



Dental Manual

A Dental Administrative Guide

2025

Dear Participating Dental Provider:

We are excited to provide you with the Asuris Northwest Health (“Asuris”) *Dental Manual*, an administrative guide to assist you and your staff in servicing our Members.

This *Dental Manual*, along with the *CDT Dental Procedure Guidelines*, provide a comprehensive, single-reference source for many of the policies and procedures necessary to support your practice when doing business with us. The *Dental Manual* is an accompaniment to your Participating Dental Agreement, which provides comprehensive details regarding the terms of your Participating Dental Agreement. Both the *Dental Manual* and the *CDT Dental Procedure Guidelines* are located on our website at **asurisdental.com**.

Your dedicated network manager is available to assist you with any questions you have relating to your Agreement, the *Dental Manual*, or the *CDT Dental Procedure Guidelines*.

Thank you for the role you and your staff play in providing a positive experience for our Members who are seeking solutions for their dental health. From time to time, you can expect to see updates to this *Dental Manual* to keep you apprised of changes and additional information as it becomes available. If you have any suggestions for what you would like to see included in the *Dental Manual*, please email our Provider Relations team at **DentalProviderRelations@asurisdental.com**.

We appreciate the quality service you provide our Members and look forward to continuing our relationship with you and your staff.

Sincerely,

Vice President Provider Networks

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Section 1: Definitions

The definitions of capitalized terms that are not otherwise defined in the body of the Agreement are set forth in this section of the *Dental Manual*.

Appeal	The process used to review an adverse determination. The process may also be known as a request for reconsideration of an adverse determination.
Billed Charges	The amount you bill for a specific dental service or procedure(s).
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services responsible for the administration of Medicare. CMS language may be different than conventional insurance contracts.
Clean Claim	A claim for Covered Services that is submitted for adjudication in accordance with applicable terms and conditions of this <i>Dental Manual</i> . A claim is considered clean when it requires no further information, adjustment, or alteration in order to be processed and paid by the Responsible Payor.
Coordination of Benefits (COB)	The determination of which Responsible Payors have primary and secondary responsibilities for paying for Covered Services in accordance with the rules set forth in the Member Contract when that Member is eligible for Covered Services from more than one Responsible Payor, including from a governmental or self-funded Responsible Payor.
Cost-Share	Any and all charges that a Participating Dental Provider may collect directly from a Member in accordance with the terms of the Member Contract which includes Copayments, Deductibles, or Coinsurance.
Covered Services	Dental services and supplies for which benefits are provided under a Member Contract.
Dental Benefits	Those covered dental services and supplies, together with exclusions and limitations, as set forth in the applicable Member Contract.
<i>Dental Manual</i>	This document, which sets forth the policies, procedures, and requirements applicable to Participating Dental Providers providing dental services to Members.
Dependent	A Member who is eligible and enrolled in a Member Contract based upon his or her relationship with a Subscriber.
Emergency Dental Care	Dental services necessary to treat a sudden onset and severity of a dental condition that leads to an immediate dental procedure to relieve pain or eliminate infection.
EOB	Explanation of benefits
Grievance	Dissatisfaction from or on the behalf of an enrollee or dental service provider about any action taken by Asuris.
HIPAA	The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.
Insured	Each individual covered under a Member Contract.
Late Claim	The submission of a claim for Covered Services to Asuris, more than 90 days (three months) from the date of service or the completion of a course of treatment. Asuris may

	deny a Late Claim unless it determines, at its discretion, that there was good cause for the delay in submitting that claim.
Medicare Advantage (MA) Plan	Asuris, a Medicare Advantage Organization offering Medicare Advantage programs through a MA contract.
Member Payments	Any and all charges that a dentist may collect directly from a Member in accordance with the terms of the Member Contract which include Copayments, Deductibles or Coinsurance.
National Provider Identifier (NPI)	The government-issued, 10-digit identification number for individual health care providers and entities.
Non- Reimbursable Services	Services that would have been Covered Services but for the fact that the Participating Dental Provider: <ol style="list-style-type: none"> 1. Rendered services that were not necessary and appropriate; or 2. Failed to comply with applicable requirements of the <i>Dental Manual</i> in connection with the provision of such services; or 3. Failed to submit a claim for such services within the submission deadlines established by the applicable <i>Dental Manual</i>.
Participating Dental Agreement	The document that defines the contractual rights and obligations between you as a Participating Dental Provider and Asuris for your participation in the Participating Dental Network which is made up of your standard contract.
Participating Dental Providers	Those Dental Providers who meet minimum participation standards as set forth in this Agreement, have been credentialed under Asuris's credentialing policies and have signed a Participating Dental Provider Agreement with Asuris.
Participating Dental Network	The Asuris dental network dental provider contracts with.
Practitioner Credentialing Application	The form that a dentist has completed setting forth requested information concerning his or her professional qualifications, experience, and other relevant credentialing information.
Provider Network	The group of Participating Dental Providers who contract with Asuris to render Covered Services to Members.
Plan	An Asuris Dental Plan.
Pre-authorization	A Participating Dental Provider's submission of information to the Responsible Payor prior to rendering services, for advanced written approval for planned services for medically necessary treatment. Pre-authorization is subject to: <ul style="list-style-type: none"> • the accuracy and completeness of the Participating Dental Provider's submission of information, • Medical Necessity, • the Member's eligibility at the time services are rendered, • the Responsible Payor's allowed payment for such services, and • the terms of the Member Contract at the time services are rendered
Predetermination	A Predetermination of benefits is a request for services submitted by a Participating Dental Provider to the Responsible Payor prior to rendering those services to determine if they are Covered Services. In addition, the Responsible Payor will also determine

	<p>whether any Dental Allowable Amount, Copayment, Coinsurance and Deductible apply. A Predetermination of benefits is not a commitment and does not create any obligation to pay any amount for services rendered. A Predetermination is subject to:</p> <ol style="list-style-type: none"> 1. the accuracy and completeness of the Participating Dental Provider's submission of information, such services being necessary and appropriate, 2. the Member's eligibility at the time services are rendered, 3. the Responsible Payor's allowed payment for such services, and 4. the terms of the Member's Contract at the time services are rendered
Responsible Payor	The Plan responsible for paying benefits for Covered Services rendered to a Member.
State	The State of Washington.
Subscriber	A Member who is eligible and enrolled in a Member Contract as an individual or as an employee or primary Member of an account.
Unbundling of Procedures	The "unbundling" of charges has been recognized on a national level as a contributing factor to the increasing cost of health care. Examples of unbundling include the use of more than one procedure code to bill for a procedure that can be adequately described by a lesser number of codes, filing for services that are an integral part of a procedure, and filing for procedures (such as "sterilization," services, or supplies) that are required in rendering dental services. When these and other unbundled claims are identified, partial denials of payment or refund request will result.
Utilization Management Program	The review process used to evaluate if services rendered to Members are necessary and appropriate.

Section 2: Contact Information

At Asuris, one of our most important goals is to nurture a relationship with you defined by mutual respect and responsiveness. Please do not hesitate to contact us with any questions.

Claims and Customer Service Contact Information

Plan	Schedule of Allowances	Customer Service	Claims Address
Asuris Northwest Health	Participating Fee Schedule	1(888)349-6558	Asuris Northwest P.O. Box 1106 Lewiston, ID 83501-1106
Medicare Advantage	Participating Fee Schedule	1(888)349-6558	TruAdvantage P.O. Box 1827 Medford, OR 97501

Your Network Manager

As a Participating Dental Provider, you have a dedicated network manager available to provide support. Please do not hesitate to contact us with any questions about your Agreement by contacting our team at **DentalProviderRelations@asurisdental.com**. The network manager for your territory will respond to you.

Section 3: Participating Dental Provider's Responsibilities

Participating Dental Provider's Responsibilities

As a Participating Dental Provider, you are solely responsible for making treatment recommendations and decisions for your Members. You are also responsible for ensuring that all claims you submit are accurate, complete and adhere to the claims filing and coding policies of Asuris.

Asuris' Responsibilities

Asuris will not interfere with your judgment with respect to a Member's treatment or the Participating Dental Provider/Member relationship. However, we do reserve the authority to make eligibility and coverage determinations and to make claims-processing decisions that may include re-bundling or down-coding. You can find additional information on claim edits in the *CDT Guide* at the end of this *Dental Manual*.

Section 4: Working with Asuris

What We Offer You

At Asuris, we are committed to helping you provide the best care to our Members and manage a successful business practice. We have built a reputation based on trust and excellent customer service, the same qualities you deliver to our Members. We offer:

- Fast, reliable, and direct electronic claims-processing.
- Dedicated provider network managers.
- Competitive reimbursement rates driven by the market.
- Online *Dental Manual* to assist providers with basic questions.
- The Asuris Participating Dental network and the Asuris TruAdvantage PPO network.
- A listing in our online provider directory, which Members can use to search for providers by location, specialty, gender, or language. Visit the directory at **asurisdental.com**.

Section 5: Conditions of Participation in Our Networks

Conditions of Participation


To participate in the Asuris dental networks, each dental professional must meet the standards, requirements, and contractual conditions described below:

General Conditions	<ul style="list-style-type: none"> You must complete a Practitioner Credentialing Application with supporting documentation. You must include an IRS letter that lists the name that is registered to the tax ID number. (Examples below) Sign the Participating Dental Agreement and continuously comply with all its terms and conditions. You must cooperate with any third-party claims administrator or network administrator engaged by Asuris.
Standards	<ul style="list-style-type: none"> You must be licensed in Washington. If you practice in a state other than Washington, you must comply with the license requirements of the state where you are located and where services are rendered to Members. You must maintain individual liability insurance in the amounts of \$1,000,000 per occurrence and \$3,000,000 in aggregate to insure you against any claim for damages arising by reason of personal injury or death caused directly or indirectly by you. DEA (Drug Enforcement Administration) and CDS (Controlled Dangerous Substances) eligible dentists who do not have an active DEA certificate will provide a DEA waiver indicating the reason for the waiver and provide a designated practitioner to write on their behalf. The alternate prescriber may be an individual or a practice but must be identified by name and NPI. The Washington providers who hold a Washington DEA certificate must be registered with the Washington prescription drug monitoring program. Prescription drug monitoring program (PDMP) is an electronic database of all the controlled prescriptions dispensed at Washington pharmacies, mail-order pharmacies delivered into Washington, and other dispensaries, such as a veterinary or medical clinic. Under the law, a prescriber may designate someone in the facility to be that prescriber's delegate for checking the prescription drug monitoring program database once that delegate has also registered. Asuris requires contracted providers in Washington to register and encourages use of the Washington prescription drug monitoring program.
Requirements	<ul style="list-style-type: none"> You must achieve a satisfactory review from the Washington State Board of Dental Examiners.

Contractual Conditions	<ul style="list-style-type: none"> • You shall notify Asuris of your intent to terminate or alter your participation. Furthermore, any individual provider wishing to join an existing group practice shall notify Asuris. • To the extent that services that otherwise meet the requirement of the Agreement are rendered by a dentist not located in Washington, the statutory and regulatory requirements of that state that are equivalent to these Contractual Conditions shall be complied with to the satisfaction of Asuris. • Excluded Persons. Participating Dental Providers represent and certifies that neither it, nor its Affiliated Parties or Downstream Entities have been suspended or excluded from participation in the Medicare program or any other federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)). Participating Dental Providers shall check appropriate databases regularly, but no less than monthly and upon hiring and subcontracting, to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in the Medicare program or any other federal health care program. Databases include the U.S. Department of Health and Human Services (“HHS”) Office of Inspector General List of Excluded Individuals/Entities (http://exclusions.oig.hhs.gov) and the General Services Administration’s System for Award Management (http://www.sam.gov/portal). Participating Dental Providers shall notify Asuris immediately in writing if Participating Dental Providers, an Affiliated Party, or any Downstream Entity is suspended or excluded from the Medicare program, or any other federal program monitored as described in this Section. Participating Dental Providers shall prohibit any Affiliated Party or Downstream Entity that appears on any of the above-listed databases or who has opted out of Medicare from doing any work directly or indirectly related to the delivery or administration of Covered Services to Medicare Advantage Members. Asuris reserves the right to require any Participating Dental Providers to demonstrate compliance with this provision upon reasonable request.
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Examples of IRS Tax Letter Required by Asuris

For verification, Asuris will accept a tax coupon or letter from the Department of Treasury (IRS) 147C or CP 575C. See the following examples of an IRS letter:

 **IRS** Department of the Treasury
Internal Revenue Service

CINCINNATI OH 45999-0038

In reply refer to: [REDACTED]
LTR 147C 0
000000 00
BODC: SB

Employer identification number: [REDACTED]

Dear Taxpayer:

Thank you for your inquiry of [REDACTED].

Your employer identification number (EIN) is [REDACTED]. Please keep this letter in your permanent records. Enter your name and EIN on all federal business tax returns and on related correspondence.

You can get any of the forms or publications mentioned in this letter by visiting our website at www.irs.gov/forms-pubs or by calling 800-TAX-FORM (800-829-3676).

If you have questions, you can call us at 800-829-0115.


If you prefer, you can write to us at the address at the top of the first page of this letter.

When you write, include a copy of this letter, and provide your telephone number and the hours we can reach you in the spaces below.

Telephone number () _____ Hours _____

Keep a copy of this letter for your records.

Thank you for your cooperation.

 **IRS** DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: [REDACTED]

Employer Identification Number: [REDACTED]

Form: SS-4

Number of this notice: CP 575 G

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [REDACTED]. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

A limited liability company (LLC) may file Form 8832, *Entity Classification Election*, and elect to be classified as an association taxable as a corporation. If the LLC is eligible to be treated as a corporation that meets certain tests and it will be electing S corporation status, it must timely file Form 2553, *Election by a Small Business Corporation*. The LLC will be treated as a corporation as of the effective date of the S corporation election and does not need to file Form 8832.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

- * Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.
- * Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
- * Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is CAME. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

Effective Date Policy

For newly credentialed or existing providers requesting a new agreement, the participation effective date is based on a complete and approved provider package, which includes, but is not limited to: completed application, approved credentialing, completed and approved contract and complete provider profile. Effective date of participation is determined by the date of the complete, approved provider package.

Participation effective date

Agreement Type	Completion Date	Effective Date of Participation
Newly credentialed or existing providers requesting a new Agreement	Complete provider package approved between the 1 st and 15 th of the month. Example: Complete provider package approved 01/05/2025	Please refer to the Effective Date Calendar below for additional information
	Complete provider package approved between the 16 th and the end of the month. Example: Complete provider package approved 1/20/2025	Please refer to the Effective Date Calendar below for additional information
Newly credentialed providers joining an existing Agreement		Date the complete credentialing application is received, or the date requested on the credentialing application, whichever is later. An application is determined to be complete as part of the credentialing approval process.
Existing credentialed provider joining an existing Agreement	Notification of joining Agreement received between the 1 st and 15 th of the month. Example: Agreement notification received 08/05/2025	1 st of the month following notification of joining Agreement. Example: Effective date 09/01/2025
	Notification of joining Agreement received between the 16 th and end of the month. Example: Agreement notification received 08/20/2025	15 th of the month following notification of joining Agreement. Example: Effective date 09/15/2025

Effective Date Calendar

Complete provider package approved:	Contract Effective Date:
January 1-15	February 15
January 16-31	March 1
February 1-15	March 15
February 16-28	April 1
March 1-15	April 15
March 16-31	May 1
April 1-15	May 15
April 16-30	June 1
May 1-15	June 15
May 16-31	July 1
June 1-15	July 15
June 16-30	August 1
July 1-15	August 15
July 16-31	September 1
August 1-15	September 15
August 16-31	October 1
September 1-15	October 15
September 16-30	November 1
October 1-15	November 15
October 16-31	December 1
November 1-15	December 15
November 16-30	January 1
December 1-15	January 15
December 16-31	February 1

***Please note:** For newly credentialed or existing providers requesting a new agreement, the participation effective date is based on a complete and approved provider package, which includes, but is not limited to: completed application, approved credentialing, completed and approved contract and complete provider profile.

Section 6: National Provider Identifier (NPI)

Overview

The National Provider Identifier (NPI) is a government-issued, 10-digit identification number for individual health care providers and organizations. The numbers are randomly assigned and contain no coded information about the individual or organization. The NPI will never expire, and your individual NPI will remain the same even if you change jobs or locations.

All dental professionals are required by federal law to obtain an NPI. Asuris requires each Participating Dental Provider to have an NPI regardless of whether they submit claims electronically. We encourage you to obtain an NPI as soon as possible; getting your NPI now will help eliminate issues with claims administration.

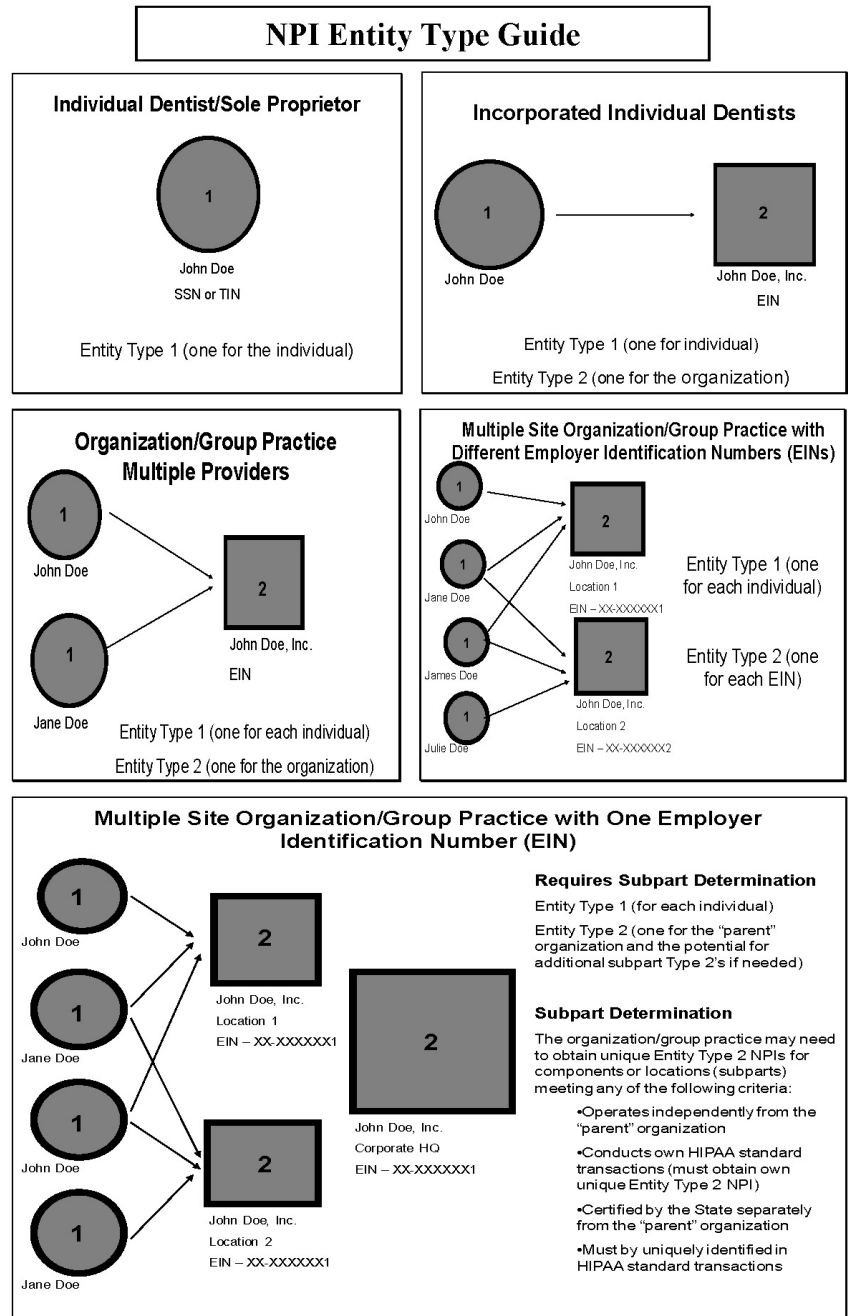
How to Apply for and Use an NPI

You can apply for an NPI at no charge through CMS' National Plan and Provider Enumeration System website at nppes.cms.hhs.gov.

You can choose to either:

- 1) Apply online and receive your NPI via email in one to five business days or
- 2) Download a printable application and submit by mail; processing takes about 20 business days.

Once you have received an NPI, email a copy of your confirmation to our Dental Provider Relations team at DentalProviderRelations@asurisdental.com and we will update your provider record. If you have questions about NPI, contact your network manager.



Section 7: Filing Provider or Practice Changes

Occasionally, you may need to submit changes to Asuris concerning relocation, adding, or changing an employer identification number (EIN) or tax identification number (TIN), adding or terminating an associate or closing a location. To make changes, forms can be found on our website at asurisdental.com. For assistance, please contact us at DentalProviderRelations@asurisdental.com.

Changes Requiring Notification

Changes to your practice that require notification include:

- Adding dentists to your practice
- Additional offices
- Change of practice name
- Changes to telephone and fax numbers
- Providers leaving the practice
- Relocation
- Retirement/death of provider
- Transfer of ownership (TIN change)

Changes to your status that require immediate written notification include:

- Accreditation
- Certification
- License to practice dentistry suspended or revoked
- Malpractice or an act of professional misconduct as found by a court or arbitrator.
- Participation
- Professional liability or malpractice insurance changed or revoked
- Qualification

Submitting Changes

For guidance on how to notify us, please consult the table below:

Type of Change	Method of Submission
Relocation, contact information (telephone, fax, etc.), adding additional practice locations	<i>Provider Information Update Form</i>
Employer Identification Number (EIN) or Taxpayer Identification Number (TIN)	<i>Provider Information Update Form</i> . A new agreement is required to be signed for network participation for the new TIN. Also include a copy of a letter from the IRS (CP 575 or 147c).
Associate dentist/orthodontist who has left your practice	<i>Provider Information Update Form</i>
Add a new associate dentist/orthodontist to your practice	Submit a credentialing application if the provider is not credentialed or submit a <i>Provider Information Update Form</i> for existing providers.
Termination of participation requires 120 days advance written notification	Send a letter of termination on your practice letterhead with a provider's signature, include the Dentist's name, practice address, TIN and network you are terming via email to DentalProviderRelations@asurisdental.com .


Section 8: Dental Plans and Benefits



The following is an overview of the dental plans offered by or administered by Asuris.

Dental Plans Offered or Administered by Asuris

Plan/ Program	Responsible Payor	Claim Type	Payment Supported by	Provider Customer Service
Enhance	Asuris	Dental	Asuris	Dental Claims customer service
Medicare Advantage	Asuris	Dental	Asuris	Dental Claims customer service

Sample Card

		Preferred Virtual Saver	
Subscriber Name JOHN Q PUBLIC ID NO 123456789		Member Name 00 JOHN Q. PUBLIC	
Group No. 12345678		Copay \$40 Up-Front Visits 4 Med Ded \$5500/\$11000 Med Out-Net Ded \$7000/\$14000 Med OOP Max \$7150/\$14300	
RxBIN 610624 RxPCN 02090000 Rx Ded \$500 Rx OOP Max INCL W/ MED			

		www.asuris.com Members Call 1 (888) 367-2109	
Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits.		www.asuris.com/provider/home Providers Call 1 (888) 349-6558 Pharmacies Call 1 (844) 765-2897 EAP 1 (866) 750-1327	
Hospitals or Physicians: Submit claims to Asuris electronically via an ANSI 837 transaction.		To find a provider outside of WA, ID, OR & UT, please visit www.multiplan.com/asuris	
 Outside of WA, ID, OR and UT			

Important note: We use assigned Subscriber identification numbers in place of Social Security numbers. Be sure to use the Member's current identification number when submitting claims to avoid delays in payment.

Section 9: Medicare Advantage

Asuris offers the following Member Contracts for its Medicare Advantage Members to choose from during the open enrollment period.




- Medicare Advantage PPO

These Medicare Advantage Member Contracts cover a limited number of dental services. Any dental service not covered by the Member Contract may be billed at your usual and customary charge. This does not include procedures that would otherwise be covered but are denied due to frequency limitations having been met. **For dental services not covered by the Member Contract, please notify the Member in writing before services are rendered.**

Please be sure to verify eligibility and benefits for all Medicare Advantage Members before rendering services.

Following is a sample of an ID Card.

TruAdvantage Member Sample Card

 SUBSCRIBER SAMPLE ID NO 123456789 <hr/> 00 SUBSCRIBER SAMPLE Group No. 26500000 In-Network PCP/SPEC \$x/\$xx <hr/> 	TruAdv Classic MEDICARE ADVANTAGE PPO <hr/> RxBIN 610623 RxPCN 02110000 Issuer (80840) Card Issue Date: mm/dd/yyyy <hr/> <table border="0"> <tr> <td>M</td><td>D</td><td>RX</td><td>V</td> </tr> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> <hr/> CMS-H5010-009-001	M	D	RX	V	Y	Y	Y	Y	 Submit claims to Asuris electronically via ANSI 837 transaction. MEDICARE LIMITING CHARGES APPLY <hr/> This card is for information only and does not certify eligibility or guarantee benefits. <hr/> <div> <div> www.asuris.com Members Call 1 (800) 541-8981 TTY/TDD Line 711 Nurse Advice24 1 (800) 310-2973 Telehealth Help 1 (877) 375-2603 Providers Call 1 (877) 508-7362 Pharmacies Call 1 (844) 765-6826 VSP Vision Care 1 (844) 872-6065 </div> <div> Members: send inquiries to the Mail Administrator Asuris PO BOX 1827 Medford, OR 97501 Submit RX Claims to: Rx Claims Processing PO BOX 20970 Lehigh Valley, PA 18002-0970 </div> </div>
M	D	RX	V							
Y	Y	Y	Y							

For Asuris eligibility, benefits and claims information visit **availity.com** to access online services or contact the Provider Contact Center at 1(888)349-6558. Information on Medicare compliance, including training, can be found on **asuris.com**.

Medicare Advantage dental reimbursement

Effective **January 1, 2023**, the reimbursement schedule amounts for covered services provided to Medicare Advantage members by dental provider shall be based upon a hierarchy determined by your network participation status in the following networks:

- United Concordia Dental
- DenteMax
- Asuris Participating Dental

Effective **January 1, 2025**, claims with dates of service on or after January 1, 2025, will be reimbursed using the new fee schedule. The new hierarchy is as follows:

- Asuris 2025 Medicare Advantage fee schedule
- United Concordia Dental
- DenteMax

Accessing 2025 Medicare Advantage fee schedule

You can view the Asuris Medicare Advantage Dental Reimbursement Rates on Availity Essentials at **availity.com**: Claims & Payments>Fee Schedule Listing. Not all plans will have the same benefits, so it is important for you to verify member eligibility and benefits on Availity Essentials: Patient Registration>Eligibility and Benefits Inquiry.

Asuris reserves the right to enter into additional agreements to rent or otherwise gain access to other provider networks in which dental providers may participate. Asuris shall place any additional networks within the list above or modify it by providing at least 60 days' advance notice.

For the Asuris Participating Dental fee schedule please visit [Availity Essentials](#). For questions related to your participating agreement with United Concordia or DenteMax, please contact them directly using the online services provided.

- Visit the [United Concordia Dental website](#) or call 1(800)307-8514.
- Complete the [DenteMax online request form](#).

Medicare Advantage compliance training

Below are links to annual general and specialized Medicare compliance training. These courses are available to all persons involved in the administration or delivery of MA Program benefits. Providers are advised to complete the training and to email Certificates of Completion to dentalproviderrelations@asurisdental.com.

Combating Medicare Parts C and D Fraud, Waste and Abuse

<https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN3995723-MLNPartsCD/FWA/story.html>

Part C Organization Determinations, Appeals, and Grievances

<https://www.cms.gov/Outreach-and-Education/MLN/WBT/PartCOrganizationDetermination/story.html>

Part D Coverage Determinations, Appeals, and Grievances

<https://www.cms.gov/Outreach-and-Education/MLN/WBT/PartDDeterminations/story.html>

Section 10: Dental4HealthSM (D4H)

Dental4HealthSM (D4H)

The oral health of your patients can have a big impact on their overall health, especially if they've been diagnosed with certain medical conditions. For members with medical and dental plans with Asuris, we're able to review their medical claims to identify and automatically enroll those with qualifying health conditions (listed in the grid below) that benefit from additional dental care. We conduct outreach and education to make sure our members are aware of the positive impacts preventive and/ or periodontal dental services have on their total well-being.

Eligible medical conditions	Two additional cleanings or periodontal maintenance visits, enhanced cleaning to remove excess plaque buildup, and:	
	Periodontal scaling covered 100%	Oral health screenings; fluoride treatments
Chronic obstructive pulmonary disease	✓	
Coronary artery disease	✓	
Diabetes	✓	
End-stage renal disease	✓	
Metabolic syndrome	✓	
Oral, head, and neck cancers		✓
Pregnancy	✓	
Sjögren's syndrome		✓
Stroke	✓	

Your Partnership with Asuris

Our Dental4HealthSM program allows us to combine expertise in all disciplines of comprehensive care. By partnering with Asuris, you can help your patients who have medical conditions that might benefit the most from preventive dental care. Through Dental4HealthSM, you can:

- Help your patients achieve better overall health
- Increase your revenue by providing additional services
- Easily identify patients who are enrolled in the program, so they can take advantage of enhanced dental benefits.
 - By logging into MyPatients'Benefits providers can quickly identify if a patient has a reported medical condition, wellness benefits and coverage (see The Provider Experience below)

The Provider Experience

We empower providers with information about patients' eligible condition(s), benefits and program treatment protocols through a convenient online portal

- 1 Medical Condition Flags
- 2 Extra Wellness Benefits
- 3 Medical Conditions

Coverage %							
Procedure		Covered	Allowance	or Copay \$	Limitation	Applied to Deductible	Applied to Maximum
D0431	Adjunctive <u>Prednisolone</u> Test >	Yes	\$30.00	100%	1 Per 6 Months ~ OC, HNC, SJS Medical Conditions	No	No
D1110	Prophylaxis Adult >	Yes	\$65.00	100%	In Network~ DM, CAD, CVA, PG, OC, HNC, SJS, ESRD, COPD, MetS Medical Conditions 4 Per Benefit Period Total ~ DM, CAD, CVA, PG, OC, HNC, SJS, ESRD, COPD, MetS Medical Conditions	No	No

The screenshot displays the 'MyPatients'Benefits' portal. At the top, it shows the user's network as 'JFE PPO' and the group as 'BLUE DENTAL CHOICE PLUS NW OCT 15'. The patient being viewed is John Doe, with a policyholder Jane Doe. The 'Medical Condition Flags' section (1) lists 'Medical Condition Flags', 'Extra Wellness Benefits', and 'Medical Conditions'. The 'Service History Snapshot' (2) shows a table of procedures with columns for Start, End, Procedure, Tooth, and Surface. The 'Wellness Benefits' section (3) shows that the patient has reported a medical condition and lists the program dollar deduction as \$31.00 remaining.

Enhanced dental benefits at no additional cost

We've made it easier financially for your patients to take advantage of the program:

- No waiting periods
- Services do not count toward the calendar year maximum (CYM)
- There are no deductibles, copayments or coinsurance; paid at 100% when visiting a participating provider.

How do my patients enroll?

Members who have medical and dental plans through Asuris and a qualifying medical condition are auto enrolled in the program. Members who have only a dental policy with Asuris must self-enroll. If your patient qualifies and needs to self-enroll, they can download the attestation form located <https://asurisdental.com/members/oral-and-overall-health>, by entering their zip code and county. Once you have identified members who are enrolled, we encourage setting up their four prophylaxis recalls.

For more information about the impact oral health has on the qualifying conditions, please visit: <https://asurisdental.com/members/oral-and-overall-health>

Eligible Dental4HealthSM plan types as of January 1, 2025

January 1, 2025, eligible Dental4Health plan types	
Plan	Eligible?
Fully insured non-ACA group	Yes
Fully insured ACA small group pediatric	Yes ¹
Self-funded group (opt-in)	Yes
Individual ACA pediatric	No
Individual non-ACA	No
Medicare Advantage (Individual and EGWP)	No
MediGap	No

¹Program coverage and benefits for ACA Small Group pediatric dental plans may vary according to each state's benchmark ACA plan. For details, contact Dana Kovaleski.

Section 11: Member Information

Verifying Member Eligibility, Benefits and Claim Status

You can obtain Member eligibility, benefits, claims status, maximums, deductibles, service history, allowance information, procedure code information, and orthodontic information via:

- **Availity Essentials:** Participating Dental Providers can access Member information on [Availity Essentials](#) to obtain immediate, up-to-the-minute access to Member information 24 hours a day, 7 days a week.
- **Interactive Voice Response (IVR) System:** Our Customer Service IVR System offers Participating Dental Providers and most Subscribers access to information stored in records and the capability of finalizing Predeterminations for payment via the telephone. This automated system requires a touch-tone telephone and provides an immediate response. **You can choose to listen to the information or, in most instances, request the information by fax.** The IVR system is available to respond to your inquiries 24 hours a day, 7 days a week, except when our databases are undergoing scheduled maintenance.

Confidentiality of Member Information

The privacy rule enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has strengthened the protections already in place at Asuris to safeguard our Members' protected health information (PHI). Since the privacy rule applies to Responsible Payors and providers, Asuris shares with you the responsibility of protecting privacy. Please see Section VIII of your Agreement for reference to your commitments regarding Member records and PHI confidentiality.

The HIPAA privacy rule allows for Asuris to share PHI with other parties without Members' authorization under certain circumstances, including when we have a business relationship with the third-party and to the extent we need to share the information to support treatment, payment, or health care operations, as defined by the privacy rule. If you have questions about the privacy rule, seek advice from your attorney or business counselor.

We are sensitive to concerns about confidentiality and will take every precaution to protect the privacy of your Members' dental records, including validating your provider information when you call us. As your Agreement with Asuris states, we may require access to or copies of Members' dental records. Our Members' health plans and insurance policies advise Members of our right to assess and handle their records to support treatment, payment, and health care operations.

Section 12: Predeterminations and Claims

Predeterminations

Download the most current ADA claim form at www.adacatalog.org. To order a hard copy, contact your dental office supplier or software administrator or call the ADA at 1(800)947-4746.

Overview

A Predetermination is a written request by a Participating Dental Provider for verification of benefits prior to rendering services. This request helps us determine how we will process a claim based on a Member's benefits. A Predetermination is not a guarantee of payment but is designed to determine:

- If a service is covered under the Member Contract
- If the procedure meets our utilization review guidelines and dental policy
- If any time limitations apply on a procedure
- The projected estimated payment for the procedure

Although not required, we recommend you submit a Predetermination for prosthetics and crowns, inlay/onlay restorations, and periodontal services totaling more than \$500 in allowable expenses.

We process a Predetermination as if it were an actual claim and respond via a pre-treatment estimate. You and the Member will be notified of all approvals and denials.

How to Submit a Predetermination

Complete the most current version of the *ADA Dental Claim Form* as if you were submitting an actual claim for services. Do not enter a date of service on the claim. Remember to:

- Enter an X in Box 1 of the claim form next to "Request for Predetermination/Pre-authorization"
- List only the services to be included in the Predetermination
- Send the Predetermination electronically

Completing a Dental Claim Form

Please follow the instructions below to complete the most current *ADA Dental Claim Form*, which you can find on the ADA website or in the most current *ADA Practical Guide to Dental Procedure Codes*. *A sample form follows these instructions.*

Header Information (blocks 1 and 2)

- 1: Enter an X in the appropriate box to indicate if this claim is a pre-treatment estimate or a claim for actual services rendered.
- 2: Predetermination/Pre-authorization Number is not required.

Other Coverage (blocks 4-11) refers to the possible existence of other medical or dental insurance policies, relevant for Coordination of Benefits.

Policyholder/Subscriber Information (blocks 12-17) documents information about the Insured person (Subscriber), who may or may not be the Member.

Member Information (blocks 18-23) refers to the Member receiving services or treatment.

Record of Services Provided (blocks 24-35) regards the treatment performed or proposed. For a Predetermination of benefits, complete this area in the same way as for an actual service, but omit the date of service. Ten lines are available for reporting.

Authorizations (blocks 36 and 37) are where the Member or Subscriber signs to provide consent for treatment and authorization for direct payment.

Ancillary Claim/Treatment Information (blocks 38-47) asks for additional information regarding the claim and the Member's prior dental history. Some of these questions may be left blank if the service is not orthodontic or prosthetic.

Billing Dentist or Dental Entity (blocks 48-52A) provides information on the dental professionals or group/corporation responsible for billing and receiving payment, which may or may not be the treating dentist. *Block 49 is specific to reporting the associated National Provider Identifier (NPI).*

Treating Dentist and Treatment Location Information (blocks 53-56A) asks for information specific to the provider. Block 54 asks for the treating dentist's NPI. To obtain an NPI, visit the Centers for Medicare & Medicaid Services' National Plan and Provider Enumeration System (NPPES) website at nppes.cms.hhs.gov/NPPES/Welcome.do. *You must submit all claims with your NPI information.*

Billing with a National Provider Identifier (NPI)

If you have a Type 1 NPI (Sole Proprietor), submit your claim using the Type 1 NPI in blocks 49 and 54. If you have a Type 2 NPI (Professional Corporation, Limited Liability Corporation or Incorporated—PA, PC, LLC or INC), submit your claim using the Type 2 NPI in block 49 and the rendering provider's NPI (Type 1) in block 54.

Sample Claim Form

ADA American Dental Association® Dental Claim Form[illegible]

©2019 American Dental Association
J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746
or go online at ADAcatalog.org

Section 13: Coordination of Benefits (COB)

Determining the Primary Responsible Payor

The following rules applicable shall be used by Asuris to determine the primary Responsible Payor.

1. The plan that covers the person as an employee or Member, other than as a Dependent, is determined to be primary before the dental plan that covers the person as a Dependent.

However, if the person is also a Medicare beneficiary, Medicare is secondary to the dental plan covering the person as a Dependent of an active employee. The order in which Dental Benefits are payable will be determined as follows:

Responsible Payor #1: Dental Benefits of a plan that covers a person as an employee, primary Member or Subscriber.

Responsible Payor #2: Dental Benefits of a plan of an active employee that covers a person as a Dependent.

Responsible Payor #3: Medicare benefits.

2. When two or more dental plans cover the same child as a Dependent of different parents:
 - a. The Dental Benefits of the plan of the parent whose birthday month and day, excluding the year of birth, falls earlier in a year should be applied before the dental plan benefits of the parent whose birthday month and day, excluding the year of birth, falls later in the year; but
 - b. If both parents have the same birthday, the Dental Benefits of the plan that has covered the parent for the longest are determined before those of the plan that has covered the parent for the shorter period of time.

However, if one of the plans does not have a provision that is based on the birthday of the parent, but instead on the gender, this results in each plan determining its benefits before the other, and the plan that does not have a provision based on a birthday will determine the order of Dental Benefits.

3. If two or more dental plans cover a Dependent child of divorced or separated parents, Dental Benefits for the child are determined in this order:

Responsible Payor #1: the plan of the parent with custody of the child.

Responsible Payor #2: the plan of the spouse of the parent with custody of the child.

Responsible Payor #3: the plan of the parent not having custody of the child.

However, if the specific terms of a court decree make one parent financially responsible for the dental care expenses of the child, and if the entity obliged to pay or provide the Dental Benefits of the dental plan of that parent has actual knowledge of those terms, the Dental Benefits of that plan are determined first. This does not apply with respect to any claim determination period or dental plan year during which any Dental Benefits are actually paid or provided before that entity has the actual knowledge.

4. The Dental Benefits of a dental plan that covers a person as an employee other than as a laid-off or retired employee, or as a Dependent of such a person, are determined before those of a dental plan that covers that person as a laid off or retired employee or as a Dependent of such a person. If the other dental plan is not subject to this rule, and if, as a result, the dental plans do not agree on the order of Dental Benefits, this paragraph shall not apply.

5. If an individual is covered under a COBRA continuation plan and also under another group dental plan, the following order of benefits applies:

Responsible Payor #1: The dental plan which covers the person as an employee or as the employee's Dependent.

Responsible Payor #2: The coverage purchased under the dental plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.

If none of the above rules determines the order of Dental Benefits, the Dental Benefits of the plan that has covered the employee, Member or Insured the longest period of time are determined before those of the other dental plan.

Coordination of Benefits Shall not be Permitted Against the Following Types of Policies

- | | |
|----------------------------------|---|
| 1. Indemnity | 4. Medicare supplement |
| 2. Excess insurance | 5. We do not coordinate with State plans (Medicaid) |
| 3. Specified illness or accident | |

Determining Your Member's Liability in a COB Situation

If the Asuris plan is the secondary plan in accordance with the order of benefits determination rules outlined above, the benefits of the plan will be reduced when the sum of:

1. The benefits that would be payable for the allowable expense under Asuris in the absence of this COB provision; and
2. The benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of Asuris will be reduced so that its benefits and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of Asuris are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Plan.

Helpful Tips

In situations where you believe your Member may be covered by more than one Responsible Payor, the following hints may help you manage the claim more efficiently:

- Determine your Member's primary Responsible Payor and submit the claim to that Responsible Payor first.
- Submit the primary Responsible Payor's Explanation of Benefits (EOB) to the secondary Responsible Payor.
- Always calculate your Member's liability by claim line rather than by using the total claim payment amount, waiting until all insurance payments have been made.
- Remember that the secondary Responsible Payor's EOB may not correctly reflect the Member's balance and that the Member's liability may be affected by contracts that you hold with the primary carrier.

Section 14: Reimbursement

Overview

Asuris will always reimburse claim payments for covered Members directly to the Participating Dental Provider.

Services That Are Not Covered

In accordance with the Asuris agreement, Participating Dental Providers agree to accept as payment in full the lesser of either their Billed Charges or the Dental Allowable Amount for dental services provided under the applicable dental program, less any applicable Member Cost-Share. You may not bill the Member for the difference between the allowed amount and your Billed Charges, except in these instances:

- **The procedure is non-covered.** If a service is not considered an eligible service under the Member's benefit plan (i.e., it is not listed on the fee schedule of allowances), you can collect your fees. You should verify with Asuris that services are covered; for any that are non-covered, please inform the Members that they will be responsible for your Billed Charges. Please note that your Participating Dental Agreement imposes additional conditions on billing of Members for any services that are not Necessary Dental Care or which are experimental/investigational, including the requirement to first obtain a written waiver of informed consent in advance from the Member.
- **A Member has exhausted their annual maximum benefit and any roll-over benefit, if applicable.** In this instance, you can collect your full fee (subject only to the Participating Dental Agreement's preconditions for billing of any services that are not Necessary Dental Care or experimental/investigational). Please verify that the Member has exhausted all benefits and inform them of their responsibility for your actual charge.

Here is an example of how we calculate the Member's Cost-Share for a Non-Reimbursable Service:

Procedure Code	Your Charge	Coverage Level	Allowed Amount	Member Cost-Share
D0460	\$50	0%	\$0	\$50

Coinsurance

If the Member's dental plan covers a procedure at less than 100%, the Member is responsible for the difference between what we pay and the allowed amount, as shown in this example:

Procedure Code	Benefit Type	Coverage Level	Allowed Amount	Member's Coinsurance
D2150	Basic	80%	\$100	\$100 x 20% = \$20

The Member's Coinsurance is based on a percentage of your Asuris applicable Dental Allowable Amount and the Member's benefit structure. The Member is responsible for all Non-Reimbursable Services. You can collect the Member's Coinsurance at the time of the visit or bill the Member after you receive payment from us.

Deductibles

Generally, the Deductible applies annually with a per-Member amount that cannot exceed a family total maximum for the benefit period. Any Member Cost-Share that applies toward the Deductible shall be based upon the provider's usual charge or the Dental Allowable Amount, whichever is less, as shown in this example:

Member's Yearly Deductible	Your Charge	Allowed Amount	Member Cost-Share Applied Toward Deductible
\$50	\$30	\$25	\$25

Common Reasons for Non-Payment

To familiarize yourself with Asuris's reimbursement requirements, please refer to the list below of messages commonly found on dental remittances to explain non-payment:

- No payment can be made. The reported procedure is covered once in a 3-year period. Benefits have been provided previously for a similar service within this time period.
- No payment can be made. The Member's coverage does not provide for this service.
- No payment can be made. The reported service is covered twice in a contract year period.
- No payment can be made. The maximum benefit amount available under the Member's coverage has been paid. **IF THIS HAS OCCURRED, YOU MAY BALANCE BILL THE MEMBER.**
- No payment can be made. An incomplete dental claim has been received in our office. Please submit a *Dental Claim Form* with the tooth number(s) for the procedure(s) reported, include x-ray(s), periodontal charting and any narrative if required.
- This Member cannot be identified from the identification number reported above. Please verify the name and number shown on the ID card. If the Member is covered, please resubmit the claim.
- No payment can be made. This service is subject to a waiting period as required under the Member's coverage.
- The maximum allowance for bitewing radiographs (x-rays) has been paid.

If you have questions about your remittance, please call the Provider Contact Center at 1(888) 349-6558, Monday through Friday, from 6:00 a.m. to 5:00 p.m. PT.

How to Access the Asuris Dental Fee Schedule

Fee schedule information can be found on the dental provider page under Provider Tools & Resources>Plan Information and Documents at **asurisdental.com**. If you have questions about a fee schedule, please contact your network manager, indicating the Plan name.

Sample Dental EOB

PROVIDER: [REDACTED] TIN: XXXXXX [REDACTED] PROVIDER #: [REDACTED] DATE: 06/19/23 PAGE 1 OF 2

FIRST DATE OF SVC	LAST DATE OF SVC	NUM OF SVCS	PL OF SVC	PROCEDURE CODE	TOOTH NUMBERS/ SURFACES	PROVIDER CHARGE	ALLOWANCE	NON- CHARGEABLE AMOUNT	NON- CHG CODE	SUBSCRIBER LIABILITY AMOUNT	SUB LIAB CODE	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID TO PROVIDER	AMOUNT(S) PAID TO SUBSCRIBER	MESSAGE CODE(S)	CLAIM NUMBER
-------------------------	------------------------	-------------------	-----------------	-------------------	-------------------------------	--------------------	-----------	------------------------------	---------------------	-----------------------------------	---------------------	------------------------------	----------------------------------	------------------------------------	--------------------	-----------------

PATIENT ACCT #: TESTCASE1-RFP PATIENT: DFTEST SUB TESTUATTETONHG ID NUMBER: [REDACTED] APPL/SUB NAME: DFTEST SUB TESTUATTETONHG

04/01/23	04/01/23	1	0	02140	02/0	45.00	45.00			45.00	A1				X5018 J9758	23142222010
						CLAIM TOTALS		.00		45.00		.00	.00	.00		MEN/FLN 888

PATIENT ACCT #: TESTCASE1-RFP PATIENT: DFTEST SUB TESTUATTETONHG ID NUMBER: [REDACTED] APPL/SUB NAME: DFTEST SUB TESTUATTETONHG

04/01/23	04/01/23	1	0	02140	02/0	45.00		45.00	07						H5152A J9758	23146218500
						CLAIM TOTALS		45.00		.00		.00	.00	.00		MEN/FLN 888

CLAIM SPECIFIC MESSAGE(S):

H5152A No payment can be made. This is a duplicate service that was reported and processed on claim number 23142222010.

PATIENT ACCT #: TESTCASE1-RFP PATIENT: DFTEST OAC TESTUATTETONHAZ ID NUMBER: [REDACTED] APPL/SUB NAME: DFTEST SUB TESTUATTETONHAZ

05/08/23	05/08/23	1	0	00150		50.00	50.00						50.00		J7060 J9758	23011355500
						CLAIM TOTALS		.00		.00		.00	50.00	.00		MEN/FLN 140

PATIENT ACCT #: TESTCASE1-RFP PATIENT: DFTEST SUB TESTUATTETONHII ID NUMBER: [REDACTED] APPL/SUB NAME: DFTEST SUB TESTUATTETONHII

04/05/23	04/05/23	1	0	03460	16	2225.00	15.00	15.00					15.00		V010 J9758	23011355502
04/01/23	04/01/23	1	0	00220											J7010 J9758	
						CLAIM TOTALS		.00		.00		.00	15.00	.00		MEN/FLN 140

EOB TOTALS: TOTAL SUBSCRIBER PAYMENTS = 5.00 TOTAL PROVIDER PAYMENTS = 565.00 PAYMENT NUMBER: 20075621

MESSAGE(S):

J7010 We are making payment for this previously processed claim. This payment represents our total responsibility for this service. We regret any inconvenience.

EXPLANATION OF BENEFITS

Section 15: Handling Overpayment Requests

Overview

Occasionally, Asuris may overpay a dental claim. Some reasons for overpayment include:

- Processing under an incorrect procedure code
- Paying a claim for a Member who is not a patient of record with the provider's office; or
- Paying a claim without coordinating benefits

In these circumstances, we are required to correct the action and issue a request for refund (invoice) to the provider, which includes information needed for the provider to refund the Responsible Payor for the overpayment.

If You Receive a Request for Refund

If you receive a letter requesting a refund, please:

- Make a copy of the letter and include it with your refund.
- **Make the check payable to ASURIS NORTHWEST HEALTH.**
- To ensure prompt and accurate posting, send your payment within fifteen (15) days of receipt to the address listed on the letter.

Please note: If payment is not received by the invoice due date, the Responsible Payor will collect the money by deducting the overpaid amount from future payments made to you by the Responsible Payor. This is called an offset. These payments may be deducted from different claims for claimants other than those who incurred the overpayment.

If You Discover an Overpayment

If you discover that Asuris has overpaid you, please call the Provider Contact Center at 1(888)349-6558 and provide the amount of the claim, the claim number, and the Member ID number. The representative will confirm the overpayment and, if necessary, have a request for refund mailed to your office. After that, you may do one of the following:

- Cash the check and wait for the request for refund letter, then follow the steps above for "If You Receive a Request for Refund."
- Return the check. To ensure we credit the refund to the appropriate account, we recommend that you wait for the request for refund letter to arrive and attach it to the check you are returning.

Section 16: Orthodontic Services

Orthodontic Claim Submission Guidelines

Orthodontia is a separate benefit from other dental services. Check the Member's benefits to determine whether it is a covered service. Orthodontia for periodontal reasons is covered only if the Member has orthodontic benefits. Please access Availity Essentials prior to treatment to determine if your Member has orthodontic benefits.

Note: Orthodontia services do not have a fee schedule. Members with an orthodontic benefit have a dollar benefit maximum. This information, if applicable, is available in an Eligibility and Benefits Inquiry on Availity Essentials.

Traditional Orthodontic Treatment Calculation

- Treatment Liability will be Calculated Based on the Member's Benefit Plan
- Treatment Payment Schedule:
 - One Initial Payment will be Calculated at 25% of the Treatment Liability Upon Banding
 - Equal Interim Payments will be Calculated on a Quarterly Basis Throughout the Treatment
 - Treatment Plans Calculated with a Total Liability of \$1000 or Less will be Paid in One Lump Sum Payment

Traditional Orthodontic Treatment in Progress

Treatment in progress includes scenarios where new group business has members in active treatment prior to coverage; a member picks up coverage after treatment began; or when a member changes their provider mid-treatment. This scenario will not result in an initial payment. Instead, the case will be initiated with scheduled installments spread evenly over the remainder of the treatment plan.

Handling traditional ortho treatment in progress:

- Require providers to submit a new claim with treatment plan information. With this option, we will prorate payment by comparing the banding date to the effective date of coverage and remaining length of treatment.

Submit claims electronically using valid orthodontic codes along with the following information in the Claims Notes or Remarks section:

- Banding date
- Total treatment charge
- Monthly payment amount
- Estimated length of treatment
- Initial banding fee or down payment
- Orthodontic treatment that started before the Member's effective date with Asuris will be reimbursed in proportion to the time remaining in treatment.

Example: If a Member's effective date with Asuris is in the 6th month of a 24-month course of treatment, payment will be prorated to the 18 months in which they became eligible. This payment, when combined with any payment made by a previous insurance carrier, cannot exceed the total billed amount.

Note: Orthodontia benefits for some groups are structured to pay for periodic treatment visits, as indicated in the Member's benefits. If you are not able to submit electronic claims for periodic treatments and the payment

received for your initial claim is not equal to the amount of the Member's available orthodontia benefit, please submit monthly or quarterly visit claims until benefits are exhausted. The last claim for treatment must indicate the date that the Member was de-banded.

Section 17: General Policies and Procedures

Quality and Utilization Review

While we continue to conduct utilization review on submitted claims, as a Participating Dental Provider we no longer require submission of radiographs or periodontal charting, except in specific cases or unless requested by the Plan.

From time to time, we may request that your practice participate in Utilization Management Programs that may include, an onsite review of facilities, onsite review of dental records, providing copies of Member dental records, audit of dental records, dental care evaluation studies, practice pattern studies and/or analysis based on claims data.

Necessary Dental Care

Our Member Contract or guide to benefits specify that all dental care—including services, procedures, supplies and appliances—must be “necessary and appropriate to diagnose or treat (the) dental condition.” Necessary and appropriate care must meet these criteria:

- The care must address the prevention, diagnosis and/or treatment of oral disease, decayed or fractured teeth, or a supporting structure weakened by disease (including periodontal, endodontic and related diseases);
- The care must be furnished in accordance with standards of good dental practice;
- The care must be provided in the most appropriate site and at the most appropriate level of services based upon the Member’s condition;
- The care must not be provided solely to improve a Member’s condition beyond normal variation in individual development and aging, including improving physical appearance that is within normal individual variation;
- The care must be as beneficial as any established alternative; and
- The care must not be solely for the Member’s or dentist’s convenience.

Section 18: Appeals and Grievances

If we deny payment of a claim, you have the right to request an Appeal. The Appeal must be in writing and received by Asuris within a specific time period of the denial, depending on the Member's plan. We will immediately acknowledge the Appeal and respond in writing within a specific period, depending on the Member's plan. You may request an expedited Appeal if you feel that any delay would prevent a Member from receiving urgently needed services. Appeal information can be submitted using the *Provider Appeal Form*, located on the **asuris.com** website.

Commercial Plan (excluding Medicare Advantage) Appeals must be mailed to:

Dental Customer Service
Appeals
P.O. Box 69437
Harrisburg, PA 17106-9437

The following information must be submitted with the Provider Appeal Form or the written description of the issue(s) on Appeal:

- i. A detailed description of the disputed issue(s);
- ii. The basis for disagreement with the decision; and
- iii. All evidence and documentation supporting your position.

Medicare Advantage Appeals must be mailed to:

Medicare Advantage/Medicare Part D
Appeals and Grievance B32AG
PO Box 1827
Medford, OR 97501

The following information must be submitted with the Provider Appeal Form or the written description of the issue(s) on Appeal:

- i. A detailed description of the disputed issue(s);
- ii. The basis for disagreement with the decision; and
- iii. All evidence and documentation supporting your position.

Invalid Appeals

Examples of invalid Appeals where an Appeal should not be initiated:

- Claim was processed incorrectly.
- Issue qualifies for an exception (for example, due diligence or a misquote).
- Claim is not clean.
- Issue qualifies as a quality of care, quality of service, and/or a quality of providers complaint (for example, provider is billing for services the Member believes were not performed).
- Exception payment request.

Who Can Receive the Appeal Determination

The following may receive an Appeal determination:

- The treating provider
- The Member (the Member who received or will receive services)
- The parents of a minor child of an intact family

- The Member's authorized representative—requires a valid disclosure authorization from the Member.

Appeal Timeline

In general, a provider or authorized representative has 180 days from the EOB print date for denied claims, date on an adverse denial letter with Appeal rights language, to file a Member Appeal. Specific timelines are in the Appeals section of the Member Contract.

Note: Generally, for timeline calculations, 180 days is used from the print date of the EOB. There is a five-business day grace period to allow for mailing and processing.

Timeframes

An internal level adverse determination Appeal or dispute for our Members must be submitted in writing within the following timeframes:

- Washington providers (select counties): Within 24 months after payment of the claim or notice that the claim was denied or within 30 months for claims subject to Coordination of Benefits.

Section 19: Provider Contract and Credentialing Termination Appeals

A contracted Participating Dental Provider may initiate an Appeal of a contract termination decision made by Asuris through the provider contract termination Appeal process.

You may also Appeal the decision of a denied credentialing application decision made by the dental credentialing committee by submitting a written notice of Appeal and any relevant material you feel pertinent to the decision.

To request an Appeal, you must send a written request to the Dental Provider Relations team, at the address listed below within thirty (30) business days of receipt of the termination notification.

By mail:

Provider Contract or Credentialing Termination Appeal
Attention: Provider Relations
P.O. Box 45132
Jacksonville, FL 32232-9902

The following information must be submitted with the Provider Appeal Form or the written description of the issue(s) on Appeal:

- i. A detailed description of the disputed issue(s);
- ii. The basis for disagreement with the decision; and
- iii. All evidence and documentation supporting your position.
- iv. Your requested outcome

Additional Information Regarding the Provider Contract Termination Appeals Process

Provider Status During a Contract Termination Appeal

You will continue as a Participating Dental Provider; however, you will be temporarily removed from all provider directories and any pending action by us is put in abeyance until the Appeal is resolved and a final decision is made. If, however, the basis for the termination decision relates to the health, safety or welfare of our Members, or if we have exercised our right to immediately terminate the provider contract for reasons allowed by the provider contract, your participation status will be terminated for the duration of the Appeal process and reinstated only if you prevail during the provider contract termination Appeal process.

The Data Bank Reportable Actions

We are required by law to report certain adverse actions or decisions against you to the data bank. If our termination decision stands, either by virtue of you choosing not to Appeal or if the decision is upheld by the Appeals panel, we may be obligated to report this termination to the data bank, as applicable. You may not “self-term” to avoid being reported to the data bank. Additional information on these reporting requirements is available on the data bank website, at npdb.hrsa.gov.

Section 20: Technology Solutions

Common Terms

The following terms are important to know when using our technology solutions.

Clearinghouse	The entity that connects your office and the insurance carrier for electronic billing
Electronic Data Interchange (EDI)	The transmission of data from one computer to another
Electronic attachment	Any clinical documentation requested by the insurer to support your claim
Practice management software	The software program that allows you to manage your practice; often includes electronic-claims capability

Electronic Claims Submission

Technology can help you spend less time on paperwork and other administrative tasks, so you can spend more time caring for your Members. Asuris offers technology solutions to help you and your staff do business with us more efficiently by:

- Improving claim payment time and office cash flow
- Reducing claim errors; and
- Increasing productivity and efficiency by reducing time spent on billing and benefit inquiries.

Electronic Claims Filing Information

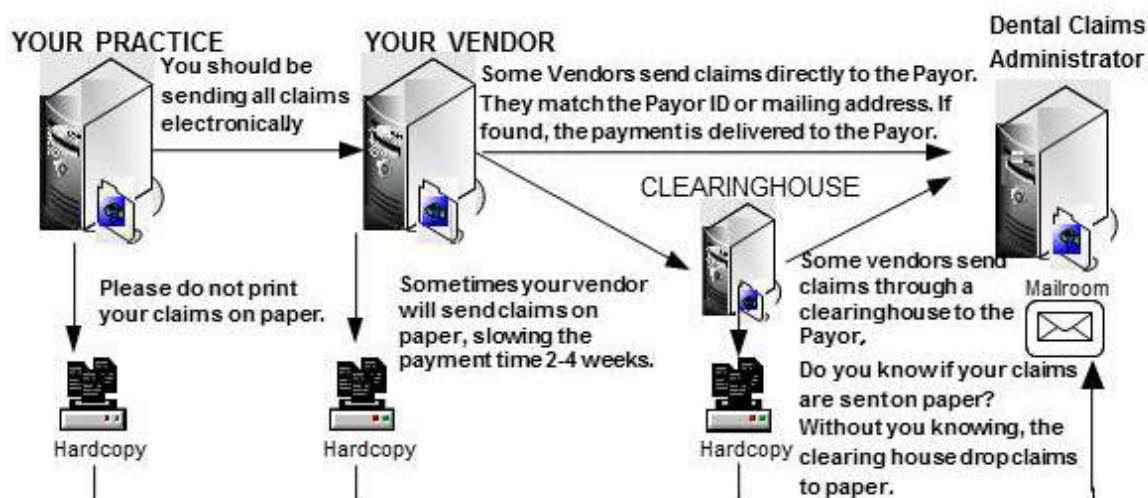
Claims are required to be submitted electronically. The advantages are listed above. One important advantage is that your vendor automatically corrects electronic claims prior to reaching us, so they are more likely to process without delay. You will receive a report confirming that your vendor did or did not receive each claim.

To get started, you will need:

- A computer with a modem and a printer
- Internet access
- Practice management or EDI-enabling software
- Notification to your software vendor of your provider billing number
- Know if your vendor is sending paper claims
- Know if your vendor's clearinghouse choice is sending claims on paper
- Ask your vendor what percentage of your claims is sent to the Responsible Payor electronically

Electronic Claims Illustration

The graphic illustrates how information flows among the entities involved in electronic claims submission.



Customer Support

If you have questions about filing claims electronically, please call our Technology Support Center at 1(800)253-0838, Monday through Friday, between 6:00 a.m. and 5:00 p.m. PST.

Self-Service Tools

Self-Service Tools and services are available to Asuris Participating Dental Providers through our dental website. Registered users will have access to all of the following online services 24 hours a day, 7 days a week. To register for any of these online services, visit **asurisdental.com**. From there, you will be directed to click on the Tools and Resources link, then click on Online Services, and finally, click Register. This will take you to Availity Essentials, where you will enter your information to register. Once you have completed the registration form, you will have a secure user ID and password, which will provide access to the tools on the following matrix.

Tool Service	What	How
MY PATIENTS' BENEFITS	Provides direct, up-to-the minute access to Member information and offers dental offices the ability to check Member eligibility and the status of Members' claims online for free.	<p>To verify Member eligibility and claim status:</p> <ul style="list-style-type: none"> Go to asurisdental.com. After being redirected to Availity Essentials, click on the For Dentists link, and then click on the My Patients' Benefits link. Enter the required provider and Member information and click Retrieve. The Eligibility information for the Member is displayed. To check the Claim Status for a Member, perform the same steps as above and click on the Claim Status tab. Select a date range and hit Retrieve.

PROVIDER CHECK INFORMATION	This online feature allows dental professionals to view check summaries, check detail and check related claims for a selected date range.	<ul style="list-style-type: none"> Go to asurisdental.com. After being redirected to Availity Essentials, click on the For Dentists link. Click on the Reimbursements link where you will be asked to enter a date range for a review of payments made to your office.
HIPAA ELIGIBILITY AND CLAIM STATUS TRANSACTIONS USING A CLEARINGHOUSE /VENDOR	Dental offices work with a multitude of Responsible Payors, and it can be difficult to determine which systems are compatible with every carrier. To make verifying eligibility and checking claim status easier for dental offices, we work with numerous clearinghouses and software vendors who can provide the ability for dental offices to perform these electronic transactions with all Responsible Payors using just one system.	Contact your software vendor to find out how you can perform these transactions through your practice management software.

Interactive Voice Response (IVR) System

Our interactive voice response (IVR) system offers physicians, dentists, other health care professionals, facilities, and their staff quick and easy access to Member information via phone. IVR is available 24 hours a day, seven days a week.

When calling our Provider Contact Center at 1(800)253-0838, use the phone prompts below to access IVR:

If the Member is an Asuris Member, press 1 and select:

1. For questions regarding dental
2. For prescription Pre-authorization questions
3. For claims or eligibility information, not including Pre-authorization
4. For questions regarding mental health, chemical dependency, and/or hemophilia medication

If you do not select one of the above options, you will be placed in the general Provider Contact Center queue.

Options

Use your phone keypad to enter the touch-tone options or speak the voice option listed below.

Note: Information about multiple Members or multiple providers can be obtained in a single session. When checking multiple Members or using more than one tax ID number, the prompting options and order of options will change. Please listen carefully to the touch-tone or voice options.

Type of inquiry	Touch-tone option	Voice option	Information required
Claim status	1	Claims	<ul style="list-style-type: none"> Provider tax ID Member ID number Member's date of birth Date of service or date range of claim

Section 21: Medical Billing for Dental Offices

Medical Claims Billed by Dental Offices

Dental offices performing procedures not on or contiguous to a tooth must report the service on a medical claim form, with CPT codes. These codes must be reported with the appropriate ICD-10 diagnosis codes.

ICD-10 Coding Resources

- ICD-10 CM and PCS medical billing codes may be helpful when submitting medical claims that require ICD-10 coding.

The following illustrates some common examples of services that should be billed as a medical benefit. This list is not all-inclusive and should be used as a reference only.

Sleep Apnea

- HCPCS E0486 Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment

TMJ

- CPT 21085 Impression and custom preparation; oral surgical splint (should not be used without surgery intervention)
- CPT 21089 Impression and custom preparation; unlisted maxillofacial prosthetic procedure (used to report mandibular repositioning devices where surgery is not part of the treatment plan for splint placement)

Implants

- CPT 21248 Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
- CPT 21249 Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete

Biopsy

- CPT 40490 Biopsy of lip
- CPT 40808 Biopsy, vestibule of mouth

Other

- CPT 41899 Unlisted procedure, dentoalveolar structures can be used for extractions, crowns, build ups, root canals, dentures, or other procedures not separately identified with a CPT or HCPCS code.
- Note: Include the corresponding CDT code in the 2400 Loop, in the SV1 segment (professional service) and the SV101-7 (description) of the electronic medical claim.

Submit Diagnosis Codes on Dental Claims

We require diagnosis codes on certain dental claims to support expanded dental care benefits for Members with such conditions as heart disease, diabetes, or pregnancy. Diagnostic codes will identify why a procedure was performed and the associated disease, illness symptom or disorder.

We encourage you to begin including diagnosis codes when submitting dental claims to us as soon as possible. You can submit dental claims using the online claims submission tool on Availity Essentials: Claims & Payment>Dental Claim. You can submit up to four diagnosis codes in the record of services provided section.

Availity Essentials also includes training on how to submit a dental claim: Help & Training>Find Help>Claim Submission>Dental Claims>Submitting Dental Claims.