**DOCUMENT HISTORY LOG**

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| --- | --- | --- | --- |
| **STATUS1** | **DOCUMENT REVISION2** | **EFFECTIVE DATE** | **DESCRIPTION3** |
| Baseline | 1.0 | September 15, 2009 | Initial version Uniform Managed Care Manual Chapter 3.18, “CHIP Dental Provider Manual Required Critical Elements.” |
| Revision | 1.1 | July 15, 2011 | Section VIII. A. “Member Complaint Process” is updated to remove the requirement for the Dental Contractor to have a local telephone number. |
| Revision | 2.0 | March 1, 2012 | Revision 2.0 applies to contracts issued as a result of HHSC RFP number 529-12-0003.  Chapter 3.18 is modified to include Medicaid Managed Care dental requirements. All sections and attachments are renumbered as appropriate. |
| Revision | 2.1 | November 15, 2012 | Section VI. A. “General Responsibilities” is modified to add requirements to obtain informed consent for utilization of a papoose board.  Attachment A is modified for clarity.  Attachment B is modified to add Federally Qualified Health Centers. |
| Revision | 2.2 | March 16, 2015 | Attachment E “Services Not Covered” is modified add “treatment and” to devices for craniofacial anomalies.  Attachment J, “Fraud Reporting” is modified to change “Click Here to Report Waste, Abuse, and Fraud” to “Under the box “I WANT TO” click “Report Waste, Abuse, and Fraud”” to conform to language on the OIG website. |
| Revision | 2.3 | May 1, 2015 | Attachment C “First Dental Home Initiative” is modified to clarify the requirements for dental anticipatory guidance. |
| Revision | 2.4 | September 1, 2015 | Section VI.A. is modified to add required language (Attachment E) and all subsequent attachments are relettered.  Section VII. is modified to add required language (Attachment G).  Section IX. is modified to add required language (Attachment G).  Attachment B “Main Dental Home” is modified to include billing requirements.  Attachment E “PA Process” is added and all subsequent attachments are re-lettered.  Attachment G “Provider Complaint and Appeal Process” is added.  Attachment J “Member Rights and Responsibilities” is modified to clarify item 8. |
| Revision | 2.5 | November 1, 2016 | Applicability is modified to add language regarding combined program manuals.  Section VI. C. is modified to add "What is HHSC's Medical Transportation Program?" and a reference to required language in Attachment G. All subsequent Attachment references are re-lettered.  Attachment G "Medical Transportation Program (MTP)" is added and all subsequent attachments are re-lettered. |
| Revision | 2.6 | April 1, 2021 | Attachment I “State Fair Hearing Information” is modified to revise “fair hearing” to the contract term, “State Fair Hearing,” revise the number of days a Member must ask for a State Fair Hearing from 90 Days to 120 Days and add a sentence to define who can be a Member’s representative.  Attachment K “Children’s Medicaid Dental Services Member Rights and Responsibilities” is modified to revise “fair hearing” to the contract term, “State Fair Hearing.”  Modified “day” and “calendar day” to the Contract term, “Day,” where applicable throughout chapter. |
| Revision | 2.7 | May 1, 2021 | Section VI. C. is modified to remove the reference to HHSC’s Medical Transportation Program.  Section V. is modified to add a bullet for Dental Contractor/Medicaid managed care organization coordination for transportation.  Attachment F is modified to remove the reference to HHSC’s Medical Transportation Program and add information on Nonemergency Medical Transportation (NEMT) services.  Attachment G is modified to remove the information on the Medical Transportation Program and replace it with required language on NEMT services.  Attachment K is modified to add additional member responsibilities when using NEMT services. |
| Revision | 2.7.1 | June 25, 2021 | Accessibility approved version. |
| Revision | 2.8 | May 1, 2022 | Added section titled, “GENERAL INSTRUCTIONS TO DENTAL CONTRACTOR” to provide guidance to DENTAL CONTRACTORs on the use of the term ‘emergency’.  Amended the term “fair hearing” to contract-defined term “State Fair Hearing” throughout the document.  Section VIII(A): Addition of MDCP/DBMD escalation help line Information  Revised to include information on the Medicaid External Medical Review process.  Section VIII(B). Adds Member option to request an External Medical Review.  Section VIII(E): Added required language for “External Medical Review Information”.  Attachment K: Added External Medical Review and MDCP-DBMD escalation help line language  Attachment N: Added required language for “External Medical Review Information”.  Attachment O: Added to include description of MDCP/DBMD escalation help line and when to utilize |
| Revision | 2.9 | May 2, 2022 | Administrative Update – Language deleted from ATTACHMENT N that reads, “Go in person to a local HHSC office”. |
| Revision | 2.10 | July 17, 2023 | Attachment N is modified to remove the language that the Member may request an IRO be present at the State Fair Hearing.  Attachment N is modified to clarify who the Member must contact for a State Fair Hearing withdrawal. |

**1** Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

2  Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.

# Applicability of Chapter 3.18

This chapter applies to Dental Contractors providing Texas Children’s Medicaid Dental Services or CHIP Dental Services to members through a dental plan. The requirements in this chapter apply to all Programs, except where noted.

Dental Contractors may develop a distinct Texas Children's Medicaid Dental Services (CMDS) or CHIP Dental Services provider manual or choose to develop a combined manual to include CMDS and CHIP Dental Services. If Dental Contractors choose to develop a combined provider manual, the manual must include distinctions between each program. For instance, program information that pertains to all managed care programs may be provided in a more generalized section of the manual. Any program information specific to CMDS or CHIP Dental Services must be contained in a specific section for that particular program.

GENERAL INSTRUCTIONS TO MCO

As used in this chapter, “emergency appeal” and “emergency State Fair Hearing” have the same meaning as “Expedited MCO Internal Appeal” or “expedited State Fair Hearing,” respectively.

| Required Element | Page Number |
| --- | --- |
| The following items must be included in the Provider Manual, but not necessarily in this order (unless specified). |  |
| Complete and attach this table to the Provider Manual when submitting the Manual for approval. Include the page number where each required critical element is located. |  |
| I. FRONT COVER |  |
| The front cover must include, at a minimum: |  |
| * Dental Contractor name |  |
| * Dental Contractor logo |  |
| * Children’s Medicaid Dental Services or CHIP Dental Services logo |  |
| * The words “PROVIDER MANUAL” |  |
| * Provider services telephone number |  |
| * Date of current publication |  |
| * Website address |  |
| **II. TABLE OF CONTENTS** |  |
| The Provider Manual must include a table of contents. |  |
| **III. INTRODUCTION** |  |
| * Quick reference phone list |  |
| * Objectives of Program(s) |  |
| * Role of Main Dental Home |  |
| * Role of First Dental Home Initiative for Medicaid Members |  |
| **IV. COVERED SERVICES** |  |
| **A.**  **Texas Health Steps Dental Services** (For Dental Contractors serving Medicaid Members) |  |
| * Refer Provider to the *Texas Medicaid Provider Procedures Manual* for information regarding Texas Health Steps dental services. |  |
| * Children of Migrant Farmworkers (Dental Contractors serving Medicaid Members will use HHSC’s provided language – **Attachment A**) |  |
| **B. Children’s Medicaid Dental Covered Services** (for Dental Contractors serving Medicaid Members) |  |
| At a minimum, the Dental Contractor must provide a benefit package to Children’s Medicaid Dental Services Members that includes Fee-for-Service (FFS) dental services currently covered under the Medicaid program. Please refer to the current *Texas Medicaid Provider Procedures Manual* for a list of limitations and exclusions. |  |
| **C.**  **CHIP Dental Covered Services** (For Dental Contractors serving CHIP Members) |  |
| At a minimum, the Texas CHIP Dental Contractor must provide a benefit package that includes the services listed in the Texas Dental Services Contract, Attachment B-2. |  |
| **V. QUALITY MANAGEMENT** |  |
| * Practice guidelines |  |
| * Focus studies and utilization management reporting requirements |  |
| **VI. PROVIDER RESPONSIBILITIES** |  |
| 1. **General Responsibilities** |  |
| * Availability and accessibility |  |
| * Main Dental Home responsibilities (Dental Contractor will use HHSC’s provided language – **Attachment B**) |  |
| * First Dental Home Initiative responsibilities (Dental Contractor will use HHSC’s provided language – **Attachment C)** |  |
| * **Updates to contact information.** Network providers must inform both the Dental Contractor and HHSC’s administrative services contractor of any changes to the provider’s address, telephone number, group affiliation, etc. |  |
| * Plan termination |  |
| * Referral to specialist process (Dental Contractor will use HHSC’s provided language – **Attachment D**) |  |
| * Verify Member eligibility and authorizations for service (Dental Contractor will use HHSC's provided language - **Attachment E**) |  |
| * Continuity of care—pre-existing condition not imposed |  |
| * Dental records: standards that dental records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. |  |
| * Access to second opinion |  |
| * Justification regarding Out-of-network referrals |  |
| * Requirements to obtain informed consent for utilization of a papoose board |  |
| **B. Routine, Therapeutic/Diagnostic, and Urgent Care Dental Services** |  |
| * Definitions |  |
| * Requirements for scheduling of appointments |  |
| **C. Coordination of Non-Capitated Services** |  |
| * Medicaid Non-Capitated Services (Dental Contractor will use HHSC’s provided language – **Attachment F**) |  |
| **VII. CHILDREN’S MEDICAID DENTAL SERVICES PROVIDER COMPLAINT AND APPEAL PROCESS** (for Dental Contractors serving Medicaid Members) |  |
| * Provider complaints/appeals to Dental Contractor (Dental Contractor will use HHSC’s provided language – **Attachment H**) |  |
| * Provider complaint process to HHSC |  |
| **VIII. CHILDREN’S MEDICAID DENTAL SERVICES MEMBER COMPLAINT AND APPEAL PROCESS** (for Dental Contractors Serving Medicaid Members) |  |
| * + - 1. **Member Complaint Process** |  |
| * + - * Definition of a Medicaid Complaint |  |
| * + - * The Member’s right to file Complaints to Dental Contractor and HHSC |  |
| * + - * The requirements and timeframes for filing a Complaint |  |
| * + - * The availability of help in the filing process |  |
| * + - * The toll-free numbers that the Member can use to file a Complaint       * MDCP/DBMD escalation help line (Dental Contractor will use HHSC’s provided language) - (Attachment O) |  |
| **B**. **Member Appeal Process** |  |
| * + - * What can I do if the Dental Contractor denies or limits my Member’s request for a Covered Service? |  |
| * + - * How will I find out if services are denied? |  |
| * + - * Timeframes for the Appeals process – the Dental Contractor must complete the entire standard Appeal process within 30 days after receipt of the initial written or oral request for Appeal.This deadline may be extended for up to 14 Days at the request of a Member; or the Dental Contractor shows that there is a need for additional information and how the delay is in the Member’s interest. If the Dental Contractor needs to extend, Member must receive written notice of the reason for delay. |  |
| * + - * When the Member has the right to request an Appeal – include option for the request of an Appeal for denial of payment for services in whole or in part. |  |
| * + - * Include notification to Member that in order to ensure continuity of current authorized services, the Member must file the Appeal on or before the later of: 10 Days following the Dental Contractor’s mailing of the notice of the Action, or the intended effective date of the proposed Action. |  |
| * + - * The Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member |  |
| * + - * Appeals must be accepted orally or in writing. |  |
| * + - * Can someone from (insert Dental Contractor name) help me file an Appeal? Yes. However, a Member’s option to request an External Medical Review and State Fair Hearing must be no later than 120 Days after the Dental Contractor mails the appeal decision notice. |  |
| * + Member’s option to request only a State Fair Hearing must be no later than 120 Days after the Dental Contractor mails the appeal decision notice. |  |
| **C. Member Expedited Dental Contractor Appeal** |  |
| * How to request an emergency Appeal (must be accepted orally or in writing) |  |
| * Timeframes |  |
| * What happens if the Dental Contractor denies the request for an emergency Appeal? |  |
| * Who can help me file an emergency Appeal? |  |
| **D**. **Member request for State Fair Hearing only** (MCO will use HHSC’s provided language – **Attachment I**)  **E. Member request for an External Medical Review** (Dental Contractors will use HHSC’s Provided language – **Attachment N**) |  |
| **IX. CHIP DENTAL SERVICES PROVIDER COMPLAINT/APPEAL PROCESS** (for Dental Contractors serving CHIP Members) |  |
| * Provider complaints to Dental Contractor (Dental Contractor will use HHSC’s provided language – **Attachment H**) |  |
| * Provider complaint and appeal process to TDI |  |
| **X. CHIP DENTAL SERVICES MEMBER COMPLAINT AND APPEAL PROCESS** (for Dental Contractors serving CHIP Members) |  |
| **A. Member Complaint Process** |  |
| * What should I do if I have a complaint? |  |
| * Who do I call? (Include at least one toll-free telephone number) |  |
| * Can someone from (insert Dental Contractor name) help me file a complaint? |  |
| * How long will it take to investigate and resolve my complaint? |  |
| * If I am not satisfied with the outcome, who else can I call? (file complaint with TDI) |  |
| * 1. **Member Appeal Process** |  |
| * What can I do if the Dental Contractor denies or limits my patient’s request for a Covered Service? |  |
| * How will I find out if the appeal is denied? |  |
| * Timeframes for appeal process |  |
| * When does the member have the right to request an appeal? |  |
| * Appeals must be accepted orally or in writing. |  |
| * Can someone from (insert Dental Contractor name) help me file an appeal? |  |
| **C. Member Expedited Dental Contractor Appeal** |  |
| * How to request an Expedited Appeal (must be accepted orally or in writing). |  |
| * Timeframes |  |
| * What happens if the Dental Contractor denies the request for an Expedited Appeal? |  |
| * Who can help file an Expedited Appeal? |  |
| **D. Member Independent Review Organization Process** |  |
| * What is an Independent Review Organization? |  |
| * How do I request a review by an Independent Review Organization? |  |
| * Timeframes |  |
| **XI. TEXAS CHILDREN’S MEDICAID DENTAL SERVICES MEMBER ELIGIBILITY, ENROLLMENT, DISENROLLMENT, AND VALUE ADDED BENEFITS** (for Dental Contractors serving Medicaid Members) |  |
| **A. Eligibility** |  |
| Determination by HHSC |  |
| **B. Verifying Eligibility** |  |
| * Dental Contractor ID card |  |
| * Call Dental Contractor |  |
| * AIS line/TXMedConnect |  |
| **C Automatic Re-enrollment** |  |
| * Within 6 months (include information that Member may choose to switch plans) |  |
| **D. Disenrollment** |  |
| * Inform the Dental Provider that he or she cannot take retaliatory action against a Member. |  |
| **E. Plan Changes** (Dental Contractor may use HHSC’s provided language – **Attachment J –** or develop their own language). |  |
| **F. Added Benefits** |  |
| * Value-Added Benefits, if applicable |  |
| **XII. CHIP DENTAL SERVICES** **MEMBER ELIGIBILITY, ENROLLMENT, DISENROLLMENT, AND VALUE-ADDED BENEFITS** (for Dental Contractors serving CHIP Members) |  |
| **A. Eligibility** |  |
| * + - * 12-month eligibility |  |
| **B. Verifying Eligibility** |  |
| * Enrollment (12-month eligibility) |  |
| * Determination by HHSC |  |
| **C. Re-enrollment** |  |
| **D. Disenrollment** |  |
| * Inform the Dental Provider that he or she it cannot take retaliatory action against a member |  |
| **E. Plan Changes** |  |
| * Members are allowed to make Dental plan changes under the following circumstances: |  |
| * For any reason within 90 Days of enrollment in CHIP; |  |
| * For cause at any time; and |  |
| * During the annual re-enrollment period |  |
| * HHSC will make the final decision. |  |
| **F. Added Benefits** |  |
| * Value-Added Benefits, if applicable |  |
| **XIII. MEMBER RIGHTS AND RESPONSIBILITES** |  |
| **A. Children’s Medicaid Dental Services Member Rights and Responsibilities** (Dental Contractor will use HHSC’s provided language – **Attachment K**) |  |
| **B. CHIP Dental Services Member Rights and Responsibilities** (Dental Contractor will use HHSC’s provided language – **Attachment L**) |  |
| **C. Fraud Reporting** (Dental Contractor will use HHSC’s provided language – **Attachment M**) |  |
| **XIV. CHILDREN’S MEDICAID DENTAL SERVICES /CHIP DENTAL SERVICES BILLING AND CLAIMS ADMINISTRATION** |  |
| * Where to send claims/Encounter Data |  |
| * Form to use |  |
| * Cost sharing schedule (for Dental Contractors serving CHIP Members) |  |
| * No co-payments for Medicaid Members |  |
| * Billing members |  |
| * Member acknowledgment statement (explanation of use) |  |
| * Private pay form agreement (provide sample and explanation of use) |  |
| * Time limit for submission of claims/claims appeals |  |
| * Claims payment |  |
| * 30-Day clean claim payment |  |
| * Claim submission requirement (within 95 Days) |  |
| * Approved claim forms |  |
| * Claims questions/appeals |  |
| **XV. CHILDREN’S MEDICAID DENTAL SERVICES/CHIP DENTAL SERVICES SPECIAL ACCESS REQUIREMENTS** |  |
| * Interpreter/translation services |  |
| * Dental Contractor/Provider coordination |  |
| * Dental Contractor/Medicaid managed care organization (MCO) coordination for transportation |  |
| * Reading/grade level consideration |  |
| * Cultural sensitivity |  |
| * The Dental Contractor must have a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member’s condition and identified needs, such as a standing referral to a specialty physician |  |

**REQUIRED LANGUAGE**

## ATTACHMENT A (for Medicaid)

### Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

**REQUIRED LANGUAGE**

## ATTACHMENT B (for Medicaid and CHIP)

### Main Dental Home

Texas defines a Main Dental Home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client’s Main Dental Home begins no later than 6 months of age and includes referrals to dental specialists when appropriate.

The Dental Contractor must develop a network of Main Dental Home Providers, consisting of Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists, who will provide preventative care and refer members to specialty care as needed.

In accordance with standards of practice and policy guidelines set forth by the American Academy of Pediatric Dentistry, Main Dental Home Providers must perform a caries risk assessment as part of the comprehensive oral examination. Main Dental Home Providers must bill one of the following caries risk assessment codes: D0601, D0602, or D0603 with every comprehensive oral examination (D0150), oral examination for a patient under 3 years of age (D0145), or periodic dental evaluation (D0120). These risk codes will be included as part of an informational component of the D0150, D0145 or D0120 billing code and do not have a separate rate attached to them. The TMHP will reject any D0150, D0145 or D0120 claim submitted without a caries risk assessment code. Providers will be given the standard 120 Day appeal period for the denied claim to submit proof of performing a caries risk assessment.

The TMPPM and the MMC-CHIP Dental Provider Manual will be effective with this change on October 1, 2015.

**REQUIRED LANGUAGE**

## ATTACHMENT C (for Medicaid)

### First Dental Home Initiative

In addition to establishing a Network of Main Dental Home Providers, the Dental Contractor must implement a “First Dental Home Initiative” for Medicaid Members. This initiative will enhance dental providers’ ability to assist Members and their primary caregivers in obtaining optimum oral health care through First Dental Home visits. The First Dental Home visit can be initiated as early as 6months of age and must include the following:

* Comprehensive oral examination;
* Oral hygiene instruction with primary caregiver;
* Dental prophylaxis, if appropriate;
* Topical fluoride varnish application when teeth are present;
* Caries-risk assessment; and
* Dental anticipatory guidance as defined in the Texas Medicaid Provider Procedures Manual (TMPPM), Volume 2, Children's Services Handbook and requires documentation of the specific information conveyed to the parent/guardian for at least 3 of the 8 anticipatory guidance topics found in the handbook.

Medicaid Members from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative provider as frequently as every 3 months if Medically Necessary.

**REQUIRED LANGUAGE**

## ATTACHMENT D (for Medicaid and CHIP)

### Referral Process

Main Dental Home Providers must assess the dental needs of Members for referral to specialty care providers and provide referrals as needed. Main Dental Home Providers must coordinate Member’s care with specialty care providers after referral.

Routine preventive care referrals must be provided within 30 Days of request.

**REQUIRED LANGUAGE**

## ATTACHMENT E

The Dental Contractor must notify providers of the Prior Authorization process. This includes access to PA requirements such as PA required services and codes. The Dental Contractor must inform Providers thatthe PA approval does not guarantee payment. The service will still be subject to retrospective review to confirm medical necessity.

**Important**: The Dental Contractor must emphasize that "PA Not Required" is not equivalent to "Medically Necessary". It is not to be assumed that payment will be dispensed for a service that does not require Prior Authorization.

**REQUIRED LANGUAGE**

## ATTACHMENT F

**For Medicaid:**

### Medicaid Services Not Covered by [insert Dental Contractor’s name]

The following Texas Medicaid programs and services are paid for by HHSC’s claims administrator instead of [insert Dental Contractor’s name]. Medicaid Members can get these services from Texas Medicaid providers.

1. Early Childhood Intervention (ECI) case management/service coordination;
2. DSHS case management for Children and Pregnant Women; and
3. Texas School Health and Related Services (SHARS).

Either the member’s medical plan or HHSC’s claims administrator will pay for treatment and devices for craniofacial anomalies, and for Emergency Dental Services that a member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

* treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts;
* treatment of oral abscess of tooth or gum origin; and
* treatment of craniofacial anomalies.

Nonemergency medical transportation (NEMT) services may be used to access Covered Dental Services provided by the Dental Contractor. NEMT Services are coordinated by the member’s Medicaid medical plan.

**For CHIP:**

### CHIP Services Not Covered by [insert Dental Contractor’s name]

Some services are paid by CHIP medical plans instead of [insert Dental Contractor’s name). These services include treatment and devices for craniofacial anomalies, and emergency dental services that a member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

* treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts;
* treatment of oral abscess of tooth or gum origin; and
* treatment of craniofacial anomalies.

**REQUIRED LANGUAGE**

## ATTACHMENT G

### NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

#### What are NEMT services?

NEMT services provide transportation to Covered Dental Services for patients who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips or transportation while receiving long-term services and supports (LTSS).

#### What do NEMT services include?

* Passes or tickets for transportation such as mass transit within and between cities or states, to include rail or bus.
* Commercial airline transportation services.
* Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vans, if necessary.
* Mileage reimbursement for an individual transportation participant (ITP) to a Covered Dental Service. The ITP can be the patient, the patient’s family member, friend, or neighbor.
* Patients aged 20 or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain a Covered Dental Services. The per diem rate for meals is $25 per day, per person.
* Patients aged 20 or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a Covered Dental Services. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
* Patients aged 20 or younger may be eligible to receive funds in advance of a trip to pay for authorized NEMT services.

If you have a patient needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of Medical Necessity for transportation of the attendant to be approved. The attendant must remain at the location where Covered Dental Services are being provided but may remain in the waiting room during the patient’s appointment.

Children 14 years of age and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone.

If you have a patient you think would benefit from receiving NEMT services, please refer him or her to their Medicaid managed care organization for more information.

**REQUIRED LANGUAGE**

## ATTACHMENT H

### Children's Medicaid Dental Services Provider Complaint and Appeal Process

The Dental Contractor must notify providers of the Provider Complaint and Appeals Process. The submitted documentation must specify the relevant subject (i.e. Appeal/Complaint). All documentation regarding an appeal/complaint must be submitted for processing. Submission copies must be retained for the provider's record.

### CHIP Dental Services Provider Complaint/Appeal Process

The Dental Contractor must notify providers of the Provider Complaint and Appeals Process. The submitted documentation must specify the relevant subject (i.e. Appeal/Complaint). All documentation regarding an appeal/complaint must be submitted for processing. Submission copies must be retained for the provider's record.

**REQUIRED LANGUAGE**

## ATTACHMENT I (for Medicaid)

### STATE FAIR HEARING INFORMATION

* **Can I ask for a State Fair Hearing?**

If you, as a member of the dental plan, disagree with the dental plan’s decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the dental plan telling them the name of the person you want representing you. A provider may be your representative. You or your representative must ask for the State Fair Hearing within 120 Days of the date on the dental plan’s letter that tells of the decision you are challenging. If you do not ask for the State Fair Hearing within 120 Days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the dental plan at (address for dental plan) or call (number for dental plan).

If you ask for a State Fair Hearing within 10 Days from the time you get the hearing notice from the dental plan, you have the right to keep getting any service the dental plan denied, at least until the final hearing decision is made. If you do not request a State Fair Hearing within 10 Days from the time you get the hearing notice, the service the dental plan denied will be stopped.

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the dental plan denied.

HHSC will give you a final decision within 90 Days from the date you asked for the hearing.

**OPTIONAL LANGUAGE**

## ATTACHMENT J (for Medicaid)

### Plan Changes:

You can change your child’s dental plan to another by contacting the Medicaid Enrollment Broker’s toll-free telephone number at 1-800-647-6558**.** During the first 90 Days after you are enrolled in a dental plan, you can change to another plan for any reason. After 90 Days with a dental plan, you can change to another plan once for any reason. If you show good cause, you can also change dental plans at any time. An example of good cause is that you can’t get the care you need through the dental plan.

If you call to change dental plans on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

* If you ask to change plans on or before April 15, the change will take place on May 1.
* If you ask to change plans after April 15, the change will take place on June 1.

**REQUIRED LANGUAGE**

## ATTACHMENT K (for Medicaid)

### CHILDREN’S MEDICAID DENTAL SERVICES MEMBER RIGHTS AND RESPONSIBILITIES

#### MEMBER RIGHTS

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   1. Be treated fairly and with respect.
   2. Know that your dental records and discussions with your dentists will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a dental plan and dentist. You have the right to change to another plan or dentist in a reasonably easy manner. That includes the right to:
   * + 1. Be told how to choose and change your dental plan and your dentist.
       2. Choose any dental plan you want that is available in your area and choose your dentist from that plan.
       3. Change your dentist.
       4. Change your dental plan without penalty.
       5. Be told how to change your dental plan or your dentist.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   1. Have your dentist explain your dental care needs to you and talk to you about the different ways your dental care problems can be treated.
   2. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   1. Work as part of a team with your dentist in deciding what dental care is best for you.
   2. Say yes or no to the care recommended by your dentist.
5. You have the right to use each available complaint and appeal process through the Dental Contractor and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   1. Make a complaint to your dental plan or to the state Medicaid program about your dental care, your dentist or your dental plan.
   2. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program. (Attachment O)
   3. Get a timely answer to your complaint.
   4. Use the plan’s appeal process and be told how to use it.
   5. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   6. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   1. Have telephone access to a dental professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   2. Get dental care in a timely manner.
   3. Be able to get in and out of a dental care provider’s office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   4. Have interpreters, if needed, during appointments with your dentist and when talking to your dental plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   5. Be given information you can understand about your dental plan rules, including the dental care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else’s convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that dentists, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Before any medically necessary dental services and treatment begin, the services and treatment must be fully explained to you and you must give permission in writing (informed consent). Your dental plan cannot prevent you from getting this information from dentists or hospitals, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

#### MEMBER RESPONSIBILITIES

* + 1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
  1. Learn and understand your rights under the Medicaid program.
  2. Ask questions if you do not understand your rights.
  3. Learn what choices of dental plans are available in your area.
     1. You must abide by the dental plan’s and Medicaid’s policies and procedures. That includes the responsibility to:
  4. Learn and follow your dental plan’s rules and Medicaid rules.
  5. Choose your dental plan and a dentist quickly.
  6. Make any changes in your dental plan and dentist in the ways established by Medicaid and by the dental plan.
  7. Keep your scheduled appointments.
  8. Cancel appointments in advance when you cannot keep them.
  9. Always contact your dentist first for your non-emergency dental needs.
  10. Be sure you have approval from your dentist before going to a specialist.
  11. Understand when you should and should not go to the emergency room.
      1. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
      2. Tell your dentist about your health.
      3. Talk to your dentist about your health care needs and ask questions about the different ways your dental care problems can be treated.
      4. Help your dentist get your dental records.
      5. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your dental health. That includes the responsibility to:
         1. Work as a team with your dentist in deciding what dental care is best for you.
         2. Understand how the things you do can affect your dental health.
         3. Do the best you can to stay healthy.
         4. Treat dentists and staff with respect.

Additional Member Responsibilities while using NEMT Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your dental appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets o tokens only to go to your dental appointment.
6. You must only use NEMT Services to travel to and from your dental appointments.
7. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

**REQUIRED LANGUAGE**

## ATTACHMENT L (for CHIP)

### CHIP DENTAL SERVICES MEMBER RIGHTS AND RESPONSIBILITIES

#### MEMBER RIGHTS:

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's dentists and other providers.
2. You have the right to know how your dentists are paid. You have a right to know about what those payments are and how they work.
3. You have the right to know how *[insert name of the Dental Contractor]* decides about whether a service is covered and/or medically necessary. You have the right to know about the people in *[insert name of the Dental Contractor]’s* office who decide those things.
4. You have the right to know the names of the dentists and other providers enrolled with *[insert name of the Dental Contractor]* and their addresses.
5. You have the right to pick from a list of dentists that is large enough so that your child can get the right kind of care when your child needs it.
6. You have the right to take part in all the choices about your child's dental care.
7. You have the right to speak for your child in all treatment choices.
8. You have the right to get a second opinion from another dentist enrolled with *[insert name of the Dental Contractor]* about what kind of treatment your child needs.
9. You have the right to be treated fairly by *[insert name of the Dental Contractor]*, dentists and other providers.
10. You have the right to talk to your child's dentists and other providers in private, and to have your child's dental records kept private. You have the right to look over and copy your child's dental records and to ask for changes to those records.
11. You have a right to know that dentists, hospitals, and others who care for your child can advise you about your child’s health status, medical care, and treatment.  Your dental plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
12. You have a right to know that you are only responsible for paying allowable copayments for covered services, up to benefit maximum limits.  Dentists, hospitals, and others cannot require you to pay any other amounts for covered services.

#### MEMBER RESPONSIBILITIES

You and *[insert name of the Dental Contractor]* both have an interest in seeing your child's dental health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits, such as encouraging your child to exercise, to stay away from tobacco, and to eat a healthy diet.
2. You must become involved in the dentist's decisions about your child's treatments.
3. You must work together with *[insert name of the Dental Contractor]‘s* dentists and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with *[insert name of the Dental Contractor]* you must try first to resolve it using *[insert name of the Dental Contractor]* 's complaint process.
5. You must learn about what *[insert name of the Dental Contractor]* does and does not cover. You must read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the dentist's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. You must report misuse of CHIP by dental and health care providers, other CHIP members, *[insert name of the Dental Contractor],* or other CHIP plans.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019.   You also can view information concerning the HHS Office of Civil Rights online at [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

**REQUIRED LANGUAGE**

## ATTACHMENT M (for Medicaid and CHIP)

### FRAUD REPORTING

#### Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care provider or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

* Getting paid for Medicaid or CHIP services that weren’t given or necessary.
* Not telling the truth about a medical condition to get medical treatment.
* Letting someone else use a Medicaid or CHIP Dental ID.
* Using someone else’s Medicaid or CHIP Dental ID.
* Not telling the truth about the amount of money or resources he or she has to get benefits.

#### To report waste, abuse, or fraud, choose one of the following:

* Call the OIG Hotline at 1-800-436-6184; or
* Visit <https://oig.hhsc.state.tx.us/> Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form.
* You can report directly to (insert Dental Contractor name):
  + (insert Dental Contractor name) name
  + (insert Dental Contractor name)’s office/director address
  + (insert Dental Contractor name)’s toll free phone number

#### To report waste, abuse, or fraud, gather as much information as possible.

* When reporting about a provider (a doctor, dentist, counselor, etc.) include:
* Name, address, and phone number of provider.
* Name and address of the facility (hospital, nursing home, home health agency, etc.)
* Medicaid number of the provider and facility, if you have it.
* Type of provider (doctor, dentist, therapist, pharmacist, etc.)
* Names and phone numbers of other witnesses who can help in the investigation.
* Dates of events.
* Summary of what happened.
* When reporting about someone who gets benefits, include:
* The person’s name.
  + The person’s date of birth, Social Security number, or case number if you have it.
  + The city where the person lives.
* Specific details about the waste, abuse, or fraud.

**REQUIRED LANGUAGE**

**ATTACHMENT N** (for Dental Contractors serving MMC Members)

**EXTERNAL MEDICAL REVIEW INFORMATION**

* **Can a Member ask for an External Medical Review?**

If a Member, as a member of the dental plan, disagrees with the dental plan’s decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the dental plan telling the Dental Contractor the name of the person the Member wants to represent him or her. A provider may be the Member’s representative. The Member or the Member’s representative must ask for the External Medical Review within 120 days of the date the dental plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member’s representative should either:

* Fill out the ‘State Fair Hearing and External Medical Review Request Form’ provided as an attachment to the Member Notice of Dental Contractor Internal Appeal Decision letter and mail or fax it to <Dental Contractor name> by using the address or fax number at the top of the form.;
* Call the DENTAL CONTRACTOR at <DENTAL CONTRACTOR telephone number>;
* Email the DENTAL CONTRACTOR at <DENTAL CONTRACTOR email address>, or;

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the dental plan, the Member has the right to keep getting any service the dental plan denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the dental plan, the service the dental plan denied will be stopped.

If the Member or the Member’s representative decides to withdraw the EMR request, the Member or the Member’s representative must initiate an EMR request withdrawal communication to the Dental Contractor. The Member or the Member’s representative, must submit the request to withdraw the EMR to the Dental Contractor using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

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**Can a Member ask for an emergency External Medical Review?**

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member’s life or health, or the Member’s ability to attain, maintain, or regain maximum function, the Member or Member’s representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling <insert Dental Contractor’s name>. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, the Member must first complete <insert Dental Contractor’s name>’s internal appeals process.

**REQUIRED LANGUAGE**

**ATTACHMENT O** (for Dental Contractors serving MMC Members)

MDCP/DBMD ESCALATION HELP LINE

**What is the MDCP/DBMD Escalation Help Line?**

The MDCP/DBMD Escalation Help Line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about Medicaid fair hearings and continuing services while appealing.

**When should I call the escalation help line?**

Call when you have tried to get help but have not been able to get the help you need. If you don’t know who to call, you can call **844-999-9543** and they will work to connect you with the right people.

**Is the escalation help line the same as the HHS Office of the Ombudsman?**

No. The MDCP/DBMD escalation help line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

**Who can call the help line?**

You, your authorized representative or your legal representative can call.

**Can I call any time?**

The escalation line is available Monday through Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.

**¿Qué es la línea de escalamiento del MDCP/DBMD?**

**La línea de escalamiento del MDCP/DBMD** ayuda a las personas con Medicaid que reciben beneficios del Programa para Niños Médicamente Dependientes (MDCP) o del Programa para Personas Sordociegas con Discapacidades Múltiples (DBMD).

La línea de escalamiento le ayuda a resolver problemas relacionados con el programa de atención médica administrada STAR Kids. Esa ayuda puede consistir en darle respuesta a las dudas que pueda tener sobre las audiencias imparciales de Medicaid o sobre la continuación de los servicios mientras se lleva a cabo la apelación.

**¿Cuándo puedo llamar a la línea de escalamiento?**

Llámenos si ha tratado de obtener ayuda y no ha recibido el tipo de ayuda que necesitaba. Si no sabe a quién recurrir, puede llamarnos al **844-999-9543** y nosotros nos encargaremos de ponerlo en contacto con el personal adecuado.

**¿Es esta la misma oficina que la Oficina del Ombudsman de HHS?**

No. La línea de escalamiento del MDCP/DBMD forma parte del programa Medicaid. El Ombudsman le ofrece una revisión independiente de sus inquietudes. Para obtener ayuda del Ombudsman comuníquese al 866-566-8989, o visite el sitio de internet hhs.texas.gov/managed-care-help. La línea de escalamiento del MDCP/DBMD está dirigida a individuos y familias que reciben beneficios del programa MDCP o DBMD.

**¿Quiénes pueden llamar a la línea de ayuda?**

Usted, su representante autorizado o su representante legal.

**¿Puedo llamar a cualquier hora?**

La línea de escalamiento está disponible de lunes a viernes de 8:00 a.m. a 8:00 p.m. Si llama después de este horario, deje un mensaje y uno de nuestros empleados de guardia capacitado se comunicará con usted.