Provider Manual

UnitedHealthcare Community Plan of Virginia

UnitedHealthcare®

Contents

Introduction—Who We Are

Welcome to UnitedHealthcare®

UnitedHealthcare welcomes you as a participating Dental Provider in providing dental services to our members.

We are committed to providing accessible, quality, comprehensive dental services in the most cost-effective and efficient manner possible. We realize that to do so, strong partnerships with our providers are critical, and we value you as an important part of our program.

We offer a portfolio of products including, but not limited to: Medicaid and Medicare Special Needs plans, as well as Commercial products such as Preferred Provider Organization (PPO) plans.

This Provider Manual (the "Manual") is designed as a comprehensive reference guide for the dental plans in your area, primarily UnitedHealthcare Medicaid and Medicare plans. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, we will send these updates to you.

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353** (Please note: all other concerns should be directed to 1-855-586-1419).

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Provider Services team at 1-855-586-1419.

Unless otherwise specified herein, this Manual is effective on August 1, 2019 for dental providers currently participating in the UnitedHealthcare network, and effective immediately for newly contracted dental providers. Please note: "Member" is used in this Manual to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us. "Manual" refers to this 2019 Provider Manual. "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Manual.

The codes and code ranges listed in this Manual were current at the time this Manual was published. Codes and coding requirements, as established by the organizations that create the codes, may periodically change. Please refer to the applicable coding guide for appropriate codes.

Thank you for your continued support as we serve the Medicaid and Medicare beneficiaries in your community.

Sincerely,

UnitedHealthcare, Professional Networks

Section 2: **Resources and Services—How We Help You**

2.1 **Quick Reference Guides—Addresses and Phone Numbers**

UnitedHealthcare is committed to providing your office accurate and timely information about our programs, products and policies.

Our **Provider Services Line** and Provider Services teams are available to assist you with any questions you may have. Our toll-free provider services number is available during normal business hours and is staffed with knowledgeable specialists. They are trained to handle specific dentist issues such as **eligibility, claims, benefits information and contractual questions**.

The following is a quick reference table to guide you to the best resource(s) available to meet your needs when questions arise:

	RESOURCE		
YOU WANT TO:	Provider Services Line— Dedicated Service Representatives Phone: 1-855-934-9818 Hours: 8 a.m.-5 p.m. (CST) Monday-Friday	Online uhcproviders.com	Interactive Voice Response (IVR) System Phone: 1-855-934-9818 Hours: 24 hours a day, 7 days a week
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

	RESOURCE:				
NEED	Address	Phone Number	Payor I.D.	Submission Guidelines	Form(s) Required
Claim Submission (initial)	**Claims:** UnitedHealthcare PO Box 2064 Milwaukee, WI 53201	**1-855-586-1419**	GP133	Within 180 days	ADA* Claim Form, 2012 version or later
Prior Authorization Requests	**PTE/Preauthorizations:** UnitedHealthcare PO Box 361 Milwaukee, WI 53201	**1-855-586-1419**	GP133	Authorizations are not required for benefits listed in the Member Benefits section.	ADA Claim Form – check the box titled: Request for Predetermination/ Preauthorization section of the ADA Dental Claim Form
Provider Appeals	**UnitedHealthcare:** Appeals Coordinator PO Box 361 Salt Lake City, UT 84131	**1-855-586-1419**	GP133	Within 60 days from the date of payment decision.	ADA Claim Form Provider narrative supporting appeal
Reprocessing & Adjustment Requests, In & Out of Network Provider Disputes	**Provider Disputes:** UnitedHealthcare P.O. Box 541 Milwaukee, WI 53201	**1-855-586-1419**	N/A	Within 90 days from receipt of payment	ADA Claim Form Reason for requesting adjustment or resubmission
UnitedHealthcare Member Complaints & Appeals	**UnitedHealthcare:** Appeals Coordinator PO Box 31364 Salt Lake City, UT 84131	**1-866-622-7982**	N/A	Appeals must be submitted within 60 days of the date of authorization decision.	N/A
UnitedHealthcare Provider UM Appeals	**UnitedHealthcare:** Appeals Coordinator PO Box 31364 Salt Lake City, UT 84131	**1-866-622-7982**	N/A	Appeals must be submitted within 60 days of the date of authorization decision.	N/A

2.2.a **Integrated Voice Response (IVR) System—1-800-822-5353**

We have a toll-free Integrated Voice Response (IVR) system that enables you to access information 24 hours a day, 7 days a week, by responding to the system's voice prompts.

Through this system, network dental offices can obtain immediate **eligibility information**, validate **practitioner participation status** and perform member **claim history** search (by surfaced code and tooth number).

2.3 **Website**

The UnitedHealthcare website at **uhcproviders.com** offers many time-saving features including **eligibility verification, benefits, claims submission and status, prior-authorization submission and status, demographic updates, print remittance information, claim receipt acknowledgement** and **network specialist locations.**

To use the website, please go to **uhcproviders.com** and register as a participating user. For assistance, please call **1-855-586-1419.**

Section 3: **Patient Eligibility Verification Procedures**

3.1 **Member Eligibility**

Member eligibility or dental benefits may be verified online or via phone.

We receive daily updates on member eligibility and can provide the most up-to-date information available.

Important Note: Eligibility should be verified on the date of service. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations and/or exclusions. ***Additional rules may apply to some benefit plans.***

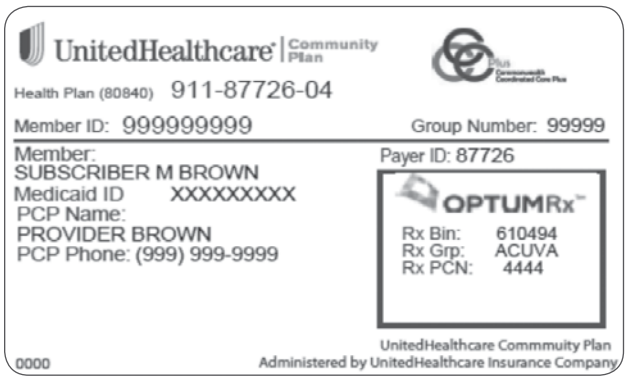
3.2 **Member Identification Card**

Members are issued an identification (ID) card by UnitedHealthcare Community Plan. There will not be separate dental cards for UnitedHealthcare Community Plan members. The ID cards are customized with the UnitedHealthcare Community Plan logo and include the toll-free customer service number for the health plan.

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

To verify a member's dental coverage, go to **uhcproviders.com** or contact the dental Provider Services line at **1-855-586-1419.**.

A sample ID card is provided below. The member's actual ID card may look slightly different.



3.3 **Eligibility Verification**

Eligibility can be verified on our website at **uhcproviders.com** 24 hours a day, 7 days a week. In addition to current eligibility verification, our website offers other functionality for your convenience, such as claim status. Once you have registered on our provider website, you can verify your patients' eligibility online with just a few clicks.

To register on the site, you will need the following information:

- Payee ID number from a remittance advice

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number. Please call **1-855-586-1419** during normal business hours for assistance with website issues.

UnitedHealthcare also offers an Interactive Voice Response (IVR) system; simply call **1-800-822-5353**. Through our IVR system, you may access real-time information, 24 hours a day, 7 days a week. The UnitedHealthcare IVR system enables you to do the following:

- Verify Eligibility
- Obtain Claim Status

3.4 **Specialist Referral Process**

If a member needs specialty care, a general dentist may recommend a network specialty dentist, or the member can self-select a participating network specialist. Referrals must be made to qualified specialists who are participating within the provider network. No written referrals are needed for specialty dental care.

To obtain a list of participating dental network specialists, go to our website at **uhcproviders.com** or contact Provider Services at **1-855-586-1419**.

Section 4: **Member Benefits/Exclusions and Limitations**

4.1 **Covered Services for UnitedHealthcare VA Medicaid LTSS plan**

Provider Quick Covered Services Reference Guide for the UnitedHealthcare Community Plan

Covered services are paid at 100% of the provider fee schedule amount with no deductible or copay amount.

Code	Description	Prior Authorization	Frequency
D0120	Periodic Oral Evaluation	No	2 per 12 month period
D0140	Limited Oral Evaluation - Problem Focused	No	1 per 12 month period
D0150	Comprehensive Oral Evaluation - New or Established Patient	No	1 per 12 month period
D0210	Intraoral - Complete Series (including bitewings)	No	1 per 3 year period
D0220	Intraoral - Periapical - First Film	No	1 per 12 month period
D0230	Intraoral - Periapical - Each Additional Film	No	1 per 12 month period
D0270	Bitewing - Single Film	No	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274
D0272	Bitewings - Two Films	No	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274
D0273	Bitewings - Three Films	No	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274
D0274	Bitewings - Four Films	No	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274
D1110	Prophylaxis - Adult	No	2 per 12 month period

4.2 **Exclusions & Limitations**

Please refer to the benefits grid for applicable exclusions and limitations and covered services. Standard ADA coding guidelines are applied to all claims.

Any service not listed as a covered service in the benefit grids (Section 4.1) is excluded.

Please call Provider Services at **1-855-586-1419** if you have any questions regarding frequency limitations.

Additional Exclusions

1. Unnecessary dental services.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons.
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting that has not had prior authorization.
7. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Service for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

9. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
10. Dental services otherwise covered under the policy, but rendered after the date that an individual's coverage under the policy terminates, including dental services for dental conditions arising prior to the date that an individual's coverage under the policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
12. Charges for failure to keep a scheduled appointment without giving the dental office proper notification.

4.3 **Appeals, State Fair Hearings, and Complaints (Grievances)**

Your Right to Appeal

Providers may have members who want to file a grievance, appeal, or request a State Fair Hearing. Providers may assist or instruct members in this process. These processes are explained in detail in the Member Handbook, which may be accessed at **uhccommunityplan.com**.

Excerpts from the Member Handbook are provided below for your reference. Please note that the Member Handbook may be updated periodically, so for the most current information, please refer to the Member Handbook at **uhccommunityplan.com**.

You have the right to appeal any adverse benefit determination (decision) by UnitedHealthcare Community Plan that you disagree with that relates to coverage or payment of services.

For example, you can appeal if UnitedHealthcare Community Plan denies:

- A request for a health care service, supply, item or drug that you think you should be able to get, or
- A request for payment of a health care service, supply, item, or drug that UnitedHealthcare Community Plan denied.

You can also appeal if UnitedHealthcare Community Plan stops providing or paying for all or a part of a service or drug you receive through CCC Plus that you think you still need.

Authorized Representative.

You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform UnitedHealthcare Community Plan of the name of your authorized representative. You can do this by calling our Member Services Department at one of the phone numbers below. We will provide you with a form that you can fill out and sign stating who your representative will be.

Adverse Benefit Determination.

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision we make to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. Refer to Service Authorization and Benefit Determinations in Section 14 of this handbook.

How to Submit Your Appeal.

If you are not satisfied with a decision we made about your service authorization request, you have 60 calendar days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at one of the numbers below if you need help filing an appeal or if you need assistance in another language or require an alternate format. We will not treat you unfairly because you file an appeal. You can file your appeal by phone or in writing. You can send the appeal as a standard appeal or an expedited (fast) appeal request.

You or your doctor can ask to have your appeal reviewed under the expedited process if you believe your health condition or your need for the service requires an expedited review. Your doctor will have to explain how a delay will cause harm to your physical or behavioral health. If your request for an expedited appeal is denied, we will tell you and your appeal will be reviewed under the standard process.

Send your Appeal request to:

UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

If you send your standard appeal by phone, it must be followed up in writing. Expedited process appeals submitted by phone do not require you to submit a written request.

Continuation of Benefits.

In some cases you may be able to continue receiving services that were denied by us while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received if the services were provided solely because of the requirements described in this Section.

What Happens After We Get Your Appeal.

Within 10 calendar days, we will send you a letter to let you know we have received and are working on your appeal. Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to make a decision on your case. This information is available at no cost to you.

You can also provide information that you want to be used in making the appeal decision in person or in writing.

Mailing Address:

UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

In-Person Address:

UnitedHealthcare Community Plan
9020 Stony Point Parkway, Suite 400
Richmond, VA 23235

You can also call Member Services at one of the numbers below if you are not sure what information to give us.

Timeframes for Appeals.

Standard Appeals

If we have all the information we need, we will tell you our decision within 30 calendar days for pre-service and 45 calendar days for post-service from when we receive your appeal request. We will tell you within 2 calendar days after receiving your appeal if we need more information.

Expedited Appeals

If we have all the information we need, expedited appeal decisions will be made within 72 hours of receipt of your appeal. We will tell you within 2 calendar days after receiving your appeal if we need more information. We will tell you our decision by phone and send a written notice within 2 calendar days from when we make the decision.

If We Need More Information

If we can't make the decision within the needed timeframes because we need more information, we will:

- Write you and tell you what information is needed. If your request is in an expedited review, we will call you right away and send a written notice later;
- Tell you why the delay is in your best interest; and
- Make a decision no later than 14 additional days from the timeframes described above.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give UnitedHealthcare Community Plan to help decide your case. This can be done by calling or writing to:

Grievance and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

You or someone you trust can file a complaint with UnitedHealthcare Community Plan if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a complaint about the way UnitedHealthcare Community Plan handled your appeal to the State through the CCC Plus Help Line at 1-844-374-9159 or TDD 1-800-817-6608.

If we do not tell you our decision about your appeal on time, you have the right to appeal to the State through the State Fair Hearing process. An untimely response by us is considered a valid reason for you to appeal further through the State Fair Hearing process.

Written Notice of Appeal Decision.

We will tell you and your provider in writing if your request is denied or approved in an amount less than requested. We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain your right to appeal through the State Fair Hearing Process if you do not agree with our decision.

Your Right to a State Fair Hearing

If you disagree with our decision on your appeal request, you can appeal directly to DMAS. This process is known as a State Fair Hearing. You may also submit a request for a State Fair Hearing if we deny payment for covered services or if we do not respond to an appeal request for services within the times described in this handbook. The State requires that you first exhaust (complete) the UnitedHealthcare Community Plan appeals process before you can file an appeal request through the State Fair Hearing process. If we do not respond to your appeal request timely, DMAS will count this as an exhausted appeal.

Standard or Expedited Review Requests.

For standard requests, appeals will be heard and DMAS will give you an answer generally within 90 days from the date you filed your appeal. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited appeal within 72 hours of receiving the letter from your doctor.

Authorized Representative.

You can give someone like your PCP, provider, or friend or family member written permission to help you with your State Fair Hearing request. This person is known as your authorized representative.

Where to Send the State Fair Hearing Request.

You or your representative must send your standard or expedited appeal request to DMAS by internet, mail, fax, email, telephone, in person, or through other commonly available electronic means. Send State Fair Hearing requests to DMAS within no more than 120 calendar days from the date of our final decision. You may be able to appeal after the 120-day deadline in special circumstances with permission from DMAS.

You may write a letter or complete a Virginia Medicaid Appeal Request Form. The form is available at your local Department of Social Services or on the DMAS website at **http://www.dmas.virginia.gov/Content_pgs/appeal-home. aspx**. You should

also send DMAS a copy of the letter we sent to you in response to your Appeal. You must sign the appeal request and send it to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219

Fax: 804-452-5454

Standard and Expedited Appeals may also be made by calling 804-371-8488.

After You File Your State Fair Hearing Appeal.

DMAS will notify you of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

State Fair Hearing Timeframes.

Expedited Appeal

If you qualify for an expedited appeal, DMAS will give you an answer to your appeal within 72 hours of receiving the letter from your doctor. If DMAS decides right away that you win your appeal, they will send you their decision within 72 hours of receiving the letter from your doctor. If DMAS does not decide right away, you will have an opportunity to participate in a hearing to present your position. Hearings for expedited decisions are usually held within one or two days of DMAS receiving the letter from your doctor. DMAS still has to give you an answer within 72 hours of receiving your doctor's letter.

Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will generally give you an answer within 90 days from the date you filed your appeal. You will have an opportunity to participate in a hearing to present your position before a decision is made.

Continuation of Benefits

In some cases you may be able to continue receiving services that were denied by us while you wait for your State Fair Hearing appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied or care is changing;
- By the date the change in services is scheduled to occur.

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. **You may, however, have to repay UnitedHealthcare Community Plan for any services you receive during the continued coverage period if UnitedHealthcare Community Plan's adverse benefit determination is upheld and the services were provided solely because of the requirements described in this Section.**

If the State Fair Hearing Reverses the Denial.

If services were not continued while the State Fair Hearing was pending

If the State Fair Hearing decision is to reverse the denial, UnitedHealthcare Community Plan must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date UnitedHealthcare Community Plan receives notice from the State reversing the denial.

If services were provided while the State Fair Hearing was pending

If the State Fair hearing decision is to reverse the denial and services were provided while the appeal is pending, UnitedHealthcare Community Plan must pay for those services, in accordance with State policy and regulations.

If You Disagree with the State Fair Hearing Decision

The State Fair Hearing decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision, you may appeal it to your local circuit court.

4.4 **Provider Disputes**

An In Network Provider Contractual Dispute is a dispute regarding the rate or amount paid on a claim. Members are not financially responsible or impacted by the outcome of such a dispute. If there is any member liability outside of their normal cost share, please refer to section 4.3 Member Appeals.

A Reprocessing or Adjustment Request is a request to reprocess a claim. Examples include submitting a corrected bill, resubmitting a claim with requested information, data entry errors made on the claim or errors in participation status.

Reprocessing Requests and Contractual Disputes may be initiated verbally or in writing to the number and address below:

1-855-586-1419

UnitedHealthcare Dental
P.O. Box 361
Milwaukee, WI 5320

When a claim is reprocessed as a result of a Reprocessing or Adjustment Request or Contractual Dispute, providers will receive a new remittance advice within 30 calendar days of receipt of the Reprocessing/ Adjustment Request or Contractual Dispute. If the Reprocessing or Adjustment Request or Contractual Dispute does not result in the reprocessing of a claim, providers will receive written notification of the outcome within 30 calendar days of receipt of the Reprocessing or Adjustment Request or Contractual Dispute.

Section 5: **Authorization for Treatment**

5.1 Dental Treatment Requiring Authorization

To make sure that desirable quality of care standards are achieved and to maintain the overall clinical effectiveness of the program, there are times when prior authorization is required prior to the delivery of clinical services.

These services may include specific restorative, endodontic, periodontic, prosthodontic and oral surgery procedures. For a complete listing of procedures requiring authorization, refer to the benefit grid within this Manual.

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment. For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at **1-855-586-1419**.

5.1.a Payment for Non-covered Services:

When non-covered services are provided for Medicaid members, providers shall hold members and UnitedHealthcare harmless, except as outlined below.

In instances when non-covered services are recommended by the provider or requested by the member, an Informed Consent Form or similar waiver must be signed by the member confirming:

- That the member was informed and given written acknowledgement regarding proposed treatment plan and associated costs in advance of rendering treatment;
- That those specific services are not covered under the member's plan and that the member is financially liable for such services rendered.
- That the member was advised that they have the right to request a determination from the insurance company prior to services being rendered.

Please note that it is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered. Members are held harmless and cannot be billed for services that are covered under the plan, in excess of cost sharing as required under the Member's benefit plan.

5.1.b After Hours Emergency

When a provider treats a patient outside of the normal business hours of 8 a.m. to 6 p.m., Monday through Friday, providers should:

1. Confirm patient eligibility on the date of service through our website, or our Interactive Voice Response system.
2. Consult the benefit guide included in this Manual to determine if services are covered under the plan and if prior authorization is required for the service.
3. Provide covered services that do not require prior authorization.
4. If prior authorization is required for a needed service, the provider should relieve the patient's immediate pain with covered services that do not require prior authorization (e.g., palliative treatment or sedative filling). The provider will submit a written request for prior authorization, and may call the provider call center on the next business day to request information for submitting an expedited prior authorization request.

Please note: Prior authorization requirements are not waived for emergency appointments. Prior authorization requests and supporting documents must be received in writing via paper, electronic or website submission, and the request must be approved prior to rendering service. Claims will be denied for services that require prior authorization, when prior authorization has not been obtained.

Section 6: **Radiology Requirements**

To learn what Prior Authorization requests would require radiographs, refer to Section 5.1.a of the Manual (Prior Authorization Submission Criteria).Guidelines for providing radiographs are as follows:

- Send a copy or duplicate radiograph instead of the original.
- Radiograph must be diagnostic for the condition or site.
- Radiographs should be mounted and labeled with the practice name, patient name and exposure date (not the duplication date).
- When a radiograph does not demonstrate a clinical condition well, an intra-oral photo and/or narrative are suggested as additional diagnostic aides.

X-rays submitted with Authorizations or Claims will not be returned. This includes original film radiographs, duplicate films, paper copies of x-rays and photographs.

Electronic submission, rather than paper copies of digital x-rays is preferred. Film copies are only accepted if labeled, mounted and paper clipped to the authorization. Please do not utilize staples.

Orthodontic and other models are not accepted forms of supporting documentation and will not be reviewed. Orthodontic models will be returned to you along with a copy of the paperwork submitted.

Please note: Authorizations, including attachments, can be submitted online at no additional cost by visiting our website: **uhcproviders.com**.

Section 7: **Claim Submission Procedures**

7.1 Claim submission best practices and required elements

Dental claim form

The most current Dental ADA claim form (2012 or later) must be submitted for payment of services rendered.

Claim submission options

Electronic claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected.

Electronic submission is private as the information being sent is encrypted. Please call 1-855-586-1419 for more information regarding electronic claims submission

Please note that our **Payor ID is GP133**

Paper Claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the 2012 or later American Dental Association (ADA) form is required.

Dental claim form required information

One claim form should be used for each patient and the claim should reflect only one treating dentist for services rendered. The claims must also have all necessary fields populated as outlined in the following:

Header Information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services or Request for

Pre-Treatment Estimate.

Subscriber information

- Name (last, first, and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Subscriber ID number

Patient Information

- Name (last, first, and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Patient ID number

Primary payer information

Record the name, address, city, state and ZIP code of the carrier.

Other coverage

If the patient has other insurance coverage, completing the “Other Coverage” section of the form with the name, address, city, state and ZIP code of the carrier is required. You will need to indicate if the “other insurance” is the primary insurance. You may need to provide documentation from the primary insurance carrier, including amounts paid for specific services.

Other insured's information (only if other coverage exists)

If the patient has other coverage, provide the following information:

- Name of subscriber/policy holder (last, first and middle initial)
- Date of birth and gender
- Subscriber ID number
- Relationship to the member

Billing dentist or dental entity

Indicate the provider or entity responsible for billing, including the following:

- Name
- Address (street, city, state, ZIP code)
- License number
- Social security number (SSN) or Tax identification number (TIN)
- Phone number
- National provider identifier (NPI)

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment

- Certification – Signature of dentist and the date the form was signed
- Name (use name provided on the Practitioner Application)
- License number
- TIN (or SSN)
- Address (street, city, state, ZIP code)
- Phone number
- NPI

Record of services provided

Most claim forms have 10 fields for recording procedures. Each procedure must be listed separately and must include the following information, if applicable. If the number of procedures exceeds the number of available lines, the remaining procedures must be listed on a separate, fully completed claim form.

- Procedure date
- Area of oral cavity
- Tooth number or letter and the tooth surface
- Procedure code
- Description of procedure
- Billed charges – report the dentist's full fee for the procedure
- Total sum of all fees

Missing Teeth Information

When submitting for periodontal or prosthodontal procedures, this area should be completed. An "X" can be placed on any missing tooth number or letter when missing.

Remarks Section

Some procedures require a narrative. If space allows, you may record your narrative in this field. Otherwise, a narrative attached to the claim form, preferably on practice letterhead with all pertinent member information, is acceptable.

Timely submission

All claims should be submitted within twelve (12) months.

Paper claims

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs should be attached, when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures. Please refer to the Exclusions, Limitations and Benefits section of this Manual to find the recommendations for dental services.

By report procedures

All "By Report" procedures require a narrative along with the submitted claim form. The narrative should explain the need for the procedure and any other pertinent information.

Using current ADA codes

It is expected that providers use Current Dental Terminology (CDT). For the latest dental procedure codes and descriptions, you may order a current CDT book by calling the ADA or visiting the catalog website at **adacatalog.org**.

ICD-10 Instructions

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)	31a. Other Fee(s)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosis Code(s) A _____ C _____	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diagnosis in "A") B _____ D _____	32. Total Fee
35. Remarks		

Instructions:

29a **Diagnosis Code Pointer:** Enter the letter(s) from Item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

29b **Quantity:** Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is "01".

34 **Diagnosis Code List Qualifier:** Enter the appropriate code to identify the diagnosis code source:
B = ICD-9-CM **AB** = ICD-10-CM (as of Oct. 1, 2013)

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

34a **Diagnosis Code(s):** Enter up to 4 applicable diagnosis codes after each letter (A.-D.). The primary diagnosis code is entered adjacent to the letter "A."

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

Insurance fraud

All insurance claims must reflect truthful and accurate information to avoid committing insurance fraud. Examples of fraud are falsification of records and using incorrect charges or codes. Falsification of records includes errors that have been corrected using "white-out," pre-or post-dating claim forms, and insurance billing before completion of service. Incorrect charges and codes include billing for services not performed, billing for more expensive services than performed, or adding unnecessary charges or services.

Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained on the claim is true and accurate.

7.2 Electronic claims submissions

Electronic Claims Submission refers to the ability to submit claims electronically versus on paper. This expedites the claim adjudication process and can improve overall claim payment turnaround time (especially when combined with Electronic Funds Transfer, which is the ability to be paid electronically directly into your bank account).

UnitedHealthcare partners with electronic clearing houses to support electronic claims submissions. While the payor ID may vary for some plans, the UnitedHealthcare number for Community Plan members is GP133. Please refer to the Important Addresses and Phone Numbers section for additional information as needed.

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process.

7.3 HIPAA-compliant 837D file

The 837D is a HIPAA-compliant EDI transaction format for the submission of dental claims. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers via established claims clearinghouses.

7.4 Paper claims submission

To receive payment for services, practices must submit claims via paper or electronically. Network dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2012 or version or later). If an incorrect claim form is used, the claim cannot be processed and will be returned.

Please refer to section 7.1 for more information on claims submission best practices and required information.

Our Quick Reference guide will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

7.5 Coordination of benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than one dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. Coordination of Benefits rules are mandated by the Department of Insurance and it is each provider's responsibility to correctly coordinate benefits.

The practitioner office is required to identify when a patient has coverage through multiple carriers and to inform DBP Dental on the claim form.

If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved – this is not a payer choice. The objective is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

When a claim is being submitted to us as the secondary payer for Coordination of Benefits (COB), a fully completed claim form must be submitted along with the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer.

Medicaid payers, such as DBP when acting on behalf of a Medicaid program, are considered secondary payers. When COB is present in this situation, providers should bill the appropriate primary carrier first, and then submit to DBP Dental for any additional payment along with primary payer's Explanation of Benefits (EOB).

7.6 Dental Claim Filing Limits & Adjustments

All Dental Claims must be submitted within one year of the date of service.

All adjustments or requests for reprocessing must be made within ninety (90) calendar days from receipt of payment. An adjustment can be requested in writing or telephonically. Please refer to the Quick Reference Guide for address and phone number information.

7.7 Claim Adjudication & Periodic Overview

Claim Processing Standards:

- 90% of Clean Claims will be adjudicated within 30 days of receipt of the claim.

Quality Assurance (QA) audits are performed to ensure the accuracy and effectiveness of our claim adjudication procedures. Any identified discrepancies are resolved within established timelines. The QA process is based on an established methodology but as a general overview, on a daily basis various samples of claims are selected for quality assurance reviews. QA samples include center-specific claims, adjustments, claims adjudicated by newly hired claims processors, and high-dollar claims. In addition, management selects other areas for review, including customer-specific and processor-specific audits. Management reviews the summarized results and correction is implemented, if necessary.

Invalid or incomplete claims:

If claims are submitted with missing information, incomplete or outdated claim forms, the claim will be rejected or returned to the provider and a request for the missing information will be sent to the provider.

If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.

7.8 Explanation of Dental Plan Reimbursement (Remittance Advice)

The Practitioner Remittance Advice is a claim detail of each patient and each procedure considered for payment. Please use these as a guide to reconcile member payments. As a best practice it is recommended that remittance advice is kept for future reference and reconciliation. Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER- Treating dentists name, Practitioner ID number

PROVIDER LOCATION AND ID - Treating location as identified on submitted claim and location ID number

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

PATIENT PAY - Any amounts owed by the patient after benefits have been applied

OTHER INSURANCE - Amount payable by another carrier

PRIOR MONTH ADJUSTMENT - Adjustment amount(s) applied to prior overpayments

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

SUBSCRIBER/MEMBER NO - Identifying number on the subscriber's ID card

PATIENT DOB

PLAN - Health plan through which the member receives benefits (i.e., UnitedHealthcare Community Plan)

PRODUCT - Benefit plan that the member is under (i.e., Medicaid or Family Care)

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In our out-of-network coverage

LINE ITEM NUMBER - Reference number for item number within a claim

DOS

CDTCODE

TOOTH NO.

SURFACE(S)

PLACE OF SERVICE - Treating location (office, hospital, other)

QTY OR NO. OF UNITS

PAYMENT PERCENTAGE - Reflects benefit coverage level in terms of percentage to be paid by plan

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

NET AMOUNT (Services Detail) - Final amount to be paid

EXCEPTION CODES - Codes that explain how the claim was adjudicated

7.9 Explanation of Benefits Sample (Page 1)

UnitedHealthcare MO Medicaid

Payee ID: 55555 | Payee Name: Dental Office Name | Remittance Date: 10/20/2017

UnitedHealthcare

Please address questions to:

UnitedHealthcare MO Medicaid
PO Box 1427
Milwaukee, WI 53201

Contact: UnitedHealthcare Community Plan - Provider Services
Phone: (855)934-9818
Fax:

Dental Office Name
Street Address
City, State ZIP

Current Period:	**10/20/2017**
Payee ID:	55555
Phone:	(555)555-5555
Fax:	(555)555-5555
Tax ID:	555555555

Remittance Summary

Fee For Service:	**$2,164.33**
Budget Allocation:	**$0.00**
Capitation:	**$0.00**
Case Fees:	**$0.00**
Additional Compensation:	**$0.00**
Prior Period Recovery and other Payee Adjustments:	**$0.00**
Total:	**$2,164.33**

What if I do not agree with this decision?
If you do not agree with the denial, you may appeal. You may appeal within 90 calendar days after the payment, denial or recoupment of a timely claim submission. Administrative appeals should be sent to the address below.
UnitedHealthcare Community Plan
P.O. Box 1427
Milwaukee, WI 53201
If you have any questions, please call Provider Customer Services at 855-934-9818

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7.9.a Explanation of Benefits Sample (Page 2)

UnitedHealthcare MO Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
Provider Name/ 55555	Dental Office Name / 55555	$4,785.00	$1,870.84	$0.00	$0.00	$0.00	$1,870.84
Provider Name / 55555	Dental Office Name / 55555	$1,110.00	$109.37	$0.00	$0.00	$0.00	$109.37
Provider Name / 55555	Dental Office Name / 55555	$450.00	$184.12	$0.00	$0.00	$0.00	$184.12
	Totals:	**$6,345.00**	**$2,164.33**	**$0.00**	**$0.00**	**$0.00**	**$2,164.33**

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7.9.b Explanation of Benefits Sample (Page 3)

UnitedHealthcare MO Medicaid

Payee ID: 55555 | Payee Name: Dental Office Name | Remittance Date: 10/20/2017

Services Detail

FFS - Fee For Service	GBA - Global Budget Allocation
CAP - Capitation	CASE - Case Fee
ENC - Encounter Payment	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Missouri
Product: UHC MO Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/16/17	D2740 4	11	1	$885.00	0	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/16/17	D2954 4	11	1	$225.00	1	$109.37	100.00 %	$109.37	$0.00	$0.00	$0.00	$0.00	$0.00	$109.37	FFS
					$1,110.00		**$109.37**		**$109.37**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$109.37**	

ITEM: 1 Exception Code: 1096 Service Authorization not Found.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Missouri
Product: UHC MO Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D2392 29 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
2	10/12/17	D7140 30	11	1	$160.00	1	$52.28	100.00 %	$52.28	$0.00	$0.00	$0.00	$0.00	$0.00	$52.28	FFS
					$295.00		**$124.12**		**$124.12**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$124.12**	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Missouri
Product: UHC MO Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0120 00	11	1	$50.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/12/17	D0220 00	11	1	$25.00	1	$9.58	100.00 %	$9.58	$0.00	$0.00	$0.00	$0.00	$0.00	$9.58	FFS
3	10/12/17	D0230 00	11	1	$20.00	1	$7.98	100.00 %	$7.98	$0.00	$0.00	$0.00	$0.00	$0.00	$7.98	FFS
4	10/12/17	D0274 00	11	1	$50.00	1	$21.63	100.00 %	$21.63	$0.00	$0.00	$0.00	$0.00	$0.00	$21.63	FFS
5	10/12/17	D2392 13 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
					$280.00		**$111.03**		**$111.03**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$111.03**	

ITEM: 1 Exception Code: 1039 This service is not covered under the plan.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Missouri
Product: UHC MO Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0150 00	11	1	$55.00	1	$39.66	100.00 %	$39.66	$0.00	$0.00	$0.00	$0.00	$0.00	$39.66	FFS
2	10/12/17	D0210 00	11	1	$125.00	1	$40.72	100.00 %	$40.72	$0.00	$0.00	$0.00	$0.00	$0.00	$40.72	FFS
3	10/12/17	D1120 00	11	1	$60.00	1	$21.95	100.00 %	$21.95	$0.00	$0.00	$0.00	$0.00	$0.00	$21.95	FFS
4	10/12/17	D1208 00	11	1	$25.00	1	$11.98	100.00 %	$11.98	$0.00	$0.00	$0.00	$0.00	$0.00	$11.98	FFS
					$265.00		**$114.31**		**$114.31**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$114.31**	

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Section 8: **Quality Management**

8.1 Quality Improvement Program (QIP) Description

UnitedHealthcare has established and continues to maintain an ongoing program of quality management and quality improvement to facilitate, enhance and improve member care and services while meeting or exceeding customer needs, expectations, accreditation and regulatory standards.

The objective of the QIP is to ensure that quality of care is being reviewed; that problems are being identified and that follow up is planned where indicated. The program is directed by state, federal and client requirements. The program addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to ensure that professionally recognized standards of care are being met. The QIP Description is reviewed annually and updated as needed.

The QIP includes, but is not limited to, the following goals:

1. To measure, monitor, trend and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks.
2. To foster continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement.
3. To evaluate the effectiveness of implemented changes to the QIP.
4. To reduce or minimize opportunity for adverse impact to members.
5. To improve efficiency, cost effectiveness, value and productivity in the delivery of oral health services.
6. To promote effective communications, awareness and cooperation between members, participating providers and the Plan.
7. To comply with all pertinent legal, professional and regulatory standards.
8. To foster the provision of appropriate dental care according to professionally recognized standards.
9. To make sure that written policies and procedures are established and maintained by the Plan to make sure that quality dental care is provided to the members.

As a participating practitioner, any requests from the QIP or any of its committee members must be responded to as outlined in the request.

A complete copy of our QIP policy and procedure is available upon request by contacting Provider Services at **1-855-812-9210.**

8.2 Credentialing

To become a participating provider in UnitedHealthcare's network, all applicants must be fully credentialed and approved by our Credentialing Committee. In addition, to remain a participating provider, all practitioners must go through periodic recredentialing approval (typically every 3 years unless otherwise mandated by the state in which you practice).

Depending on the state in which you practice, UnitedHealthcare will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. UnitedHealthcare will request a written explanation regarding any adverse incident and its resolution, and will request corrective action be taken to prevent future occurrences.

Before an applicant dentist is accepted as a participating provider, the dentist's credentials are evaluated. Initial facility site visits are required for each location specified by the state requirements for some plans and/or markets. Offices must pass the facility review prior to activation. Your Professional Networks Representative will inform you of any facility visits needed during the recruiting process.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. UnitedHealthcare will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make

sure that criteria are within generally accepted guidelines. You have the right to appeal any recredentialing decision regarding your participation made by UnitedHealthcare based on information received during the recredentialing process. Appeals do not apply to initial credentialing providers unless state law dictates otherwise. To initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Department. Appeals will be accepted and reviewed for states with appeal rights.

UnitedHealthcare contracts with an external Credentialing Verification Organization (CVO) to assist with collecting the data required for the credentialing and recredentialing process. Please respond to calls or inquiries from this organization or our offices to make sure that the credentialing and/or recredentialing process is completed as quickly as possible.

It is important to note that the recredentialing process is a requirement of both the provider agreement and continued participation with UnitedHealthcare. Any failure to comply with the recredentialing process constitutes termination for cause under your provider agreement.

So that a thorough review can be completed at the time of recredentialing, in addition to the items verified in the initial credentialing process, UnitedHealthcare may review provider performance measures such as, but not limited to:

- Utilization Reports
- Current Facility Review Scores
- Current Member Chart Review Score
- Grievance and Appeals Data

Recredentialing requests are sent 6 months prior to the recredentialing due date. The CVO will make 3 attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, UnitedHealthcare will also make an additional 3 attempts, at which time if there is no response, a termination letter will be sent to the provider as per their provider agreement.

A list of the documents required for Initial Credentialing and Recredentialing is as follows (unless otherwise specified by state law):

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits — limits $1/3m
- Explanation of any adverse information, if applicable
- Five years' work in month/date format with no gaps of 6 months or more; if there are, an explanation of the gap should be submitted
- Education (which is incorporated in the application)
- Current Medicaid ID (as required by state)

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable

- Malpractice face sheet which shows their name on the certificate, expiration dates and limits— limits $1/3m
- Explanation of any adverse information, if applicable
- Current Medicaid ID (as required by state)

Any questions regarding your initial or recredentialing status can be directed to our Provider Services line.

We also accept the Council for Affordable Quality Healthcare (CAQH) process for credentialing/recredentialing application submissions, unless state law requires differently.

UnitedHealthcare is committed to supporting the American Dental Association (ADA) and CAQH ProView in streamlining the credentialing process, making it easier for you to complete one application for multiple insurance companies and maintain your credentials in a secure and central location at no cost to you.

If you are new to CAQH ProView, visit **ADA.org/godigital** to get started. If you are already using CAQH ProView, we are able to accept your CAQH ID number provided that your profile data, credentialing documents and attestation show Complete and Current.

Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require Delegated Entities to maintain the confidentiality of credentialing information. Credentialing staff or representatives will not disclose confidential care provider credentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

8.3 Site Visits

With appropriate notice, provider locations may receive an in-office site visit as part of our quality management oversight processes. All surveyed offices are expected to perform quality dental work and maintain appropriate dental records.

The site visit focuses primarily on: dental recordkeeping, patient accessibility, infectious disease control, and emergency preparedness and radiation safety. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the Clinical Affairs Committee, leading to a corrective action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

8.4 Preventive Health Guideline

The UnitedHealthcare approach to preventive health is a multi-focused strategy which includes several integrated areas. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. We have a long history of working with customers on education and outreach programs focusing on wellness, oral health management and the relationship between oral disease and overall health.

We strive to ensure that all of our programs and review criteria are based on the most current clinical evidence. The UnitedHealthcare Dental Clinical Policy and Technology Committee (DCPTC) researches, develops and implements the clinical practice guidelines recommendations, based on principles of evidence-based dentistry, that are then reviewed and endorsed by the UnitedHealthcare National Medical Care Management Committee (NMCMC). Our guidelines are consistent with the most current scientific literature, along with the American Dental Association's (ADA's) current CDT- codes and specialty guidelines as suggested by organizations such as the American Academy of Periodontology, American Academy of Pediatric Dentistry, American Association of Endodontists, American College of Prosthodontists and American Association of Oral and Maxillofacial Surgeons. We also refer to additional resources such as the Journal of Evidence Based Dental Practice, the online Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence-Based Dentistry. Other sources of input are the respected public health benchmarks, such as Healthy People 2020 and the Surgeon General's Report on Oral Health in America, along with government organizations such as the National Institutes of Health and Center for Disease Control.

Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations..

Caries Management begins with a complete evaluation including an assessment for risk.X-ray periodicity – X-ray examination should be tailored to the individual patient based on the patient's health history and risk assessment/vulnerability to oral disease and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.

- Recall periodicity — Frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.
- Preventive interventions — Interventions to prevent caries should consider AAPD periodicity guidelines while remaining tailored to the needs of the individual patient based on age, health history, and risk assessment/vulnerability to oral disease. These preventative interventions include but are not limited to regular prophylaxis, fluoride application, placement of sealants, dietary counseling and adjunctive therapies where appropriate.
- Caries Classification and Risk Assessment Systems - methods of caries detection, classification, and risk assessment combined with prevention strategies, can help to reduce patient risk of developing advanced disease and may even arrest the disease process. Consideration should be given to these conservative nonsurgical approaches to early caries; or alternatively, where appropriate, to minimally invasive approaches, conserving tooth structure whenever possible.

Periodontal Management – Screening, and as appropriate, complete evaluation for periodontal diseases should be performed on all adults, and children in late adolescence and younger, if that patient exhibits signs and symptoms or a history of periodontal disease.

- A periodontal evaluation should be conducted at the initial examination and periodically thereafter, as appropriate, based on American Academy of Periodontology guidelines.
- Periodontal evaluation and measures to maintain periodontal health after active periodontal treatment should be performed as appropriate.
- Special consideration should be given to those patients with periodontal disease, a previous history of periodontal disease and/or those at risk for future periodontal disease if they concurrently have systemic conditions reported to be linked to periodontal disease such as diabetes, cardiovascular disease and/or pregnancy complications.

Oral cancer screening – Should be performed for all adults and children in late adolescence or younger if there is a personal or family history, if the patient uses tobacco products, or if there are additional factors in the patient history, which in the judgment of the practitioner elevate their risk.

- Screening should be done at the initial evaluation and again at each recall.
- Screening should include, at a minimum, a manual/visual exam, but may include newer screening procedures, such as light contrast or brush biopsy, for the appropriate patient.

Additional areas for prevention evaluation and intervention – Include malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition.

Multiple channels of communication will be used to share information with providers and members via manuals, websites, newsletters, training sessions, individual contact, health fairs, in-service programs and educational materials. It is the mission of UnitedHealthcare to educate providers and members on maintaining oral health, specifically in the areas of prevention, caries, periodontal disease and oral cancer screening.

Section 9: **Utilization Management Program**

9.1 Utilization Management

Through Utilization Management practices, UnitedHealthcare aims to provide members with cost-effective, quality dental care through participating providers. By integrating data from a variety of sources, including provider analytics, utilization review, prior authorization, claims data and audits, UnitedHealthcare can evaluate group and individual practice patterns and identify those patterns that demonstrate significant variation from norms.

By identifying and remediating providers who demonstrate unwarranted variation, we can reduce the overall impact of such variation on cost of care, and improve the quality of dental care delivered.

9.2 Community Practice Patterns

Utilization analysis is completed using data from a variety of sources. The process compares group performance across a variety of procedure categories and subcategories including diagnostic, preventive, minor restorative (fillings), major restorative (crowns), endodontics, periodontics, fixed prosthetics (bridges), removable prosthetics (dentures), oral surgery and adjunctive procedures. The quantity and distribution of procedures performed in each category are compared with benchmarks such as similarly designed UnitedHealthcare plans and peers to determine if utilization for each category and overall are within expected levels.

Significant variation might suggest either overutilization or underutilization. Variables which might influence utilization, such as plan design and/or population demographics, are taken into account. Additional analysis can determine whether the results are common throughout the group or caused by outliers.

9.3 Evaluation of Utilization Management Data

Once the initial Utilization Management data is analyzed, if a dentist is identified as having practice patterns demonstrating significant variation, his or her utilization may be reviewed further. For each specific dentist, a Peer Comparison Report may be generated and analysis may be performed that identifies all procedures performed on all patients for a specified time period. Potential causes of significant variation include upcoding, unbundling, miscoding, excessive treatment, under-treatment, duplicate billing, or duplicate payments. Providers demonstrating significant variation may be selected for counseling or other corrective actions.

9.4 Utilization Management Analysis Results

Utilization analysis findings may be shared with individual providers in order to present feedback about their performance relative to their peers.

Feedback and recommended follow-up may also be communicated to the provider network as a whole. This is done by using a variety of currently available communication tools including: Provider Manual/Standards of Care

- Provider Training
- Continuing Education
- Provider News Bulletins

9.5 Utilization Review

UnitedHealthcare shall perform utilization review on all submitted claims. Utilization review (UR) is a clinical analysis performed to confirm that the services in question are or were necessary dental services as defined in the member's certificate of coverage. UR may occur after the dental services have been rendered and a claim has been submitted (retrospective review).

Utilization review may also occur prior to dental services being rendered. This is known as prior authorization, pre-authorization, or a request for a pre-treatment estimate. UnitedHealthcare does not require prior authorization or pre-treatment estimates (although we encourage these before costly procedures are undertaken).

Retrospective reviews and prior authorization reviews are performed by licensed dentists.

Utilization review is completed based on the following:

- To ascertain that the procedure meets our clinical criteria for necessary dental services, which is approved by the Clinical Policy and Technology Committee, Clinical Affairs Committee, and state regulatory agencies where required.
- To determine whether an alternate benefit should be provided.
- To determine whether the documentation supports the submitted procedure.
- To appropriately apply the benefits according to the member's specific plan design.

9.6 Fraud and Abuse

Every network provider and third-party contractor of UnitedHealthcare is responsible for conducting business in an honest and ethical way. This entails fostering a climate of ethical behavior that does not tolerate fraud or abuse, remaining alert to instances of possible fraud and/or abuse and reporting such situations to the appropriate person(s).

We conduct programs and activities to deter, detect and address fraud and abuse in all aspects of our operations. We utilize a variety of resources to carry out these activities, including anti-fraud services from other affiliated entities, as well as outside consultants and experts when necessary.

If adverse practice patterns are found, interventions will be implemented on a variety of levels. The first is with the individual practitioners. The emphasis is heavily weighted toward education and corrective action. In some instances, corrective action, ranging from reimbursement of overpayments to additional consideration by UnitedHealthcare's Peer Review Committee— or further action, including potential termination— may be imposed.

If mandated by the state in question, the appropriate state dental board will be notified. If the account is Medicaid, the Office of the Inspector General or the State Attorney General's office will also be notified.

All Network Providers and third-party contractors are expected to promptly report any perceived or alleged instances of fraud. Reporting may be made directly to the compliance helpline at 1-800-455-4521.

Section 10: **Evidence-Based Education**

10.1 Evidence-based Dentistry & the Clinical Policy & Technology Committee

According to the American Dental Association (ADA), Evidence-Based Dentistry is defined as:

"An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences." Evidence-based dentistry is a methodology to help reduce variation and determine proven treatments and technologies. It can be used to support or refute treatment for the individual patient, practice, plan or population levels. At United Healthcare, it ensures that our clinical programs and policies are grounded in science. This can result in new products or enhanced benefits for members. Recent examples include: our current medical-dental outreach program which focuses on identifying those with medical conditions thought to be impacted by dental health, early childhood caries programs, oral cancer screening benefit, implant benefit, enhanced benefits for periodontal maintenance and pregnant members, and delivery of locally placed antibiotics.

Evidence is gathered from published studies, typically from peer reviewed journals. However, not all evidence is created equal, and in the absence of high quality evidence, the "best available" evidence may be used. The hierarchy of evidence used at United Healthcare is as follows:

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies
- Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines)

Evidence is found in a variety of sources including:

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks

Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At UnitedHealthcare, we use evidence as the foundation of our efforts, including:

- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

The Dental Clinical Policy and Technology Committee (DCPTC) is responsible for developing and evaluating the inclusion of evidence-based practice guidelines, new technology and the new application of existing technology in the UnitedHealthcare dental policies, benefits, clinical programs, and business functions; to include, but not limited to dental procedures, pharmaceuticals as utilized in the practice of dentistry, equipment, and dental services. The DCPTC convenes bimonthly and no less frequently than four times per year. The DCPTC is comprised of Dental Policy Development and Implementation Staff Members, Non-Voting Members, and Voting Members. Voting Members are UnitedHealth Group Dentists with diverse dental experience and business background including but not limited to members from Utilization Management and Quality Management.

Section 11: **Governing Administrative Policies**

11.1 Appointment Scheduling Standards

We are committed to assuring that providers are accessible and available to members for the full range of services specified in the DBP provider agreement and this manual. Participating providers must meet or exceed the following state mandated or plan requirements:

- **Emergency appointments** . . . . . Immediately
- **Urgent care appointments**. . . . . Within 24 hours
- **Routine care appointments**. . . . . Offered within 30 calendar days of the request

We will monitor compliance with these access and availability standards through a variety of methods including member feedback, a review of appointment books, spot checks of waiting room activity, investigation of member complaints and random calls to provider offices. Any concerns are discussed with the participating provider(s). If necessary, the findings may be presented to UnitedHealthcare's Quality Committee for further discussion and development of a corrective action plan.

- A true emergency is defined as services required for treatment of severe pain, swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions which if not immediately diagnosed and treated, would lead to disability or death.
- Urgent care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
- Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

Dental offices that operate by "walk-in" or "first come, first served" appointments must meet the above state mandated or plan requirements, and are monitored for access and waiting times, where applicable.

11.2 Missed Appointments

Offices should inform patients of office policies relating to missed appointments and any fees that may be incurred as a result.

11.3 Emergency Coverage

All network dental providers must be available to members during normal business hours. Practitioners will provide members access to emergency care 24 hours a day, 7 days a week through their practice or through other resources (such as another practice or a local emergency care facility). The out-of-office greeting must instruct callers what to do to obtain services after business hours and on weekends, particularly in the case of an emergency.

UnitedHealthcare conducts periodic surveys to make sure our network providers' emergency coverage practices meet these standards.

11.4 New Associates

As your practice expands and changes and new associates are added, please contact us to request an application so that we may get them credentialed and set up as a participating provider.

It is important to remember that associates may not see members as a participating provider until they've been credentialed by our organization.

If you have any questions or need to receive a copy of our Provider Application packet, contact our Provider Services Line at **1-855-812-9210.**

11.5 Change of Address, Phone Number, Email, Fax or Tax Identification Number (TIN)

When there are demographic changes within your office, it is important to notify us as soon as possible so that we may update our records. This supports accurate claims processing as well as helps to make sure that member directories are up to date.

Changes should be submitted to:

UnitedHealthcare
Government Programs Provider Relations
2300 Clayton Road, Suite 1000
Concord, CA 94520

Requests must be made in writing with corresponding and/or backup documentation. For example, a tax identification number (TIN) change would require submission of a copy of the new W9, versus an office closing notice where we'd need the notice submitted in writing on office letterhead.

When changes need to be made to your practice, we will need an outline of the old information as well as the changes that are being requested. This should include the name(s), TIN(s) and/or Practitioner ID(s) for all associates to whom the changes apply.

UnitedHealthcare reserves the right to conduct an on-site inspection of any new facilities and will do so based on state and plan requirements.

If you have any questions, don't hesitate to contact Provider Services for guidance.

11.6 Office Conditions

Your dental office must meet applicable Occupational Safety & Health Administration (OSHA) and American Dental Association (ADA) standards.

An attestation is required for each dental office location that the physical office meets ADA standards or describes how accommodation for ADA standards is made, and that medical recordkeeping practices conform with our standards.

11.7 Sterilization and Asepsis-Control Fees

Dental office sterilization protocols must meet OSHA requirements. All instruments should be heat sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure. The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA guidelines.

Sterilization and asepsis control fees are to be included within office procedure charges and should not be billed to members or the plan as a separate fee.

11.8 Recall System

It is expected that offices will have an active and definable recall system to make sure that the practice maintains preventive services, including patient education and appropriate access. Examples of an active recall system include, but are not limited to: postcards, letters, phone calls, emails and advance appointment scheduling.

11.9 Transfer of Dental Records

Your office shall copy all requested member dental files to another participating dentist as designated by UnitedHealthcare or as requested by the member. The member is responsible for the cost of copying the patient dental files if the member is transferring to another provider. If your office terminates from UnitedHealthcare, dismisses the member from your practice or is terminated by UnitedHealthcare, the cost of copying files shall be borne by your office. Your office shall cooperate with UnitedHealthcare in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

11.10 Nondiscrimination

The Practice shall accept members as new patients and provide Covered Services in the same manner as such services are provided to other patients of your practice. The Practice shall not discriminate against any member on the basis of source of payment or in any manner in regards to access to, and the provision of, Covered Services. The Practice shall not unlawfully discriminate against any member, employee or applicant for employment on the basis of race, ethnicity, religion, national origin,

ancestry, disability, medical condition, claims experience, evidence of insurability, source of payment, marital status, age, sexual orientation or gender.

11.11 Cultural Competency

Cultural competence is of great importance to the field of dentistry. In an increasingly diverse society, it is necessary for dental professionals to be culturally competent health care providers. Cultural competence includes awareness and understanding of the many factors that influence culture and how that awareness translates into providing dental services within clients' cultural parameters.

UnitedHealthcare recognizes that the diversity of American society has long been reflected in our member population. UnitedHealthcare acknowledges the impact of race and ethnicity and the need to address varying risk conditions and dental care disparities. Understanding diverse cultures, their values, traditions, history and institutions is integral to eliminating dental care disparities and providing high-quality care. A culturally proficient health care system can help improve dental outcomes, quality of care and contribute to the elimination of racial and ethnic health disparities.

UnitedHealthcare is committed to providing a diverse provider network that supports the achievement of the best possible clinical outcomes through culturally proficient care for our members.

This website contains valuable materials that will assist dental providers and their staff to become culturally competent: **http://www.hrsa.gov/culturalcompetence/index.html**

Section 12: **Plan Specific Information**

12.1 Plan-specific information

In Virginia, UnitedHealthcare offers the following products for the Medicaid Long Term Services and Support (LTSS) program members, otherwise referred to as the Commonwealth Coordinated Care Plus Program:

- UnitedHealthcare Community Plan

The dental benefit is limited to preventative and diagnostic treatment for adults. There are no patient copayments or coinsurance for covered services. Covered services are paid at 100% of the provider's fee schedule amount for that service, subject to additional requirements in the provider agreement and contained in this Manual.

12.2 Medicaid LTSS Overview

The Virginia Medicaid Long Term Services and Support (LTSS) Program, also referred to as the Commonwealth Coordinated Care Plus Program (CCC), serves members throughout the Commonwealth of Virginia with complex care needs through an integrated delivery model. The LTSS Program uses a care management approach for the centralized coordination of care for patients.

UnitedHealthcare Community Plan offers a value-added dental benefit for adults that includes preventative and diagnostic care.

APPENDIX A: **Attachments**

A.1 Fraud, Waste and Abuse Training

Providers are required to establish written policies for their employees, contractors or agents and to provide training to their staff on the following policies and procedures:

1.Provide detailed information about the Federal False Claims Act,

2.Cite administrative remedies for false claims and statements,

3.Reference state laws pertaining to civil or criminal penalties for false claims and statements, and

4.With respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs,include as part of such written policies, detailed provisions regarding care providers policies and procedures for detecting and preventing fraud, waste and abuse.

The required training materials can be found at the website listed below. The website provides information on the following topics:

- FWA in the Medicare Program
- The major laws and regulations pertaining to FWA
- Potential consequences and penalties associated with violations
- Methods of preventing FWA
- How to report FWA
- How to correct FWA

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

A.2 Practitioner Rights Bulletin

If you elect to participate/continue to participate with UnitedHealthcare, please complete the application in its entirety; sign and date the Attestation Form and provide current copies of the requested documents. You also have the following rights:

To review your information

This is specific to the information the Plan has utilized to evaluate your credentialing application and includes information received from any outside source (e.g., malpractice insurance carriers; state license boards) with the exception of references or other peer-review protected information.

To correct erroneous information

If, in the event that the credentialing information you provided varies substantially from information obtained from other sources, we will notify you in writing within fifteen (15) business days of receipt of the information. You will have an additional fifteen (15) business days to submit your reply in writing; within two (2) business days we will send a written notification acknowledging receipt of the information.

To be informed of status of your application

You may submit your application status questions in writing or telephonically.

To appeal adverse Committee Decisions

1. Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.

2. Providers rejected for recredentialing based on a history of adverse actions, and who have no active sanctions, have appeal rights only in states that require them or due to Quality of Care concerns against DBP members. An appeal, if allowed, must

be submitted within 30 days of the date of the rejection letter. The provider has the right to be represented by an attorney or another person of the provider's choice.

3. Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least 1 member who is of the same specialty as the provider who is submitting the appeal.
4. PRC will consider all information and documentation provided with the appeal and make a determination to uphold or overturn the Credentialing Committee's decision. The PRC may request a corrective action plan, a Site Visit and/or chart review.
5. Within 10 days of making a determination, the PRC will send the provider, by certified mail, written notice of its final decision, including reasons for the decision.

Credentialing Supervisor
Credentialing Department
2300 Clayton Road, Suite 100
Concord, CA 94520

All documents regarding the recruitment and contracting of providers, payment arrangements, and detailed product information are confidential proprietary information that may not be disclosed to any third party without the express written consent of UnitedHealthcare, Inc.