy - Body Of Mandible</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7946</td>
<td>Lefort I - (Maxilla - Total)</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7947</td>
<td>Lefort I - (Maxilla - Segmented)</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7948</td>
<td>Lefort Ii Or Lefort Iii (Osteoplasty Of Facial Bones) - Without Bone Graft</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7949</td>
<td>Lefort Ii Or Lefort Iii - With Bone Graft</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7950</td>
<td>Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7951</td>
<td>Sinus Augmentation With Bone Or Bone Substitutes</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7955</td>
<td>Repair Of Maxillofacial Soft And/Or Hard Tissue Defect</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7960</td>
<td>Frenulectomy - Also Known As Frenectomy Or Frenotomy - Separate Procedure</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7963</td>
<td>Frenuoplasty</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7970</td>
<td>Excision Of Hyperplastic Tissue - Per Arch</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7971</td>
<td>Excision Of Pericoronal Gingiva</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D7972</td>
<td>Surgical Reduction Of Fibrous Tuberosity</td>
<td>Narrative of medical necessity, xrays or photos optional</td>
</tr>
<tr>
<td>D8010</td>
<td>Limited Orthodontic Treatment Of The Primary Dentition</td>
<td>Narrative, GD attestation, photos, x-rays</td>
</tr>
<tr>
<td>D8020</td>
<td>Limited Orthodontic Treatment Of The Transitional Dentition</td>
<td>Narrative, GD attestation, photos, x-rays</td>
</tr>
<tr>
<td>D8030</td>
<td>Limited Orthodontic Treatment Of The Adolescent Dentition</td>
<td>Narrative, GD attestation, photos, x-rays</td>
</tr>
<tr>
<td>D8040</td>
<td>Limited Orthodontic Treatment Of The Adult Dentition</td>
<td>Narrative, GD attestation, photos, x-rays</td>
</tr>
<tr>
<td>D8050</td>
<td>Interceptive Orthodontic Treatment Of The Primary Dentition</td>
<td>HLD score sheet, narrative, trmt plan, GD attestation, photos, x-rays, med narr if applicable</td>
</tr>
<tr>
<td>D8060</td>
<td>Interceptive Orthodontic Treatment Of The Transitional Dentition</td>
<td>HLD score sheet, narrative, trmt plan, GD attestation, photos, x-rays, med narr if applicable</td>
</tr>
<tr>
<td>D8070</td>
<td>Comprehensive Orthodontic Treatment Of The Transitional Dentition</td>
<td>HLD score sheet, narrative, trmt plan, GD attestation, photos, x-rays, med narr if applicable</td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive Orthodontic Treatment Of The Adolescent Dentition</td>
<td>HLD score sheet, narrative, trmt plan, GD attestation, photos, x-rays, med narr if applicable</td>
</tr>
<tr>
<td>D8120</td>
<td>Removable Appliance Therapy</td>
<td>Treatment plan and narrative of medical necessity</td>
</tr>
<tr>
<td>D8220</td>
<td>Fixed Appliance Therapy</td>
<td>Treatment plan and narrative of medical necessity</td>
</tr>
<tr>
<td>D8670</td>
<td>Periodic Orthodontic Treatment Visit (As Part Of Contract)</td>
<td>Trmt notes, doc of compliance, GD attestation, photos, panorex, copy of initial approval if applicable</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic Retention (Removal Of Appliances, Place Retainers)</td>
<td>Diagnostic quality post trmt photos</td>
</tr>
<tr>
<td>D8692</td>
<td>Replacement Of Lost Or Broken Retainer</td>
<td>Copy of approved D8680</td>
</tr>
<tr>
<td>D8999</td>
<td>Unspecified Orthodontic Procedure, By Report</td>
<td>tx plan, fee, ran for transfer, org-rocs, pymt,hist, pan, ceph, HLD scoresheet</td>
</tr>
<tr>
<td>D9220</td>
<td>Deep Sedation/General Anesthesia - First 30 Minutes</td>
<td>Narrative of medical necessity with pre authorization</td>
</tr>
<tr>
<td>D9221</td>
<td>Deep Sedation/General Anesthesia - Each Additional 15 Minutes</td>
<td>Narrative of medical necessity with pre authorization</td>
</tr>
<tr>
<td>D9241</td>
<td>Intravenous Conscious Sedation/Analgesia - First 30 Minutes</td>
<td>Narrative of medical necessity with pre authorization</td>
</tr>
<tr>
<td>D9242</td>
<td>Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes</td>
<td>Narrative of medical necessity with pre authorization</td>
</tr>
<tr>
<td>D9420</td>
<td>Hospital or Ambulatory Surgical Center Call</td>
<td>Narrative of time spent and medical necessity with claim</td>
</tr>
<tr>
<td>D9920</td>
<td>Behavior Management, By Report</td>
<td>Narrative of medical necessity with claim</td>
</tr>
<tr>
<td>D9940</td>
<td>Occlusal Guard, By Report</td>
<td>Documentation of medical necessity</td>
</tr>
<tr>
<td>D9999</td>
<td>Unspecified Adjunctive Procedure, By Report</td>
<td>Descr.procedure,narr.of med.nec.,GA checklist, Hospital/Outpatient Facility Name (as needed)</td>
</tr>
</tbody>
</table>
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Dental Treatment Plan

In accordance with good dental practice, a treatment plan will be developed and described for each patient on the ADA 2012 Claim Form following a comprehensive examination.

Any dental treatment plan, including those not requiring prior authorization, may be reviewed by Horizon NJ Health dental consultants.

In those instances where prior authorization is necessary, a Horizon NJ Health dental consultant may modify the dentist’s treatment plan in accordance with Horizon NJ Health guidelines. Such modifications are designed to provide dental treatment to the member that is adequate for the correction of the problem, that can be expected to last for the longest period of time, and represents, in the opinion of the dental consultant(s), the most efficient allocation of Horizon NJ Health resources. If in the professional judgment of the dentist, such modification is not appropriate, the dentist may request another review by the dental consultant. A further review by the Program Dental Director may be requested.

In any dental treatment plan, the dentist must discuss the proposed treatment plan and receive approval from the member and/or family member/guardian before submission for authorization and prior to initiation of treatment. It is suggested that the dentist have the member sign the office records or a separate statement declaring that the treatment plan meets with his/her approval. No alteration of the treatment plan will be reimbursed based on the subsequent rejection of all or part of that treatment plan by the member or family member/guardian.

Consideration for development of a dental treatment plan will be based upon the least costly treatment that meets the requirements of the specific situation. On the basis of post-utilization review, any dental treatment plan, including those not requiring prior authorization, may be reviewed by Horizon NJ Health dental consultants to determine appropriateness of treatment. If the treatment is not appropriate, the payment will be recovered.

Authorization for a dental treatment plan does not guarantee eligibility for payment under Horizon NJ Health. It is recommended that, on the first visit of each month, eligibility should be checked by calling the Physician and Health Care Hotline at 1-800 682-9091 or through the provider portal.

Amalgam Restoration

Reimbursement for amalgam restoration will include treatment of pulp exposure, lining or base, restoration, polishing of restoration and local anesthesia or analgesia. The procedure code must be selected on the basis of the number of surfaces restored per individual tooth (not on the basis of individual restorations); therefore, the fee for any surface will include one or more restorations on that surface. Only one code per tooth is reimbursable. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal or lingual surface(s) of the tooth.

Interproximal Fillings

Extensions of interproximal fillings into self-cleansing areas will not be considered as additional surfaces. An additional surface will be reimbursable only when the buccal (facial) or lingual margin extends beyond the proximal one-third of the buccal (facial) and/or lingual surface(s).

Proximal Restorations

Proximal restorations in anterior teeth are normally considered to be single-surface restorations. When access to a proximal cavity is gained by involvement of a second surface, reimbursement will be permitted for only one surface. A two or three-surface proximal restoration will be reimbursed only when the facial and/or lingual margin(s) of the restoration extends beyond the proximal one-third of the facial and/or lingual surface(s).

Proximal Fillings

Extensions of proximal fillings into self-cleansing areas will not be considered as additional surfaces. In selecting the code to be submitted for an individual tooth please note that only one code is reimbursable per tooth. The fee for any surface will include one or more restorations on that surface. A reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal (facial) or lingual surface(s) of the tooth. Reimbursements for a restoration will include treatment of pulp exposure, lining or base, restoration and local anesthesia or analgesia.
Diagnostic Services: Clinical Laboratory Services

“Clinical laboratory services” includes services provided by:

- Independent clinical laboratories, including physician/dentist-operated, out-of-hospital laboratories that primarily perform diagnostic work referred by other practitioners.
- Hospital laboratories and laboratories of educational institutions that provide laboratory services to ambulatory members as requested by a licensed practitioner.

Services provided by any of the laboratories referenced above must be billed directly to Horizon NJ Health by the laboratory and not by the dentist. Please note that Horizon NJ Health members are capitated to LabCorp for all laboratory services, except during an inpatient hospitalization.

All facilities or entities that perform clinical laboratory testing will have certification for the services they are performing. Reimbursement for laboratory testing performed will not be made to any facility without such CLIA certification. It will be the initiating entity’s responsibility to refer tests to laboratories that are participating and have a valid CLIA identification number.

Oral Surgery

Extraction of impacted teeth should be done only when conditions arising from such impactions warrant their removal. The extraction of asymptomatic impacted teeth or those teeth where dental/medical necessity cannot be demonstrated will not be accepted for reimbursement.

- In order to qualify for surgical removal of a tooth with partial or complete bony impaction, the following will be required:
  - Incision of overlying soft tissue
  - Removal of bone, and/or
  - Sectioning of the tooth
- Extractions in more than one quadrant of the mouth must be justified as an emergency procedure
- Requests for reimbursement or prior authorization of oral surgical procedures, when such authorization is necessary, must include a detailed description including dates, diagnosis, site and size of the operative area (number of lesions, and/or number and size of lacerations). For prior authorization, pre-operative and any post-operative radiographs, along with radiological, operative and laboratory reports, should be submitted directly to the Horizon NJ Health dental consultant with the ADA 2012 Claim Form. The dentist will also be responsible for making available all other reports, including hospital radiographs, upon request.
- The dentist performing a biopsy will receive reimbursement for the surgical portion only.
  - The laboratory performing the diagnostic service (and not the dentist) should bill the program directly for these diagnostic services.
  - There will be reimbursement to the dentist when the biopsy is performed as an independent procedure, separate and apart, on a different date from the excision of the entire lesion.
**Adjunctive General Services: Anesthesia**

Rules for anesthesia, intravenous sedation and analgesia are as follows:

- The administration of local anesthesia is considered part of the operative or surgical procedure, and no additional fee will be paid.

- In any setting exclusive of a hospital, when general anesthesia is provided by the dentist, it may be reimbursed subject to the following:
  1. Necessity for same is demonstrated.
  2. Reimbursement can only be made to a dentist who satisfies all established rules and regulations and has such written certification (permit), which may be required by the State of New Jersey or the state in which the service is being rendered.

- When the dentist performing the dental service (attending dentist) also administers the general anesthesia, only procedure code 09220 can be used, and reimbursement will be limited to one general anesthesia charge per visit.

- When general anesthesia is administered by a dentist whose sole function is to administer general anesthesia, such service is reimbursable if:
  a. Anesthetic management is necessary to perform restorative dentistry alone or restorative dentistry in conjunction with other dental services.
  b. Special general anesthesia codes are utilized.
  c. An anesthesia record is maintained and submitted with the ADA 2012 Claim Form for anesthesia and treatment.
     i. The anesthesia record submitted will show elapsed anesthesia time, pinpoint the time and amounts of drugs administered, pulse rate and character, blood pressure and respiration.
     ii. Elapsed anesthesia time means the time from induction of the general anesthesia to the point in time when the anesthetist is no longer in personal attendance.

- Reimbursement for the administration of intravenous sedation will be subject to the following conditions:
  1. Such sedation is administered continuously during the operative or surgical procedure.
  2. No reimbursement will be made for injections given as pre-operative medication.
  3. The practitioner will record the need for this service.
  4. The person administering the intravenous sedation is a dentist satisfying all rules and regulations as established and has such written certification (permit) as is required by the State of New Jersey or may be required in the state in which the procedure is being performed.
  5. There will be only one charge for intravenous sedation per visit.

- An inhalation anesthetic for the purposes of analgesia will be reimbursable as part of an operative or surgical procedure, subject to the following conditions:
  1. Analgesia is administered, as needed, continuously during the operative or surgical procedure.
  2. No reimbursement will be made for an injection given as pre-operative medication.
  3. The practitioner should state the need for this service.
  4. The practitioner administering the analgesia is a dentist satisfying all the rules and regulations as established and when required, has such written certification (permit) as may be required by the State of New Jersey or by the state in which the procedure is being performed.
  5. There can be only one charge for analgesia per visit.
Within the scope of accepted dental practice, intradermal, subcutaneous, intramuscular and intravenous injections will be reimbursable in the office or home as follows:

- Reimbursement for the above injections will be on a flat-fee basis and are all inclusive for the cost of the service and the drug.
- A visit for the sole purpose of an injection will be reimbursable for the injection only. If other dental procedures are performed that are reimbursable, an injection may, if medically indicated, be reimbursed in addition to the other procedures. The drug administered will be consistent with the diagnosis and will conform to accepted medical and pharmacological principles in respect to dosage, frequency and route of administration.
- Intravenous injections will be reimbursable only when performed by the dentist.
- No reimbursement will be made for vitamins, liver or iron injections, or combinations thereof, except in laboratory proven deficiency states requiring parenteral therapy.
- No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.
- No reimbursement will be made for an injection given as a preoperative medication in conjunction with general anesthesia or as a local anesthetic which is part of an operative or surgical procedure.
- The appropriate procedure code, name of the drug injected, dosage and route of administration, along with the complete diagnosis for which the injection was given will be inserted on the ADA 2012 Claim Form under “Remarks.”

Drugs, biologicals or supplies used, administered or provided by the dentist will be considered part of the professional service and no additional fee will be authorized.

Special Needs Patients

Dentists who treat Horizon NJ Health special needs patients, i.e. patients with developmental disabilities, should be available to assist and to consult with patient caregivers. When a caregiver is in need of advice, clarification or education, you, as the treating dentist, should be available to provide such information.

Behavior Management

Dentists may receive a behavior management fee for treating special needs patients, based on the needs of the member. A fee is paid per 15-minute unit and prior authorization is not necessary. Reimbursement for four or more units will be at the discretion of a Horizon NJ Health dental consultant and based on services provided, as demonstrated by documentation in the patient’s record. This includes, but is not limited to: a visual examination of the patient; appropriate radiographs; dental prophylaxis, including extra scaling and topical applications such as fluoride treatments; nonsurgical periodontal treatment, including root planning and scaling; the application of dental sealant on molars and premolars; thorough inquiries regarding a patient’s medical history; and most importantly, consultations with patient caregivers to establish a thorough understanding of proper dental management during visits.

Home Visits

When medically necessary, home visits for patients with developmental disabilities will be reimbursed under code 9410. Preoperative and postoperative evaluations associated with inpatient operative and surgical procedures will be reimbursed under code 9420.

Informed Consent

Informed consent, signed by the patient or authorized person, must be obtained prior to any surgical procedure.

All dentally necessary hospitalizations for a developmentally disabled patient are coordinated through a Horizon NJ Health Professional Relations Service Representative.
Utilization Review, Quality, Peer Review and TAMI Review

Utilization Review, Quality and Peer Review are considered to be ongoing components of the dental services provided to members.

Utilization refers to that service, procedure or item provided to a member by a qualified physician or health care professional, in a setting, at a time and in an amount that is appropriate and acceptable to the standards of the profession.

Utilization Review is the retrospective analysis of the performance of a dentist with respect to the efficient provision of services while also considering fiscal accountability.

Quality is that standard of dental care or degree of excellence that generally prevails throughout the profession. Quality standards are accepted and agreed upon by those who provide similar services as judged by competent practitioners who are qualified to perform those procedures.

Dental Review is the current, ongoing review of the degree of quality in the delivery of continuing dental services. This process which consistently monitored and maintained by those who provide direction, coordination and regulation to the profession.

Peer Review is the evaluation by practicing dentists of the quality and efficiency of services ordered and/or performed by other practicing dentists. Peer Review is the all-inclusive term for dental review efforts, including dental practice analysis, inpatient hospital/extended care utilization review, and dental claims audit and review. Peer review will include, but not be limited to, the following:

- A clinical examination made on a sampling of cases. Such examination may be made before, during or upon completion of treatment.
- Additional diagnostic aids and data which may be requested to evaluate the case.
- Adequate records which must be maintained by the dentist providing treatment and will be available for inspection.
- In the event a dentist fails to respond to a request of the New Jersey Division of Medical Assistance and Health Services for office records, radiographs and/or other materials and correspondence within 30 days, the Division may recover any reimbursement related to the services involved, or if in reference to services not yet paid, reimbursement may be denied.

TAMI Review is that review done by a claims examiner, whereby during the course of processing for payment, a claim is subjected to the Tooth Allocation Map Inquiry (TAMI). This system selects for further review and investigation any claim which shows a duplication of services or services presented in an illogical or impossible sequence.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Program and Guidelines

Horizon NJ Health General Dentists must furnish Early and Periodic Screening, Diagnosis and Treatment (EPSDT) equivalent services. EPSDT is a federally mandated, comprehensive child health program for Medicaid recipients from birth through 20 years of age, pursuant to section 1905 of the Social Security Act (42 U.S.C. 1936 (d)) and federal regulation (42 CFR 441.50et seq.).

In recognition of the unique challenges that go with providing dental care for children, and in compliance with the federally mandated EPSDT Program, the following assessments must be included:

- Thorough observation of all conditions present in the oral cavity and contiguous structures, including an oral cancer screening.
- Assessment of dental development.
- Charting of all abnormalities.
- Development of a complete treatment plan to be recorded in its entirety, including provisions for further treatment and follow-up care, by referral if necessary.
- Anticipatory guidance concerning dental health to the patient or parent/guardian.
- Assessment of the caries index and nutritional needs relating to oral health and oral hygiene practices.
- Assessment of systemic or topical fluoride needs. CDT code D0145 should be submitted for oral evaluations of members under three (3) years of age. This evaluation will have the same frequency limitations as a periodic oral evaluation.
Confidentiality

All participating dentists are to treat their members’ dental records confidentially and to comply with all federal and state laws and regulations.

The enrollment form, signed by Horizon NJ Health members, authorizes the release of dental information to Horizon NJ Health on behalf of Horizon NJ Health staff.

Corrective Action Program

Horizon NJ Health is committed to working cooperatively with participating physicians and other health care professionals to resolve any identified areas of noncompliance with administrative or quality standards. When a compliance problem is identified, the Dental Director or his/her designee will contact the physician or health care professional to discuss the situation and confirm the awareness of the appropriate policies and procedures. All attempts will be made to educate our participants on our policies and procedures.

Steps in the corrective action process include, but are not limited to, the following:

1. Notification to the provider of Horizon NJ Health standards and clinical practice guidelines.
2. Physician or health care professional is monitored according to these guidelines.
3. Administrative or quality-of-care issues are identified by Horizon NJ Health and reviewed by the Dental Director.
4. Dental Director identifies deficiencies that need to be reviewed by the Peer Review Committee (hereafter identified as the “Committee”).
5. If the Committee or Dental Director identifies a concern, the dentist is notified and given the opportunity to respond before a final determination is made.
6. Actions that can be taken by the Committee regarding any identified deficiencies include, but are not limited to:
   • Individual education.
   • Monitoring of sanctions.
   • Termination from the network.
7. The Corrective Action Program contains important safeguards for the physician or health care professional to ensure that all decisions are made fairly with the goal of improving quality of care and service to our members.

Sanctions

It is the goal of Horizon NJ Health to resolve identified deficiencies in a fair manner, which allows the opportunity for education and fair due process where indicated. When noncompliance significantly affects the quality of care provided to a member, Horizon NJ Health may impose sanctions through the Corrective Action Program. Sanctions will only be imposed after a thorough review of the issue. The provider will be afforded ample opportunity to respond to the issue as outlined in the Corrective Action Plan.

If formal sanctioning proceedings are implemented and the outcome is to last 30 days or more, the National Practitioner Data Bank must be notified.

Inquiry, Complaint and Appeals Process

Horizon NJ Health has established and maintains a system and procedure for resolution of dental inquiries, complaints and grievances by enrollees and health care professionals. The complaint/grievance procedure is available to all enrollees and health care professionals. Timely resolution will be reached within 48 hours in urgent cases and within 30 calendar days from initiation of the complaint for all other issues.

Inquiry Procedure

Telephone inquiries will be handled on the same day, or at the latest within one business day of receipt.

Complaint Resolution for Members and Health Care Professionals

The procedure for initiating a complaint is outlined below:

1. When a member or health care professional is dissatisfied with care or service received, a complaint can be initiated by:
   • Calling a Horizon NJ Health Customer Service Representative. (1-877-765-4325 for members and 1-800-682-9091 for dentists).
   • Submitting a written complaint to:
     Scion Dental
     Complaints Department
     Milwaukee, Wisconsin 53201
2. Submitting a verbal or written request directly to the Department of Banking and Insurance via telephone, fax or online complaint to:

Department of Banking and Insurance (DOBI)
20 West State Street
P.O. 325
Trenton, NJ 08625
1-800-446-7467
www.state.nj.us/dobi

3. The provider/complainant will be notified in the following timeframes:
   • Urgent cases including verbal notification will be addressed within 48 hours.
   • Notification of the resolution of complaints resolved within five business days will be given verbally by a Complaints Coordinator. If Horizon NJ Health is unable to reach the initiator of the complaint through a telephone call, written notification of the outcome will be sent within 30 days.
   • Filers of complaints not resolved within five business days will receive written notification of the outcome within 30 days. Complaints not resolved within five business days will be considered a grievance.

4. All members and health care professionals will either verbally or in the written notification be informed of their right to appeal within 90 days of the resolution. No penalty will be taken against a member or health care professional for filing a complaint/grievance or subsequent appeal. Fair Hearing Procedures, including the Medicaid enrollee’s right to access the Medicaid Fair Hearing process, is also included in the verbal and/or written notification.

5. The complaint/grievance is considered resolved unless an appeal is requested.

Utilization Management Member Appeals Process

Horizon NJ Health has developed and implemented appeal policies to receive and adjudicate utilization management appeals made by members or health care professionals acting on behalf of members with the member’s documented consent. This procedure will ensure timely resolution, be easily accessible and provide prompt, fair and full investigation of member appeals.

The procedure to process an appeal is as follows:

1. A member or health care professional acting on behalf of a member (with the member’s documented consent) may submit an appeal within 90 days of receiving a denial letter for a dental or orthodontic procedure or out of network provider. Hospitals may obtain consent from the covered person prior to receiving hospital services. The consent is valid for all stages of internal and external appeals. Patients may revoke consent at any time. Members can verbally appeal adverse utilization management determinations. All appeals from a physician must be submitted with a written signed consent from the member except when the request is for an expedited resolution. Physicians and/or all other health care professionals must provide the covered person notice of an appeal whenever an appeal is initiated and again each time the appeal is continued to the next stage, including any appeal to an IURO. All written appeals must be submitted to the following address:

   Horizon NJ Health Appeals Unit
   P.O. Box 295
   Milwaukee, WI 53201

2. A member may also make an appeal or grievance by contacting Member Services at 1-877-765-4325 for assistance with writing the appeal.

3. All appeals (regardless of level or type) must include the following information:
   • Name, address and phone number (if applicable) of the member(s) and/or dentist(s)/physician(s) making the appeal;
   • Member identification number;
   • Date(s) of service;
   • Name(s) of dentist/physician, vendor or facility;
   • Specific details regarding the actions in question;
   • The nature and reasoning behind the appeal;
   • The desired outcome;
   • Supporting documentation, i.e. dental record;
   • Consent form.

Continuation of Benefits

Services are covered while an appeal is pending. If the member requests a Medicaid Fair Hearing and wishes to request continuation of benefits, they must do so in writing within 10 days of the date of the denial. If the appeal is denied, the member may be required to pay for the cost of these services.
Stage One Appeal

A member or health care professional acting on behalf of a member (with member’s documented consent), who is dissatisfied with any utilization management determination, will have the opportunity to speak to and appeal that determination with the Dental Director or physician designee who rendered the determination.

Verbal and written notification of urgent or emergent appeals determinations will be completed as soon as possible and will not exceed 72 hours after the initiation of the appeal request.

Stage One utilization management appeal determinations, including written notification, will be completed within 10 calendar days.

If the appeal is not resolved to the member’s satisfaction, we will provide a written explanation as how to proceed to a Stage Two appeal. Stage Two appeals must be filed within 90 days from the date of receipt of the result of the action from the Stage One appeal. All adverse determination letters will document the clinical rationale for the decision, including a declaration that the clinical rationale used in making the appeal decision will be provided in writing upon request.

Stage Two Appeal

If a Stage Two appeal is received, it is acknowledged by us in writing within 10 business days of receipt and referred to the Appeals Committee, which is a panel of dentists, physicians and/or other health care professionals selected by us who have not been involved in the utilization management determination.

The Appeals Committee will have available a consulting practitioner who is trained or who practices in the same specialty as would typically manage the case being appealed. Verbal and written notification of urgent or emergent appeals determinations will be completed as soon as possible and will not exceed 72 hours after the initiation of the appeal request. Stage Two utilization management appeal determinations, including written notifications, will be completed within 20 business days and will not exceed 30 calendar days after the initiation of the Stage Two appeal.

All adverse determination letters will document the clinical rationale for the decision, including notice that the clinical rationale used in making the appeal decision will be provided in writing upon request.

Stage two appeal deadlines may be extended for up to 14 calendar days if the enrollee requests an extension, or if Horizon NJ Health shows to Division of Medical Assistance and Health Services (DMAHS) satisfaction that an extension is in the best interest of the enrollee while additional information is obtained.

At this appeal level, the appellant is provided with the opportunity to present pertinent information regarding the case directly to the Appeals Committee either in person or via telephone. The in-person or telephone call presentation will be completed within a reasonable timeframe, as dictated by the health care issue being presented, and will take place in community locations that are convenient and accessible to the appellant.

The in-person or telephone presentation before the Appeals Committee is non-adversarial. Horizon NJ Health will permit the appellant to be accompanied by a representative of the appellant’s choice to any proceedings and grievances.

Stage Three Appeal

If the Appeals Committee upholds the Stage 2 appeal, the member, or health care professional acting on behalf of the member (with the member’s written consent) may request a Stage 3 appeal with the Independent Utilization Review Organization (IURO) assigned by the New Jersey Department of Health and Senior Services. All Stage 2 determination notifications will explain the reasons for the decision.

Those appeals initiated by a member or health care professional acting on behalf of a member (along with the member’s documented consent) will include instructions on how to file an external appeal by an Independent Utilization Review Organization (IURO) designated by the New Jersey Department of Health and Senior Services.

Independent Utilization Review Organization
Office of Managed Care
Division of Health Care Quality and Oversight
P.O. Box 360
Trenton, NJ 08625-0360

Stage 3 appeals must be filed within four months from the date of receipt of the determination from the second stage appeal.

The IURO will review the appeal and respond to the member/health care professional within 30 days.
Member Administrative Appeal

The member can request an appeal of any unfavorable decision or unfavorable complaint/grievance resolution.

All appeal requests must be sent to the Appeals Coordinator at Horizon NJ Health to the following address:

Horizon NJ Health Appeals Unit  
P.O. Box 295  
Milwaukee, WI 53201

This request must be received within 90 days the date of the complaint/grievance resolution letter.

Once all required information is received, the appeal will be investigated and resolved.

The case will be reviewed within 20 business days and will not exceed 30 calendar days. The member will be notified in writing of the decision.

All notifications will state reasons for the decision and include information on how to access the Medicaid Fair Hearing process.

Additional Appeal Rights

NOTE: Notwithstanding anything to the contrary, Medicaid, NJ FamilyCare A and certain NJ FamilyCare D and Program Status Code 380 members have the right to file for a Medicaid Fair Hearing. Medicaid Fair Hearings must be requested within 20 days of notice of adverse action. Members have the right to represent themselves at the Medicaid Fair Hearing or to be represented by an attorney, friend or other spokesperson. Medicaid Fair Hearings are obtained through the New Jersey Department of Human Services by writing to the following address:

New Jersey Division of Medical Assistance and Health Services (DMAHS)  
Fair Hearing Services  
P.O. Box 712  
Trenton, NJ 08625-0712

A member may also appeal to the New Jersey State Department of Health and Senior Services and/or the State Department of Banking and Insurance. Their addresses are:

New Jersey State Department of Health and Senior Services  
Office of Managed Care  
P.O. Box 360  
Trenton, NJ 08625-0360

OR

New Jersey Department of Banking and Insurance  
Office of Enforcement and Consumer Protection  
20 West State Street  
P.O. Box 329  
Trenton, NJ 08625-0329  
1-800-446-7467

If the member requests a Medicaid Fair Hearing and wishes to request continuation of benefits, they must do so in writing within 10 days of the date of the denial. If the appeal is denied, the member may be required to pay for the cost of these services.

Utilization Management Provider Appeals Process

Horizon NJ Health has developed and implemented policies and procedures to receive and adjudicate appeals from participating physicians, vendors and facilities of health care services related to adverse dental utilization management determination(s). Any provider can request a reconsideration of a determination not to certify an admission, a continued hospitalization or a level of care determination. Medical appeals are appeals of determinations regarding dental utilization management appropriateness filed directly by the physician or health care professional not on behalf of the member.

Please note that a dentist, physician or health care professional has the option of whether to file a Provider Utilization Management Appeal or a Member Utilization Management Appeal (on behalf of the member). Hospitals may obtain consent from the covered person prior to receiving hospital services.
This consent is valid for all stages of internal and external appeals. Patients may revoke consent at any time. Dentists, physicians and/or other health care professionals must provide the covered person notice of an appeal whenever an appeal is initiated, and again each time the appeal is continued to the next stage, including any appeal to an IURO. Information on filing a Member Dental Medical Appeal is set forth in Section “Utilization Management Member Appeal Process.”

A dentist, physician or health care professional may not initiate both utilization management appeals processes with respect to the same appeal.

Utilization Management Dental Appeals

The procedure to process an appeal is as follows:

1. A dentist, physician, vendor and/or facility may submit a formal written request for further review of a Horizon NJ Health utilization management decision. The appeal must be submitted within 90 days of receiving a denial letter for an inpatient service or an outpatient service or within 60 days from the date of the complaint/grievance notification. Health care professionals must submit all appeal requests in writing except when the request is for an expedited resolution. All written appeal requests must be submitted to the following address:

   Horizon NJ Health Appeals Unit
   P.O. Box 295
   Milwaukee, WI 53201

2. All appeals (regardless of level or type) must include the following information:
   • Name, address and phone number of the physician(s), vendor or facility making the appeal;
   • Member identification number;
   • Date(s) of service;
   • Name(s) of physician, vendor or facility whereby services were rendered;
   • Specific details regarding the actions in question;
   • The nature and reasoning for the appeal;
   • The desired outcome;
   • Supporting documentation, i.e. dental record.

Continuation of Benefits

Services are covered while an appeal is pending. If the member requests a Medicaid Fair Hearing and wishes to request continuation of benefits, they must do so in writing within 10 days of the date of the denial. If the appeal is denied, the member may be required to pay for the cost of these services.

Stage One Appeal

A health care professional who is dissatisfied with any utilization management determination will have the opportunity to speak to and appeal that determination with the Dental Director or physician designee who rendered the determination.

Verbal and written notification of urgent or emergent appeals determinations will be completed as soon as possible and will not exceed 72 hours after the initiation of the appeal request.

Stage One utilization management appeal determinations, including written notifications, will be completed within 20 business days, and will not exceed 30 calendar days of the initiation of the Stage One appeal request.

If the appeal is not resolved to satisfaction, we will provide a written explanation as how to proceed to a Stage Two appeal. Stage Two appeals must be filed within 60 days from the receipt of the action from the Stage One appeal. All adverse determination letters will document the clinical rationale for the decision including a statement that the clinical rationale used in making the appeal decision will be provided in writing upon request.

Stage Two Appeal

Upon receipt of all required information, the case will be presented to the Horizon NJ Health Level Two Appeals Committee, which is a panel of physicians and/or other health care professionals not involved in the utilization management determination. The Appeals Committee will have available a consulting practitioner who is trained or practices in the same specialty as would typically manage the case being appealed. The Committee will review the case and make a determination.

Verbal and written notification of urgent or emergent appeals determinations will be completed as soon as possible and will not exceed 72 hours after the initiation of the appeal request.
Stage Two utilization management appeal determinations, including written notification, will be completed within 20 business days and will not exceed 30 calendar days of the initiation of the Stage Two appeals. All adverse determination letters will document the clinical rationale for the decision and include a declaration that the clinical rationale used in making the appeal decision will be provided in writing upon request.

**Horizon NJ Health Appeals**
210 Silvia St.
West Trenton, NJ 08628
Phone: 1-800-682-9094
Ext 89609 Option #2

**Claim Appeals Process**

This section describes procedures through which participating and nonparticipating health care professionals have a right to a written appeal of disputes relating to payment of claims as defined below. As always, Horizon NJ Health procedures are intended to provide our Participating Dentists with a prompt, fair and full investigation and resolution of their claims. The procedure includes a Stage Two, binding and nonappealable external Alternative Dispute Resolution (ADR) option for claim payments that dentists and health care professionals continue to dispute after pursuing their appeal through Horizon NJ Health Stage One internal appeals process. No dentist who exercises the right to file an appeal under this procedure will be terminated or otherwise penalized for filing and pursuing such an appeal.

When a health care professional is dissatisfied with a claims payment (or determinations, prompt pay or no payment made by Horizon NJ Health), he/she may file a claim appeal as described herein. All claim appeals must be initiated on the applicable appeal form created by the Department of Banking and Insurance and must be received by Horizon NJ Health within ninety (90) calendar days following receipt by the dentist or health care professional of the final claim determination.

To file a claim appeal, a health care professional must mail the appeal form and any supporting documentation to Horizon NJ Health at the following address:

**Horizon NJ Health Appeals**
P.O. Box 295
Milwaukee, WI 53201

**Stage One**

A Horizon NJ Health employee who serves as an appeals resolution analyst will review all claim appeals. All such individual appeals resolution analysts are personnel of Horizon NJ Health who are not responsible on a day-to-day basis for the payment of claims. The appeals resolution analyst will review all submitted documentation and confer with all necessary Horizon NJ Health departments depending on the nature of the claim appeal. Upon review by the appeals resolution analyst, a decision will be rendered. Written notification will be sent to the health care professional within thirty (30) calendar days of the date that Horizon NJ Health received the claim appeal request. If the dentist, physician or other health care professional is not notified in a timely manner of the determination, the physician or health care professional may refer the dispute to arbitration.

**Stage Two – Alternative Dispute Resolution (ADR)**

 Horizon NJ Health has established a binding and non-appealable external ADR mechanism that involves arbitration, and in some cases, mediation, for dentists and health care professionals who remain dissatisfied with the result of their pursuit of an appeal through the stage one internal claim appeal process. These mechanisms are described below:

All adverse decisions made by a Claim Appeal Reviewer may be appealed by the dentist or health care professional through an independent, binding ADR process. Arbitration must be initiated on or before the 90th calendar day following receipt of the determination of an internal appeal. Disputes must be in the amount of $1,000 or more. Dentists and health care professionals may aggregate claims to reach the $1,000 minimum under circumstances in which the same claim issue is involved. Participating and nonparticipating dentists or health care professionals may initiate the above binding and nonappealable external ADR review of an adverse decision of a dentist or health care professional claim appeal review after the stage one internal appeal by filing a request for external ADR review. These requests must include the written findings from the Stage One appeal determination and must be submitted within ninety (90) calendar days of the date of the claim appeals reviewer’s written decision to the following address:
All external ADR appeal requests must be submitted on the applicable appeal form created by the Department of Banking and Insurance. The ADR arbitrator is subject to change by Horizon NJ Health. Proceedings under any such external ADR mechanism, including the method of selecting the mediator or arbitrator that will mediate or arbitrate the case, will be in accordance with the rules followed by the ADR organization.

The recommended decision of the ADR organization’s arbitrator will be issued no later than thirty (30) calendar days from the receipt by the ADR organization of all documentation necessary for the arbitrator to complete the review. The decision rendered through the ADR organization’s arbitrator will be binding and nonappealable.

Additional Review

Notwithstanding of previous review standards, physicians have the right, at any time regarding any issue, to seek assistance from the following:

<table>
<thead>
<tr>
<th>DENTAL BENEFIT</th>
<th>Covered Population</th>
<th>Medicaid/ FamilyCare A</th>
<th>MLTSS</th>
<th>NJ FamilyCare ABP</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
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<td>Ages 0-18</td>
<td>Covered</td>
<td>Covered</td>
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<td>$5 copay except for preventive dentistry visits</td>
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<tr>
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<td>$5 copay except for preventive dentistry visits</td>
<td>$5 copay except for preventive dentistry visits</td>
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<tr>
<td>Orthodontia</td>
<td>Ages 0-18</td>
<td>Limited coverage</td>
<td>Limited coverage</td>
<td>Limited coverage</td>
<td>Limited coverage – $5 copay</td>
<td>Limited coverage – $5 copay</td>
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**Third-Party Liability (TPL)**

a. The dentist will utilize, whenever available, and report, any other public or private third-party sources of payment for services rendered to enrollees. Horizon NJ Health, as a Medicaid plan, is always the payor of last resort.

b. If the dentist is aware of third-party coverage, he or she will submit claims first to the appropriate third-party before submitting a claim to Horizon NJ Health.

c. If the dentist knows that the third-party will neither pay for nor provide the covered service, and the service is medically necessary, the dentist may bill Horizon NJ Health without having received a written denial from the third party.

d. When sharing of TPL information by the dentist:
   1. The dentist will notify Horizon NJ Health within 30 days after he/she learns that an enrollee has health insurance coverage not reflected in the health insurance provided by Horizon NJ Health. The dentist must also notify Horizon NJ Health of any casualty insurance coverage, or any change in the enrollee’s health insurance coverage.
   2. If a member has retained counsel who either may institute or has instituted a legal cause of action for damages against a third party, the dentist will notify Horizon NJ Health in writing. This notification must include the enrollee’s name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee’s legal representative, copies of pleadings and any other document related to the action that is in the dentist’s possession or control. This will include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee’s diagnosis and the nature of any service provided to the enrollee.
   3. The dentist will notify Horizon NJ Health within 30 days of the date it becomes aware of the death of one of its Medicaid enrollees age 55 or older, giving the enrollee’s full name, Social Security number, Medicaid identification number and date of death.
   4. The dentist agrees to cooperate with Horizon NJ Health’s and the State’s efforts to maximize the collection of third-party payment by providing to the contractor updates to the information required by this section.

**Horizon NJ Health Dental Spot Checks**

Each month, Horizon NJ Health does a quality check of participating offices. This survey is called a “Spot Check.” The purpose of the survey is to ensure that Horizon NJ Health’s members residing in each individual county have adequate access to dental care and that the network dentists in each county meet appointment availability standards that are stipulated in the Medicaid/NJ FamilyCare Managed Care contract.

**After-Hours Coverage**

All General Dentists and specialty care dentists must be available to Horizon NJ Health members 24 hours a day, seven days a week as stated in the contractual agreement. General Dentists and specialists should make arrangements via an answering service during off hours. If an answering machine is used, a forwarding telephone number to connect with a dentist must be given. Instructions for emergency room care in life-threatening situations are acceptable. Instructions for emergency room care in place of contact with a health care professional when there is no life-threatening emergency (i.e., sore throat, pain in ear, etc.) are unacceptable.
Response Time

The dentist will respond to after-hours telephone calls regarding dental care within the following timeframes:
15 minutes for crisis situations, 45 minutes for non-emergent, symptomatic issues and same day for asymptomatic concerns. If a General Dentist or specialist is identified as noncompliant, every effort will be made to educate the dentist on Horizon NJ Health policy. If this does not produce a favorable outcome, Horizon NJ Health will implement the corrective action plan outlined below:

1. A certified letter will be mailed to the General Dentist or specialist by the Horizon NJ Health Quality Improvement Department reviewing the contractual obligation to provide after-hours coverage and suggesting ways the dentist can become compliant. The General Dentist or specialist will have two weeks (10 business days) to respond to Horizon NJ Health with an improvement action.

2. A Provider Service Representative will call the General Dentist or specialist in the evening, 15 business days after the receipt of the certified letter to verify that a new procedure has been implemented. The findings will be recorded on the original data collection sheet.

3. If a satisfactory improvement action procedure has been implemented, a certified letter, signed by the Quality Improvement Department will be sent to the General Dentist or specialist thanking him/her for his/her cooperation.

4. If a satisfactory procedure is not implemented, a detailed report on the case will be forwarded to the Quality Improvement Department for review and further investigation.

For more information about the Horizon NJ Health corrective action plan, contact the Horizon NJ Health Dental Program at 1-800-682-9094.