TITLE 482 MANAGED CARE

CHAPTER 5 THE DENTAL BENEFITS PACKAGE

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

001.01 INTRODUCTION. This chapter sets forth the responsibilities of the Dental Benefits Manager, a Prepaid Ambulatory Health Plan, in delivering the dental benefits package to their managed care members. While the provider is responsible for providing services to the member, the Dental Benefits Manager, as the contracting entity with the Department, assumes primary administrative and operational responsibility for the development and implementation of the managed care requirements. In developing its program for the delivery of the dental benefits package, the Dental Benefits Manager must incorporate the information contained in this Title, as well as 471 Nebraska Administrative Code (NAC) 6, which defines in detail the minimum service provisions required for dental services under Nebraska Medicaid.

002. DENTAL BENEFITS PLAN. Medicaid managed care delivers the dental benefits package to eligible Medicaid members through a Prepaid Ambulatory Health Plan. The following provisions describe the Dental Benefits Manager's responsibilities in Managed Care.

002.01 GENERAL REQUIREMENTS. The Dental Benefits Manager is responsible for establishing a statewide system of dental services. The Dental Benefits Manager is required to comply with, but is not limited to, the following general requirements:

(A) Credential only providers enrolled in Nebraska Medicaid;

(B) Provide a full array of services along a continuum of care in accordance with 471 NAC 6;

(C) Provide access to dental services and necessary referrals twenty-four (24) hours per day, seven (7) days per week;

(D) Provide a client handbook, a comprehensive list of providers, and other informational materials about the dental benefits package to its members. The Dental Benefits Manager must not perform any direct solicitation to individual Medicaid members. The Department must approve any general marketing to Medicaid members prior to use and must comply with applicable marketing guidelines;

(E) Comply with Medicaid's continuous Quality Assessment and Performance Improvement, provide dental services meeting Medicaid's quality standards, and comply with all requests for reports and data to ensure that the Quality Assessment and Performance Improvement requirements are met (See 482 NAC 6);

(F) Coordinate activities with Medicaid, other managed care contractors, and other providers for services, as appropriate, to meet the needs of the member, and ensure systems are in place to promote well-managed patient care;
(G) Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;
(H) Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;
(I) Allow members with chronic, severe conditions, or experience-sensitive conditions to go directly to a qualified provider within the Dental Benefits Manager's network;
(J) Report all fraud and abuse information to Medicaid in a timely manner; and
(K) Make available twenty-four (24) hour, seven (7) days per week access by telephone to a live voice (an employee of the plan or an answering service) so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours.

003. DENTAL BENEFITS PACKAGE GENERAL PROVISION. All services provided under managed care must meet the requirements of 471 NAC unless specifically waived by the Department.

003.01 GUIDELINES. The provider and Dental Benefits Manager must apply the same guidelines for determining coverage of services for the managed care member as Medicaid applies to non-managed care members.
(A) Actual provision of a service included in the dental benefits package must be based on whether the service could have been covered by Nebraska Medicaid on a fee-for-service basis under Title 471 NAC.
(B) All services in the dental benefits package must be provided or approved by the Dental Benefits Manager.

004. SERVICES IN THE DENTAL BENEFITS PACKAGE. The Dental Benefits Manager must provide the services listed in the Nebraska Medicaid Dental Fee Schedule in amount, duration and scope defined by Medicaid in 471 NAC 6.

004.01 DENTAL BENEFITS MANAGER AND ACCESS STANDARDS. The Dental Benefits Manager is responsible for ensuring the eligible member has access to all services when medically necessary.

004.01(A) ACCESSIBILITY. The Dental Benefits Manager must ensure services provided to the member are accessible, in terms of timeliness, amount, duration, and scope, as those services provided to the non-managed care member.

004.01(B) LIMITATIONS. The Dental Benefits Manager may place appropriate limits on services based on medical necessity or utilization control.

004.01(C) ADDITIONAL AND SUBSTITUTE SERVICES. The Dental Benefits Manager is allowed to provide additional medically necessary services than those covered by

Medicaid. The Dental Benefits Manager is also allowed to provide substitute dental services when the Dental Benefits Manager determines the service is more cost effective than the covered service and the health status of the member is expected to improve or stabilize.

(i) If the Dental Benefits Manager provides additional or substitute dental services, the Department will not adjust the rate or total payment to the Dental Benefits Manager as the contract between the two parties dictate. The rate will remain within the rate range that the Centers for Medicare and Medicaid Services approved and certified.

005. SERVICES FOR EMERGENCY MEDICAL CONDITIONS. Prior approval by the member's Dental Benefits Manager is not required for receipt of emergency dental services.

005.01 EMERGENCY SERVICES PROVIDED. The Dental Benefits Manager must cover and pay for emergency dental services regardless of whether the provider that furnishes the services participates in the Dental Benefits Manager network.

006. COORDINATION OF SERVICES. The following rules apply when coordination of services is required between the physical health plan responsible for the core benefits package and the Dental Benefits Manager responsible for the dental benefits package, as addressed by the Department in regulations governing both components of managed care. In situations where the individual is only a member of a health plan or the Dental Benefits Manager, but not both, the payment of the associated service is coordinated with the Department on a fee-for-service basis.

006.01 INPATIENT CARE AND SERVICES. The member's Heritage Health plan will be responsible for reimbursing all inpatient services. The Dental Benefits Manager will not be responsible for reimbursing any inpatient or related services.

006.02 ANESTHESIOLOGY ASSOCIATED WITH DENTAL SERVICES. Anesthesiology services associated with dental services, authorized by the Dental Benefits Manager, are the responsibility of the Heritage Health plan if the member is also a member of a health plan.

007. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS. The Dental Benefits Manager must offer to contract with all Federally Qualified Health Centers and Rural Health Clinics in the State.

007.01 NOTIFICATION TO THE DEPARTMENT. If the Dental Benefits Manager and a Federally Qualified Health Center or Rural Health Clinic cannot agree upon a contract, the Dental Benefits Manager must notify the Department.

008. INDIAN HEALTH PROTECTIONS. The Dental Benefits Manager must reimburse Indian Health Services, Tribal 638, and Urban Indian Health providers, whether participating in the network, payment for covered services provided to Indian members who are eligible to receive services from these providers.

009. PAYMENT FOR SERVICES. The Department pays the Dental Benefits Manager a capitated payment for the services it provides. The Department pays a monthly capitation fee to the Dental

Benefits Manager for each enrolled member. The monthly capitation fee includes payment for all services in the dental benefits package.

009.01 CAPITATION RATES. The capitation payment rates are actuarially determined and are based on the member's age. The Department may adjust rates when it is determined appropriate.

009.02 PAYMENT IN FULL. Payment to the Dental Benefits Manager is payment in full for all services included in the dental benefits package. The Dental Benefits Manager must not request additional payment from the Department or a member.

009.02(A) BILLING THE CLIENT. The Dental Benefits Manager must not bill a member for a coverable service, regardless of circumstances. A provider of a service may only bill the client pursuant to 471 NAC.

009.03 RECOUPMENTS AND RECONCILIATION. When the Department incorrectly makes a payment to the Dental Benefits Manager, the Department must recoup those payments from the Dental Benefits Manager. The Dental Benefits Manager must work with the Department to identify the discrepancy and must allow the Department to recoup and reconcile such payments.