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AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 5, 2022

Item Number: VIII

Title: Proposed Changes to the Dental Master Plan Document (MPD)

SUMMARY

When PEBP onboarded to the new Third-Party Administrator, UMR, PEBP plan rules were applied as written in the MPD; however, this identified several unanticipated discrepancies in how plan rules were being applied in practice versus the actual language of the Master Plan Document. In many cases, the plan language was found to be vague and thus, the interpretations between HealthSCOPE Benefits and UMR differed. This was further highlighted during audits performed by Claims Technologies Inc. (CTI) and has been the subject of provider complaints.

As a result, PEBP, CTI, and UMR staff reviewed the MPD in-depth to identify areas that could be improved immediately, without any impact to coverage or benefits and avoiding a special open enrollment period.

This report proposes plan language changes to the Dental Master Plan Document for clarity in the current plan year (PY2023) and going forward.

REPORT

OVERVIEW

When conducting the review, it was noted that updating targeted sections in the plan document would create conflict with other parts of the Master Plan Document. These conflicts are also addressed. The overall intent of the proposed changes is to clarify any potential conflicts in the plan's language.

PROPOSED PLAN LANGUAGE CHANGES

The entirety of the current plan document can be found here: https://pebp.state.nv.us/wp-content/uploads/2022/05/FINAL-PY2023-Dental-Life-MDP-20220526.pdf, however the specific pages where changes are being proposed are attached as **Attachment B**.

The following is a summary of clarifications and changes by page identifier and heading:

Page 13 - Basic Services, Explanation and Limitations
The language of the plan document needed to be clarified for oral surgery due to language conflict between the Dental and Medical benefit.

Removed

- Oral surgery, limited to alveoplasty or alveolectomy, removal of cysts or tumors, torus, and impacted wisdom teeth, including local anesthesia and postoperative care
- Appliance for thumb sucking (individuals under 16 years of age) or night guard for bruxism (grinding teeth). This had confusing language that caused additional processing time because the nightguard could be used for periodontal disease. This is updated in the subsequent ending two bullet points, below.

Added

- Emergency palliative treatment for pain.
- Uncomplicated oral surgery is surgery not identified as "complex oral surgery." Oral surgery is limited to removal of teeth, incision, and drainage.
- Complex oral surgery means procedures including surgical extractions of teeth, impactions, alveoloplasty or alveolectomy, vestibuloplasty, and residual root removal, including local anesthesia and postoperative care.
- Appliance for thumb sucking (for individuals under 16 years of age)
- occlusal guard or night guard. A requirement for "Bruxism" was removed to coincide with industry standards.

Page 21 – Dental Claims Administration
Removed the requirement for invoices to pay claims. This requirement caused an extensive delays in claims processing. While this is required for medical due to heavy mark up of medical devices, this is not a concern for dental and only creates more manual interventions and delays.

Page 37-38 – Participant Contact Guide
Added United Healthcare for Basic Life Insurance

For Diversified Dental Services the contact information was updated.
Added bullet point reflecting Principal Dental Network for providers outside of Nevada.

Page 40-44 – Key Terms and Definitions
The definition for Cost-Efficient was removed because claims were being repriced for cost-efficient services. This is removed to avoid conflict when updating "Medically Necessary," below.

Definition for Dental was updated. Injury was removed and clarified to "see Injury to Sound and Natural Teeth." This was conflict noted in during the review of the plan document that needed to be clarified.

Updated definition of Injury to Sound and Natural Teeth to exclude "this does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing." This was conflict noted in during the review of the plan document that needed to be clarified.

Updated definition of "Medically Necessary" to exclude references to "cost-efficient" and "appropriate." Numerous claims were repriced due to a more cost-efficient benefit, namely resin-composite fillings when compared to silver Amalgam fillings. By removing these references, claims will pay based on how they are submitted by the provider.

STAFF RECOMMENDATION

Approve the proposed changes for the Dental and Life Master Plan Document for Plan Year 2023 going forward.

ATTACHMENT B

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Basic Services	After the Deductible is met, the Plan pays 80% of the discounted allowed fee schedule	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies
- Dental visit during regular office hours for treatment and observation of injuries to teeth and supporting structures (other than for routine operative procedures)
- After hours for emergency dental care
- Consultation by a specialist for case presentation when a general dentist has performed diagnostic procedures
- Emergency treatment
- Film fees, including examination and diagnosis, except for injuries
- Dental CT scans are allowed at varying frequencies depending on the type of service.
- Periapical, entire dental film series (14 films), including bitewings as necessary every 36 months **or** panoramic survey covered once every 36 months
- Basic services are subject to the individual Plan Year maximum dental benefit.
- Full-mouth periodontal maintenance cleanings, payable four times per Plan Year. Even if your dentist recommends more than four periodontal maintenance cleanings, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year
- Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition
- For multiple restorations, one tooth surface will be considered a single restoration
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.
- Biopsy, examination of oral tissue, study models, microscopic exam
- Emergency palliative treatment for pain.
- Uncomplicated oral surgery is surgery not identified as "complex oral surgery." Oral surgery is limited to removal of teeth, incision, and drainage.
- Complex oral surgery means procedures including surgical extractions of teeth, impactions, alveoloplasty or alveolectomy, vestibuloplasty, and residual root removal, including local anesthesia and postoperative care

- ~~Oral surgery, limited to alveoplasty or alveolectomy, removal of cysts or tumors, torus, and impacted wisdom teeth, including local anesthesia and postoperative care~~
- Amalgam restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings, retention pin when used as part of restoration other than a gold restoration
- Appliance for thumb sucking (individuals under 16 years of age) or night guard for bruxism (grinding teeth)
- Dental CT scans, depending on the type and necessity are allowed by the Plan. Contact the claims administrator for more information. You must have the CDT code of your requested procedure before calling
- Initial installation of a removable, fixed or cemented inhibiting appliance to correct thumb sucking is payable for individuals under age 16 years
- No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Major Services	After the Deductible is met, Plan pays 50% of the discounted allowed fee schedule.	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies to Major services
- Major services are subject to the individual Plan Year maximum dental benefit
- No coverage for a crown, bridge, or gold restoration when the tooth was prepared before coverage under the dental Plan began
- Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. Gold restorations (inlays and onlays) covered only when teeth cannot be restored with a filling material

- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the third-party administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's explanation of benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny deductible credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list.

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- ~~For providers such as hospitals and facilities that bill for items such as orthopedic devices/implants or other types of biomaterial, the Plan has the right to request a copy of the invoice from the organization that supplied the device/implant/biomaterial to the hospital or facility. The Plan has the right to deny payment for such medical devices until a copy of the invoice is provided to the Plan's claims administrator.~~

NOTE: Claims are processed by PEBP's third-party administrator in the order they are received. If a claim is held or "soft denied" that means that PEBP's third-party administrator is holding the claim to receive additional information, either from the participant, the provider or to get clarification on benefits to be paid. A claim that is held or soft denied will be paid or processed when the requested additional information is received. Claims filed while another is held or soft denied may be paid or processed even though they were received at a later date.

NOTE: It is your responsibility to maintain copies of the explanation of benefits provided to you by PEBP's third party administrator or prescription drug administrator. Explanation of benefits

Participant Contact Guide

Express Scripts Pharmacy Benefit Administrator Customer Service and Prior Authorization (855) 889-7708 *www.Express-Scripts.com* **Express Scripts Home Delivery** PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708 **Accredo Specialty Pharmacy** Customer Service: (855) 889-7708 **Express Scripts Benefit Coverage Review Department** PO Box 66587, St. Louis, MO 63166-6587 Phone: 800-946-3979 **Express Scripts Clinical Appeals Department** PO Box 66588 St. Louis, MO 63166-6588 Phone: 800-753-2851 Fax: 877-852-4070 **MCMC LLC** **Attn: Express Scripts Appeal Program** 300 Crown Colony Dr. Suite 203 Quincy, MA 02169-0929 617-375-7700 ext. 28253 / Fax: 617-375-7683	Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and Premier Plan Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews, appeals
Diversified Dental Services 5470 Kietzke Lane, Ste 300~~PO Box 36100~~ ~~Las Vegas, NV 89133-6100~~ Reno, NV 89511 ProviderRelations@ddsppo.com ~~1-Northern Nevada: (866) 270-8326~~ ~~Southern Nevada: (800) 249-3538~~866-270-8326 diversifieddental.com~~www.ddsppo.com~~	PPO Dental Network • Statewide PPO Dental Providers • ~~National PPO Dental Providers~~ • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 *www.stateofnv.healthplanofnevada.com*	Southern Nevada Health Maintenance Organization (HMO) • Medical claims/provider network
VIA Benefits 10975 Sterling View Drive, Suite A1	Medicare Exchange • Medigap (Supplemental) plans

Participant Contact Guide

South Jordan, UT 84095 (888)598-7545 *https://my.viabenefits.com/pebp* Phone: (888) 598-7545; Fax: (402) 231-4310	• Medicare Advantage Plans (HMO and PPO) • Voluntary Vision • Voluntary Dental • HRA claims administrator
United Healthcare Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Basic Life Insurance for eligible active and retirees
The Standard Insurance Company 900 SW Fifth Avenue Portland, OR 97204 (888) 288-1270 *www.standard.com/mybenefits*	• ~~Basic Life Insurance~~ • Voluntary (Supplemental) Life Insurance • Voluntary Short-Term Disability • Travel Assistance • Beneficiary designations
Office for Consumer Health Assistance 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 *http://dhhs.nv.gov/Programs/CHA/Contact_Gov CHA/*	**Consumer Health Assistance** • Concerns and problems related to coverage • Provider billing issues • External review information
The Living Will Lockbox c/o Nevada Secretary of State 101 North Carson St., Ste. 3 Carson City, NV 89701 Phone: (775) 684-5708; Fax: (775) 684-7177 https://www.nvsos.gov/sos/online-services/nevada-lockbox	**Living Will Information** • Declaration governing life-sustaining treatment/do not resuscitate order • Durable power of attorney for health care decisions

Base Plan: The Self-Funded Consumer Driven Health Plan (CDHP). The base Plan is also defined as the "default Plan" where applicable in this document and other communication materials produced by PEBP.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Bitewing X-Rays (dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework (dental) Fixed: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.

Business Day: Refers to all weekdays, except Saturday or Sunday, or a state or federal holiday.

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Coinsurance: That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan's Deductible. The Coinsurance varies depending on whether in-network or out-of-network providers are used.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the *Coordination of Benefits* section).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

~~**Cost-Efficient:** See the definition of medically necessary for the definition of cost-efficient as it applies to dental services that are medically necessary.~~

Course of Treatment (Dental): The planned program of one or more services or supplies, provided by one or more dentists, to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Dental Expenses: See the definition of *Eligible Dental Expenses*.

Crown (Dental): The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible dental expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the *Dental Expense Coverage* section of this document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, ~~injury,~~ decay, malformation, disease or infection. Dental services and supplies are covered under the dental expense coverage plan and are not covered under the medical expense coverage of the Plan unless the medical plan specifically indicates otherwise in the Schedule of Medical Benefits.

For injury to teeth see *Injury to Sound and Natural Teeth*, below.

Dental Care Provider: A dentist, dental hygienist nurse, or other health care practitioner (as those terms are specifically defined in this section of the document) who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty Area	Services related to the diagnosis, treatment, or prevention of diseases
Endodontics	The dental pulp and its surrounding tissues.
Implantology	Attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	Extractions and surgical procedures of the mouth.
Orthodontics	Abnormally positioned or aligned teeth.
Pedodontics	Treatment of dental problems of children.

Maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Fixed Appliance: A device that is cemented to the teeth or attached by adhesive materials.

Fluoride: A solution applied to the surface of teeth, or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Definitions* section).

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal Regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Impression: A negative reproduction of the teeth and gums from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Injury to Sound and Natural Teeth (ISNT): An injury to the teeth caused by trauma from an external source. ~~This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing.~~ Benefits for injury to sound and natural teeth are payable under the medical plan (see also the definition of Sound and Natural Teeth).

Inlay: A restoration made to fit a prepared tooth cavity and then cemented into place (see the definition of restoration).

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from out-of-network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the in-network contracted amount may be applied to out-of-network provider charges.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
- is determined by the Plan Administrator or its designee to meet all the following requirements:
  - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
  - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
  - It is an "appropriate" service or supply given the patient's circumstances and condition; and
  - It is a ~~"cost-efficient" supply or~~ level of service that can be safely provided to the patient; and
  - ~~It is safe and effective for the illness or injury for which it is used.~~

  ~~A medical or dental service or supply will be considered to be "appropriate" if:~~

  ~~It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.~~

  ~~It is care or treatment that is: as likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.~~

~~A medical or dental service or supply will be considered to be "cost-efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the~~

~~service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.~~

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A hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or health care facility or other more costly facility.

- The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital or health care facility.

Non-Network: See Out-of-Network Services.

Non-Participating Provider: A health care provider who does not participate in the Plan's Preferred Provider Organization (PPO).

Office Visit: A direct personal contact between a dentist or other dental care practitioner and a patient in the dental care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CDT coding.

Onlay: An inlay restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthodontics, Orthodontia: The science of the movement of teeth to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as prognathism, retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.