Healthplex Provider Manual

Provider Services
Commercial PPO
& Dentcare plans 877-363-4627
Government plans 877-282-7012

Online
www.UHCdental.com

healthplex

CONTENTS

Welcome to Healthplex, Inc. We're excited to have you as one of our network healthcare professionals.

Healthplex, a part of the UnitedHealthcare organization, is committed to providing access to high quality affordable dental care and to improving the oral health of our community.

This provider manual is an extension of your Healthplex Provider Agreement. It is designed to be a comprehensive reference guide with tools and information needed to successfully administer Healthplex plans. As changes and new information arise, updates to the manual will be posted on the Provider Portal, along with the latest version of the manual. Sign in to UHCdental.com and select Manuals/Other Supporting Documents under Quick Links.

Whether you are new to Healthplex, or a long-standing provider of care to Healthplex members, we thank you for your participation in our network. If you have any questions or concerns about the information contained within this provider manual, please contact the Healthplex Provider Services team at the telephone number listed on the cover of this manual.

Provider Online Academy

Provider Online Academy is a resource for 24/7, on-demand, interactive, and self-paced courses for providers that cover the following topics:

- Dental provider portal training guide and digital solutions
- Dental plans and products overview
- Up-to-date dental operational tools and processes
- State-specific training requirements

To access Provider Online Academy, visit UHCdental.com/provideracademy.

Required trainings

To remain compliant with the New York State Department of Health requirement, all participating health care professionals who have regular and essential contact with our Medicaid members are required to complete the New York cultural competency training by December 31st annually.

To complete the training:

- Visit uhcdental.com/provideracademy > State-specific training page > New York
- Select the "New York Specific Cultural Competency Training - Required Training"
- Start course to complete the attestation form and submit
- After submitting the completed Attestation, click the link found on the next page. You will be directed to the U.S. Department Of Health and Human Services website to register and complete the training.

2.1 HEALTHPLEX CLIENT REFERENCE GUIDE

Healthplex participating providers may see members from the following clients.

Client	Commercial PPO Dentcare	Government: • Amida Care • ConnectiCare • Elderplan/Homefirst • Excellus Blue Cross Blue Shield • VNS/SelectHealth • Univera
Portal	UHCdental.com	UHCdental.com
Provider Services #	877-363-4627 8 a.m.–5 p.m. ET, M-F (IVR: 24/7)	877-282-7012 8 a.m.–5 p.m. ET, M-F (IVR: 24/7)
Payer ID #	52133	52133
PTE/Prior Authorizations	Online: UHCdental.com Mail: P.O. Box 30567 Salt Lake City, UT 84130-0567	Online: UHCdental.com Mail: P.O. Box 30605 Salt Lake City, UT 84130-0605
Claims	Online: UHCdental.com Mail: P.O. Box 30567 Salt Lake City, UT 84130-0567	Online: UHCdental.com Mail: P.O. Box 30605 Salt Lake City, UT 84130-0605
Corrected claims or adjustments	P.O. Box 30567 Salt Lake City, UT 84130-0567	P.O. Box 30605 Salt Lake City, UT 84130-0605
Claim disputes or appeals	P.O. Box 30569 Salt Lake City, UT 84130-0569	P.O. Box 30569 Salt Lake City, UT 84130-0569

2.2 MEMBER ELIGIBILITY

Eligibility should be verified on the date of service. Eligibility may be verified one of three ways:

1. Online Provider Web Portal (UHCdental.com)
2. Interactive Voice Response (IVR) available through the Provider Services line
3. By speaking with a Provider Services Representative

Important Note: 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.**

2.3 ONLINE PROVIDER WEB PORTAL

The Healthplex website, UHCdental.com, offers many time-saving features including eligibility verification, prior authorization, claims submission and status, remittance, procedure level pricing, fee schedules, benefit information, provider search and much more 24 hours a day, seven days a week.

We also have a self-service feature that allows your office to validate, change and attest to your office information online. Participating providers are expected to validate and attest to their

demographic information every 90 days. To access this feature, click on Provider Self Service after you register and log in to UHCdental.com.

For registration instructions and information on using our portal, please refer to the online User Guide at UHCdental.com. If you have any questions or need assistance with registration, contact Provider Services.

2.4 INTEGRATED VOICE RESPONSE (IVR) SYSTEM

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

Through this system, network dental offices can obtain immediate eligibility information, check the status of claims and receive an explanation of benefits. The system also has the ability to fax eligibility confirmation directly to the caller.

Refer to the Healthplex Client Reference Guide in Section 2.1 for the appropriate Provider Services number.

3.1 CLAIM SUBMISSION OPTIONS

Paper Claims

When submitting a paper claim, dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2019 version or later). Refer to Section 2.1 Healthplex Client Reference Guide for the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

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.

Electronic Claims

Electronic Claims Submission refers to the ability to submit claims electronically versus 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).

The Healthplex payer ID number is 52133. If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may sign up with one to initiate this process.

The Healthplex website (UHCdental.com) also offers the feature to directly submit your claims online through the provider portal. Refer to Section 2.3 for more information on how to register as a participating user.

3.2 URGENT REQUESTS – FOR URGENT PRE SERVICE REQUESTS

In emergency situations requiring prior authorization of benefits, contact Provider Services to facilitate receipt and processing of the request.

3.3 TIMELY SUBMISSION (TIMELY FILING)

It is the provider's responsibility to submit claims in a timely manner. All claims should be submitted within:

- 180 days from the date of service for Commercial PPO claims
- 90 days from the date of service for Government claims

All adjustments or requests for reprocessing must be made within 365 days from date of service, or date of eligibility posting, only if the initial submission time period has been met. An adjustment can be requested in writing or by phone.

Secondary claims must be received within 365 calendar days of the primary payer's determination.

3.4 ELECTRONIC PAYMENT AND STATEMENTS

The ePayment center is an online portal which will allow you to enroll in electronic delivery of payments and electronic remittance advice (ERA).

Through the ePayment Center, we will continue to offer a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the ePayment Center enrollment portal.

ePayment Center allows you to:

- Improve cash flow with faster primary payments and speed up secondary filing/ patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7
- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

1. Visit UHCdental.epayment.center/register
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and setup your account
5. Log into UHCdental.epayment.center
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click "Submit"
10. Upon completion of the registration process, your bank account will undergo a prenotification process to validate the account prior to commencing the electronic fund transfer delivery. This process may take up to 6 business days to complete

Need additional help? Call 1-855-774-4392 or email help@epayment.center.

In addition to a no-fee ACH option, other electronic payment methods are available through Zelis Payments.

The Zelis Payments advantage:

- Access all payers in the Zelis Payments network through one single portal
- Experience award winning customer service
- Receive funds weeks faster than mailed checks and improve the accuracy of your claim payments
- Streamline your operations and improve revenue stability with virtual card and ACH
- Protect your account with 24/7 Office of Foreign Assets Control (OFAC) fraud monitoring
- Reduce costs and boost efficiency by simplifying administrative work from processing payments
- Gain visibility and insights from your payment data with a secure provider portal. Download files (10 years of storage) in various formats (XLS, PDF, CSV or 835)

Each Zelis Payments product gives you multiple options to access data and customize notifications. You will have access to several features via the secure web portal.

All remittance information is available 24/7 via provider.zelispayments.com and can be downloaded into a PDF, CSV, or standard 835 file format. For any additional information or questions, please contact Zelis Payments Client Service Department at 1-877-828-8770.

3.5 COORDINATION OF BENEFITS

Coordination of Benefits (COB) is used when a member is covered by more than one dental insurance policy.

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.

If the patient is a dependent child, the primary coverage would be that of the parent whose date of birth is earliest in the calendar year.

For Medicaid plans, Medicaid is always the payer of last resort.

Federal law takes precedence over State law and private contracts. Medicare is the secondary payer regardless of state law or plan provisions.

3.6 OVERPAYMENT RECOUPMENT

Healthplex cannot go back more than two (2) years for a recoupment unless it is for fraud and recovery efforts required by state or federal governments (Insurance Law Section 3224-b).

In the case of government Managed Care Plans, overpayments discovered as a result of an audit by a Health Plan can be recouped going back as far as six (6) years.

Healthplex must allow our providers the opportunity to challenge an overpayment recovery of previously paid claims. Within thirty (30) days of the provider receiving the Refund Request Letter, the provider may challenge Healthplex's request for reimbursement in writing. The challenge should outline the specific groups on which they are challenging the recovery. Copies of relevant Explanation of Benefits, Coordination of Benefits information, and/or the calculation used to base the refund request can be supplied to the provider upon request. If the provider needs additional time after receiving the relevant information, Healthplex will allow fifteen (15) days for the provider to submit a final summary of their challenge, including any supporting documentation. Once Healthplex receives the final summary from the provider, Healthplex will respond in writing with the final determination in a timely manner.

4.1 SPECIALTY REFERRAL

No authorization is needed for participating dentists to refer members to a specialist.

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.

To obtain a listing of participating dental network specialist, go to our website at UHCdental.com. Click "Find a Dentist" on the top right and then choose member's plan type to search by location. You may also contact Provider Services at the telephone number listed in Section 2.1 Healthplex Client Reference Guide.

4.2 GUIDELINES FOR PARTICIPATING PROVIDERS

Patient Records

All patient records must be retained for 10 years. Healthplex reserves the right to access these records and expects the office to have procedures in place to retrieve any necessary records if stored off site during this time period.

Administrative Fees

Healthplex does not reimburse providers an administrative fee for the following:

- **No Show/Missed Appointments** - The Federal Centers for Medicare and Medicaid Services (CMS) has advised the State that government plan providers are prohibited from billing beneficiaries, including but not limited to, Medicaid and CHP managed care enrollees, for missed appointments.

Healthplex general dentists may have members who continually miss appointments removed from their roster by contacting Provider Services.

- **Medical Record Copy Fee** - If it is a provider's practice to charge patients for copies of their medical records (private pay and third party insurance), providers may bill the plan enrollee. **Note:** Sections 17 and 18 of the Public Health Law stipulate that the maximum amount that may be charged for paper copies of health records and/or patient information furnished pursuant to such sections may not exceed seventy-five cents per page.

Capitation

Capitation is an alternative to the traditional PPO/Indemnity insurance system. Under a capitation arrangement, the General Dentist is compensated monthly at a PMPM (per member per month) rate.

If you are contracted under a capitated arrangement, you will receive a monthly capitation roster listing all assigned members and their capitation rates. Each roster also includes member ID numbers, group numbers, and reflects any changes made during the previous month.

Member scheduling should adhere to the defined appointment standards in Section 10.6.

Encounter submission is required for all services rendered and can be submitted directly to Healthplex through the provider portal at UHCdental.com.

Fee-For-Service

For each covered procedure, the dental office agrees to accept the amount on the fee-for-service schedule of allowance for each respective plan.

The reimbursement rate on the schedule of allowance is inclusive of any lab fees.

Covered Services

Guidelines listed in the MMIS Guidelines of the state the provider is practicing in are all inclusive for covered services and conform to generally accepted standards of dental practice (please see Section 6 of this Manual).

For those plans that follow the Commercial Managed Care Guidelines, see Section 7.

All covered services are rendered without charge to the patient with the exception of coinsurance, which are collected at the time of service. ADA claim forms (2019 or later version) with required documentation should be submitted to Healthplex.

For prosthetic services, claim forms should be submitted upon completion (insertion).

5.1 DIAGNOSTIC

Diagnostic Procedures Summary

Diagnostic services include the oral examination and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the patient's oral health.

Reimbursement for Radiographs

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation.

Reimbursement for multiple x-rays of the same tooth or area may be denied if Healthplex determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. Healthplex utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health, and the American Dental Association. These guidelines were developed in conjunction with the Food and Drug Administration.

The maximum reimbursement for radiographs shall be limited to the fee for a complete series.

Comprehensive Exams

Comprehensive examinations are used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, prosthetic appliances, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

This applies to new patients, established patients who have had a significant change in health conditions or other unusual circumstances such as established patients who have been absent from active treatment for three or more years.

Periodic Exams

A periodic examination is performed on a patient of record to determine any changes in the patient's dental and medical health status since their previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

5.2 PREVENTIVE

Preventive Services Summary

Preventive services include routine prophylaxis (including supragingival scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures. Prophylaxis includes necessary scaling and polishing.

Fluoride

The topical application of fluoride treatment is usually allowed once every 6 months. Fluoride treatments can be rendered to adults only in the following situations:

- Adults with systemic illnesses that cause xerostomia (dry mouth), or those taking medications with the same result.
- Adults treated with radiation therapy to the head and neck that resulted in xerostomia.
- Adults with a high rate of interproximal caries.
- Adults wearing orthodontic appliances that make it difficult to remove plaque.
- Adults who have been treated for periodontal disease and exhibit recession (exposure of the root surfaces) and sensitivity.

Fluoride treatment should not be routinely rendered to adults who display poor oral hygiene and request to receive the procedure as a substitute for brushing and flossing.

Sealants

- Sealants are covered for patients between age 5 through 15 once in a 60-month period per tooth.
- Sealants should be applied to the occlusal surfaces of all erupted and previously un-restored first and second permanent molars.
- Priority should be given to applying sealants to newly erupted molars.
- Sealants will not be covered when they are placed over restorations.

Space Maintainers

- Space maintainers are a covered service for patients with deciduous or mixed dentitions when determined by a Healthplex Consultant to be indicated due to the premature loss of a posterior primary tooth.
- Space maintainers will not be covered for the loss of a first deciduous molar if the first permanent molar is fully erupted.

A lower lingual holding arch placed when there is no premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

5.3 RESTORATIVE

Restorative Services

- Restorative services (amalgams and composites) are provided upon removal of decay and restoration of dental structures (teeth) to a reasonable condition.
- Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.
- Restorations are expected to last a reasonable amount of time. Repeated unexplained failures will result in Peer Review and may necessitate removal of the dentist from the network. The material used is clinically determined by the dentist.
- Total restoration per tooth by amalgam and/or composite is not to exceed the allowable fee for a four surface filling within a reasonable amount of time.
- If amalgam fillings are not routinely done by an office, the office must use the procedure which is routinely used and must not charge the patient extra.
- Crowns will not be routinely covered if functional replacement of tooth structure with other restorative material is possible.

- Crowns will not be routinely approved on molars that have been endodontically treated without prior approval.

5.4 ENDODONTIC

Endodontic Services Summary

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

Claims must be submitted with pre-operative radiographs.

Pulpotomies

Pulpotomies will only be covered on primary or permanent teeth with no evidence of internal resorption, furcation or periapical pathology for patients up to age 21.

An emergency pulpotomy should be billed as Palliative Treatment.

Root Canals

- Root canal therapy for permanent teeth includes pulpectomy shaping and enlarging the canals, temporary fillings, filling of root canal(s), and progress radiographs. The fee does not include the final restoration.
- The acceptable standard employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet Healthplex's treatment standards, Healthplex can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the Healthplex Consultant reviews the circumstances.
- Claims submitted for root canal treatment services done in an emergency situation should be submitted with recent pre-operative periapical x-rays for retrospective review.

Please note that radiographs are included in the fee for the root canal procedure.

When Root Canal Therapy and Pulpotomy may NOT be covered

- Root resorption has started and exfoliation is imminent.
- Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal), deeming tooth non-restorable.
- General oral condition does not justify root canal therapy due to the loss of arch integrity.
- Tooth does not demonstrate adequate bone support.
- Tooth demonstrates active untreated periodontal disease.

5.5 PERIODONTAL

Periodontic Services

Periodontal scaling and root planing, gingivectomy (associated with drug therapy, hormonal disturbances or congenital defects), and certain other procedures may be considered for coverage (see state MMIS Guidelines for limitations).

The state MMIS Guidelines may provide basic periodontal coverage. Scaling and Root Planing are covered when clinically indicated, but only when documentation is submitted to justify the service. This would include periodontal charting to show pocket depths, a description of the soft tissue, the type and amount of bone loss, the presence of mobility and the prognosis. Periodontal maintenance may also be covered for patients who have previously been treated for periodontal disease.

Gingivectomies may also be covered, but only to treat severe hyperplasia documented by a history of drug therapy, hormonal imbalances or congenital defects.

5.6 PROSTHETIC SERVICES

Removable Prosthetic Services

Provisions for removable prosthesis include initial placement when masticatory function is impaired or when the existing prosthesis is at least four years old and unserviceable.

- All necessary restorative work must be completed before fabrication of a partial denture.
- Abutments for a partial denture must be free of active periodontal disease, and have adequate bone support.
- Removable prosthetics require prior approval. To be considered, mounted full mouth x-rays and complete treatment plans must be submitted for review.
- In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with dentures is required for authorization.
- For Medicaid, partial dentures will generally not be covered if eight points of posterior contact are present.

Reimbursement for Dentures

- Payment for dentures includes any necessary adjustments, repairs or relines necessary during the six (6) month period following delivery of a new prosthesis.
- Indirect relines are covered once every 24 months.

Fixed Prosthetic Services

Fixed bridgework is generally considered beyond the scope of the Medicaid, and Child Health Plus programs.

Covered

For Medicaid, fixed bridgework may only be considered for the replacement of permanent anterior teeth in a mouth exhibiting low caries rate and sound periodontal condition, and only in cases where there is a documented physical/neurological disorder that would preclude placement of a removable prosthesis or in those cases requiring cleft palate stabilization.

Not Covered

Approval will be denied if:

- periodontal involvement is present within the arch.
- root canal therapy is necessary on any tooth in the arch.
- there are any additional missing teeth in the arch.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

In cases other than for cleft palate stabilization, treatment would generally be limited to replacement of a single maxillary anterior tooth or replacement of two adjacent mandibular teeth.

5.7 ORAL AND MAXILLOFACIAL SURGERY

Covered Services

Local anesthesia and routine post-operative care are included in the fees for extractions and will not be reimbursed separately.

"Erupted surgical extractions" are defined as extractions requiring elevations of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Claims for all oral surgical procedures except non-surgical extractions must include a pre-operative x-ray, biopsy report & narrative to be considered for reimbursement.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Not Covered

Prophylactic removal of asymptomatic teeth or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

When to Refer to an Oral Surgeon

Oral surgery procedures may be referred to participating surgeons in the following situations:

- Surgery unable to be performed by the general practitioner.
- Patient's medical condition requires special care and/or general anesthesia.

5.8 ORTHODONTIC SERVICES

Orthodontic Services Summary

Orthodontic services include Limited and Comprehensive orthodontic treatment based on plan benefit guidelines.

For Medicaid and Child Health Plus (CHP) plans, state MMIS Guidelines are applied using the Handicapped Labio-Lingual Deviation (HLD) Index Report. The Handicapped Labio-Lingual Deviation (HLD) Index Report is available for download at UHCdental.com under Resources > Resource library.

Orthodontic records submitted for review must be of acceptable quality standards and of diagnostic value. Records of poor quality will be returned to the provider, and result in the pending of the prior authorization.

Disparities between the condition, or scores, indicated by the provider on the HLD Index Report, and the orthodontic records provided may result in the prior authorization request being returned without being reviewed.

The pre-orthodontic treatment visit does not require prior authorization. Reimbursement is available once per twelve (12) months prior to initiation of orthodontic treatment and includes the consultation; therefore, consultation will not be reimbursed separately.

For an approved course of orthodontic treatment, the orthodontist should retain an Informed Consent Form which must be signed by the patient and parent (or guardian) after they are advised of the following:

- Age limits for orthodontic coverage (if applicable);
- Projected length of treatment;
- Expectations of patient compliance with noted consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner; and,
- The patient responsibility for payment should coverage be lost for any reason.
- Itemized list of services and fees not covered as per contract.

If a provider initiates discontinuation of treatment as dictated by the American Association of Orthodontics, please notify Healthplex as soon as possible.

In an effort to support suitable billing practices, Healthplex utilizes a case fee reimbursement structure for all comprehensive orthodontic treatment approved. Under this structure, a provider agrees to accept this payment in full for orthodontic cases regardless of length of treatment whether short or in excess of the time period allotted to reimbursement. Insertion and retention must be paid by Healthplex for the case fee to apply.

Limited Orthodontic Treatment

Limited orthodontic treatment can be considered for the permanent dentition that does not require, or will eliminate the need for, a full course of comprehensive treatment.

For prior authorization the following shall be submitted:

- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- Orthodontic treatment plan to include description of appliance(s);
- Diagnostic photographs; and
- Diagnostic panoramic radiographs and cephalometric radiographs.

Reimbursement is available once per lifetime and includes appliances, insertion, adjustments, treatment visits, repairs, removal, passive retention visits up to a year and initial retainers.

The case start date is considered to be the insertion date of the appliance(s) which must occur within six (6) months of approval.

Comprehensive Orthodontic Treatment

Comprehensive orthodontic treatment can be considered for the late mixed or permanent dentition, and will not be approved if significant number of primary teeth remain.

For Medicaid and CHP plans, the member must meet the criteria outlined by state MMIS Guidelines to be eligible for treatment. The member's dentition must exhibit an automatic qualifier listed on the HLD Index or score a minimum of twenty-six (26) points on the HLD Index in order to qualify for treatment.

For prior authorization requests the following shall be submitted:

- The completed HLD Assessment Tool;
- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- Orthodontic treatment plan to include description of appliance(s);
- Diagnostic casts or digital study models (when requested);
- Diagnostic photographs;
- Diagnostic panoramic and cephalometric radiographs (when applicable);
- For orthognathic surgical cases: the surgical consult, complete treatment plan and a statement signed by the parent/guardian and recipient that they understand and accept the proposed

surgical treatment, and that the approval for orthodontic treatment is contingent upon the adherence to the surgical treatment plan; and
- Medical diagnosis (when applicable).

Please note: All needed dental treatment (preventive and restorative) should be completed prior to initiating orthodontic treatment.

For Medicaid and CHP plans, in cases where treatment was approved based upon the presence of an impacted anterior tooth (or teeth) not indicated for extraction, an attempt must be made to align the impacted tooth (or teeth). Benefits may be terminated if impacted tooth (or teeth) are extracted.

In addition to submission requirements already noted, the following must be met:

- The prior authorization request to start a case must include treatment visits. Treatment visits will be considered at four (4) quarterly intervals. The maximum number of quarterly intervals to be considered on any one prior authorization is four (4);
- After the initial four (4) quarterly intervals, recertification for the remainder of the treatment is necessary. Please submit current progress photographs with a copy of the treatment record for review.
- The case start date is considered to be the banding date which must occur within six (6) months of approval;
- We routinely require progress photos (with braces either on or off), when the Provider is submitting a claim for orthodontic retention (D8680).
- If an orthodontic case is being considered for continuation of treatment when it has not had a prior approval under the Medicaid program, a completed HLD scoresheet should be submitted by the Provider, along with the standard orthodontic records usually submitted for review.

The case fee includes the active and retention phases of treatment, and is based on eligibility and age limitations.

Documentation for Completion of Comprehensive Cases – Final Records

Attestation of case completion must be submitted on the provider's letterhead to document that active treatment had a favorable outcome and that the case is ready for retention. Procedure code D8680, orthodontic retention, shall be submitted on the visit to remove the bands and place the case in retention.

Continuation of Treatment/Transfer Treatment

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NY Medicaid Program

For continuation of care for transfer cases, a prior authorization must be submitted to request the remaining treatment visits for case completion. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval if applicable;
- A copy of the orthodontic treatment notes if available from provider who started the case;
- A copy of ledger showing payments made by previous carrier when the patient changes insurance;
- Recent diagnostic photographs and/or panoramic radiographs and pre- treatment photos and/or panoramic radiographs if available;
- The date when active treatment was started and the expected number of months for active treatment; and

- If re-banding is necessary: a new treatment plan, estimated treatment time and documentation to support the treatment change is required.

5.9 ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services Summary

Adjunctive general services include general anesthesia, intravenous sedation, consultations, and emergency services provided for relief of dental pain.

Palliative Treatment

Procedure code 9110 is used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph.

If any other services (filling, endodontic, oral surgery, etc.) are billed for on the same day, the palliative treatment code will be denied.

Please include tooth number or area involved.

Intravenous Sedation and General Anesthesia

Intravenous sedation and general anesthesia will only be a covered service for a participating dentist who holds current certification and licensure to administer such anesthesia per state and federal guidelines.

Requests for intravenous sedation and general anesthesia will be reviewed on a case-by-case basis.

A case will be covered for clients with physical and mental health problems of such severity that treatment cannot be reasonably attempted without the use of intravenous sedation or general anesthesia.

Intravenous sedation or general anesthesia may be allowed when a surgical procedure is being rendered.

Claims for sedation must include a narrative of medical necessity.

For cases requiring intravenous sedation or general anesthesia, providers must document the following in the clients chart for appropriate psychosomatic disorders:

- diagnosis,
- description of past evidence of situational anxiety or uncontrolled behaviors, and
- in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group.

Apprehension alone is not typically considered medically necessary.

Intravenous Sedation and General Anesthesia Reimbursement

Services not documented as required may be denied for payment.

Claims for intravenous sedation and general anesthesia should be submitted with the proper procedure code. A narrative should be included indicating the medical necessity.

General anesthesia, intravenous sedation and conscious sedation are only covered in conjunction with covered restorative or surgical dental procedures.

Payment for general anesthesia or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure Code D9310

Procedure code D9310 - Consultation will only be reimbursed to a specialist other than the one providing definitive treatment.

A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist.

When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure Code D9999

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described in the current CDT.

Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

Please refer to www.emedny.org for the most current information on the New York State MMIS Guidelines.

6.1 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 New York State Medicaid Fee Schedule at https://www.emedny.org/ProviderManuals/Dental.

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.

You can submit your authorization request electronically, by paper through mail, or online at UHCdental.com. All documentation submitted should be accompanied with an ADA Claim Form with the box titled "Request for Predetermination/Preauthorization" checked. Refer to Section 2.1 for appropriate mailing address.

Prosthodontics

When submitting for Prosthodontics (Removable) CDT codes D5000-D5899, providers are REQUIRED to:

- submit a Justification of Need for Replacement Prosthesis Form with ALL prior approval requests for replacement denture(s) only if replacement occurs within 8 year frequency limit
- complete the entirety of the Justification of Need for Replacement Prosthesis Form prior to submitting it to Healthplex
- identify if initial or replacement removable prosthesis. Provider must identify if it is a second replacement within the frequency limit per the new form

Implants

When submitting Implant Services D6000-D6199 CDT codes, providers are REQUIRED to:

- submit an Evaluation of the Dental Implant Patient Form with ALL prior approval requests for all dental implants
- complete the entirety of the Evaluation of the Dental Implant Patient Form prior to submitting it to Healthplex

Samples of the Need for Replacement Prosthesis Form and Evaluation of the Dental Implant Patient Form can be found in Appendix A. The forms can also be found on UHCdental.com/resources.

Please note that some Medicare plans administered by Healthplex follow Commercial Managed Care Guidelines; some follow Medicaid Guidelines.

7.1 COSMETIC PROCEDURES

These services include posterior facings, cosmetic bonding, diastemas, etc.

- Inform the patient that the services requested are cosmetic and possibly outside of plan coverage and that they must pay the full fee for such treatment.
- In the event that the patient insists the treatment is covered by the plan, you may send a pre-certification form to Healthplex stating the conditions of the case.
- If authorization is **received**, inform the patient and proceed with the treatment.
- If authorization is **denied**, inform the patient of the costs and treatment time involved and proceed accordingly.

7.2 REPAIR OF DAMAGED FACINGS

- Stained or discolored facings or restorations are cosmetic problems which are not covered, and must be paid for by the patient.
- Cracked, chipped or missing facings:
  - If the appliance can be rebuilt and/or rendered smooth and non irritating without being removed from the mouth, the patient should not be charged as this is a covered procedure.
  - If the appliance must be removed in order to restore or establish function, this treatment is covered and the patient may be required to pay a fee according to the Group Benefit Profile.

7.3 ENDODONTIC TREATMENT

Goal

To perform Root Canal Therapy for patients who have demonstrated effective home care and a willingness to have the tooth restored.

Method

Root Canal Therapy will be performed if:

- The tooth is periodontally sound. If the tooth is periodontally involved, it must be determined that the periodontal situation can be reversed.
- The tooth can be restored to a functional level.
- The patient has previously demonstrated that he/she can maintain the tooth by maintaining an adequate level of oral hygiene.

7.4 ORAL SURGERY

Goal

To treat patients requiring oral surgery in the most effective and efficient manner, and thereby eliminate any present or future dental difficulties.

Method

Routine oral surgery is to be provided by the individual participating dentist.

Oral surgery may be referred to participating surgeons in the following situations:

- Surgery unable to be performed by the general practitioner due to inadequate facilities
- Procedure is beyond the scope of the general practitioner
- Patient whose medical condition requires special oral surgery care

7.5 PERIODONTAL TREATMENT

Goal

To render the mouth in a condition that will enhance the patient's ability to maintain their natural teeth.

Method

1. Perform a complete oral examination including a full series of x-rays; note any significant factors in the patient's medical history and fully chart the condition of the mouth including: existing prostheses, missing teeth, bone loss/pocketing and tooth mobility.
2. Prepare a comprehensive treatment plan including all other anticipated specialty referrals.
3. Inform the patient about all adjunctive dental services necessary to support the periodontal therapy. The patient must agree to pay for those services which may not be covered. (The program DOES NOT cover periodontal splinting.) A disclosure form must be completed, signed and placed in the patient's file.
4. Provide initial periodontal therapy including: prophylaxis, scaling and root planing, and home care instruction. The patient must demonstrate his/her ability and desire to maintain oral hygiene for a period of six months.
5. After the completion of periodontal care, the responsibility for routine dental maintenance will revert to the general dentist.
6. Any extenuating circumstances requiring an exception to the above guidelines will be evaluated by a Healthplex dental consultant.

NOTE:

TMJ cases are not covered and will not be considered for referral. Arthritis cases or other systemic illnesses also will not be eligible for treatment.

7.6 PROSTHETIC TREATMENT

Goal

To provide restorative services that best meet the patient's long term oral health needs. To this end, participating providers will consider the patient's ability to maintain proper oral hygiene and willingness to care for a prosthetic device.

NOTE: As with most dental plans, Healthplex programs cover the most economic treatment alternative that will satisfactorily restore a given condition. This means that intracoronal restorations are covered unless a crown is the only adequate option. Partials may be covered instead of fixed bridges if multiple edentulous areas or free end saddles exist in a given arch.

SECTION 8. MEDICARE

What is Medicare?

- Healthplex administers various Medicare Plans.
- Medicare is a health insurance program for members who are
  - 65 years or older, or;
  - Under 65, but who have certain disabilities or conditions.
- The Original Medicare Plan is offered to members through the Federal Government. This is a fee for service plan that eligible members belong to unless they choose coverage through a Medicare Health Plan.
- Medicare dental benefits are administered by Healthplex through various Medicare Health Plans. Members generally receive all their health benefits through the Plans, and the Plans contract with Healthplex for the dental services. Not all Medicare Health Plans include a dental benefit. But some that do, offer this benefit through Healthplex. The exact dental benefit administered by Healthplex varies by Plan.

Please contact Provider Services for details on Medicare plans you participate with.

Quality Control Methods

Healthplex employs various methods to ensure quality control. Included are provider credentialing, site visits, and the use of forms.

Provider Credentialing

- Ensures that all providers meet the requirements established by the federal and state governments, the State Education and Licensing Department and the Health Plans regarding qualifications to provide dental services to patients.
- Healthplex follows the guidelines established by the National Committee for Quality Assurance (NCQA).

Claim Forms

- Claim forms submitted by our dental providers yield data on the type and quantity of dentistry being done at each site.
- Observed frequencies are compared to established norms. The office submitting statistics deviating from these norms is notified and the matter is referred to the Quality Management Department.

Chart Reviews

- Chart reviews are performed to evaluate the diagnostic, preventive and restorative quality, type and frequency of services being rendered to Healthplex members.
- Random charts from offices are audited for diagnostic and other clinical service checks.
- Identified issues are addressed by Healthplex.

9.1 UTILIZATION MANAGEMENT

Utilization Management Program

A comprehensive program to determine medical necessity for health care services that are proposed, are currently being provided, or have already been provided based on standard clinical and/or utilization criteria.

The goal of the Healthplex Utilization Management program is to utilize healthcare benefit resources, improve medical appropriateness and monitor the quality of services provided. The program's objectives are to:

- Provide access to dental care services in the most appropriate and cost-efficient setting.
- Support providers to enhance patient care and/or access of services.
- Identify members considered "at risk" for incurring extensive health care expenses or requiring extensive and ongoing dental care for chronic or catastrophic illness to promote the most efficient use of available benefit resources.
- Reduce overall dental and healthcare expenditures by developing and implementing programs which encourage preventive health and dental care behaviors.

The program consists of the following components:

Prospective Review

Involves prior review and certification of services including, but not limited to, specialty care services, elective surgeries and selected dental treatments. It also includes review and certification of out-of-plan referrals.

Concurrent Review

Involves the ongoing review of the medical necessity of patient care. The review involves communication with the patient's dentist, chart review and communication with other health professionals involved in the patient's care. The review also involves discharge planning to ensure that services are available to meet the patient's home health planning needs.

Retrospective Review

Involves a review of medical records to make a coverage determination after services that have not been previously authorized have been rendered.

Technology Review

Involves the evaluation of new developments in equipment, dental devices, treatments, dental procedures, surgical procedures, pharmaceuticals and clinical trials.

Scientific evidence and determinations from regulatory bodies are components of the review and form the basis for the decision-making.

Reconsideration of Adverse Determination

Involves a review of clinical data and criteria used in the determination when the member's dental care provider was not involved in the initial determination.

The review is conducted by the dental clinician who made the initial determination.

Appeal of a Denial or Limitation of a Dental Service

In any case where a health plan Member, or a Provider acting on behalf of a health plan Member, with the Member's consent, is not satisfied with the denial, termination or limitation of a dental service, as determined by Healthplex, he/she may file an Appeal. An Appeal received from a Provider without the Member's written consent will not qualify as an Appeal and shall be deemed a dispute of payment of a claim. No Member or Provider who files an Appeal to a Denial, Termination or Limitation of a dental service with Healthplex will be discriminated against and Healthplex will take no retaliation response to the filing of an Appeal to a Denial, Termination or Limitation of a dental service. The goal is to review and conduct all appeals in an expedited manner.

Appeal Procedure

- Healthplex shall establish and maintain a system for the resolution of appeals initiated by members or by providers, acting on behalf of a member and with the member's written consent, with respect to the denial, termination or other limitation of covered dental services ("Denial of Service"). This is referred to as utilization management determinations. Appeals received from a provider without a member's consent will not quality for this process and will be processed as a dispute of payment of claim.
- No member or provider who exercises the right to file an appeal will be subject to disenrollment or otherwise penalized solely due to such an appeal. At no time will Healthplex cease provision of services pending an appeal investigation.

Member Appeals may be oral or written to the claim dispute or appeals phone number or address listed in Section 2.1 Healthplex Client Reference Guide.

9.2 UTILIZATION MANAGEMENT PROGRAM

Overview of Program

Through Utilization Management practices, Healthplex 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, patient encounter forms, and audits, Healthplex 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.

We cannot over-emphasize the importance of encounter data.

This data is the only means by which our client can track provision of services to their members who are assigned to capitated offices.

Once the above analysis is complete, the Utilization Management Committee determines whether a provider is in compliance with group performance standards.

Program Non-Compliance

Providers who are not in compliance undergo review by the Utilization Management Committee to determine the following:

- Reason for Non-Compliance
  - Circumstances beyond the provider's control. (e.g. few visits that quarter lead to a low utilization rate, and provider has demonstrated appropriate outreach mechanisms).
  - Circumstances within the provider's control. (i.e. provider providing fewer services to managed care recipients than other providers in the peer group, provider over utilizing adult fluoride treatment as compared to peer group, etc.).
- Need for a Corrective Action Plan
- Corrective Action Plans may include:
  - On-site visits for chart review.
  - Proof of outreach program. This may include demonstration of an active recall system, including written and/or verbal communication with the patient pool, patient education materials, etc.
  - Sanctions against provider – sanctions range from a warning to removal of the provider from the network. All sanctions are subject to the provider's right to due process and appeal.

Written statement from the provider outlining and/or confirming their plan to correct any issues.

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 Healthplex 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 considered. Additional analysis can determine whether the results are common throughout the group or caused by outliers.

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.

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. Communications must comply with all applicable federal and state requirements regarding privacy and security, as well as those related to efficiency, economy, and quality of care.

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

Utilization Review

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

Retrospective reviews and prior authorization reviews are performed by a licensed dentist or specialist.

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.

Evidence-Based Dentistry and the Dental Clinical Policy and Technology Committee (DCPTC)

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 Healthplex, 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 Healthplex, 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 Healthplex 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 every other month 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.

10.1 GENERAL REQUIREMENTS

Non-discrimination

You will accept members as new patients and provide Covered Services in the same manner as such services are provided to other patients of your practice. You will 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. You will 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.

Federal and State Laws

Provider agrees to comply with all applicable federal and state laws relating to nondiscrimination and equal employment opportunity, including the Civil Rights Act of 1964 (42 U.S.C § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R Parts 80 and 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, any applicable state anti-discrimination laws, and all rules and regulations issued hereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. Provider agrees to provide physical and program accessibility of dental services to persons with physical and sensory disabilities pursuant to Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by any applicable DHFS regulations (45 C.F.R. Part 84) of CMS regulation (42 C.F.R. Parts 417 and 434) and all guidelines and interpretations issued pursuant thereto.

10.2 PROVIDER RIGHTS & RESPONSIBILITIES

Channels of Communication

- Provider and Healthplex understand that in order to maintain a functional business relationship, open channels of communication are imperative between both parties.
- Provider agrees to comply with any of the following requests in a prompt manner:
  - Additional documentation for services rendered
  - Responses to grievances and appeals
  - Inquiries for additional information pertaining to a Member or Member's experience in their office
  - Any additional requests of which timing is a critical factor

Policies and Procedures

Provider agrees to comply with any and all policies, rules and regulations of Healthplex including, but not limited to, claims processing, credentialing, quality or cost containment standards established by Healthplex and Plans. Provider agrees to refer patients that require covered specialty services (oral surgery, endodontics, prosthetics, periodontics and orthodontics, if covered through the Member's benefit plan in the applicable state) that Provider does not perform, only to dental specialists designated by Healthplex.

Amendment or Restated Agreement

Healthplex may amend or restate the Provider Agreement by sending a copy of the amendment or restated agreement to the Provider at least 30 days prior to its effective date. If the Provider does not object to the amendment or restated agreement in writing within the 30-day notice period, then the Provider will have accepted the proposed amendment or restated agreement as of the end of the 30-day notice period. The Provider can object within the 30-day notice period, by providing written notice to Healthplex, then the parties shall confer in good faith to reach an agreement. If such agreement cannot be reached, Healthplex may terminate the Agreement.

New associates

As your office expands and new associates are added, please contact us to request an application. This allows us to credential the associate and list them as a participating provider.

It is important to remember associates cannot see members as a participating provider until they have been credentialed by our organization.

To request a provider application packet, visit UHCdental.com > Join our network or contact Provider Services.

Change of address, phone number, email address, fax or tax identification number

As a participating provider, it is important to notify us of any demographic changes within your practice. This ensures accurate claims processing and helps maintain up-to-date directories for members.

Requests for demographic changes must be submitted in writing with supporting documentation. For example, a TIN change requires a new W9, while an office closing notice must be on office letterhead. In addition, when making changes, the old information and the requested updates, including names, TINs, and Practitioner IDs for all affected associates must be provided.

Changes should be submitted to:

Healthplex – RMO

ATTN: 400-Provider Services

P.O. BOX 30567

Salt Lake City, UT 84130

Fax: 1-855-363-9691

Email: dbpprvfx@uhc.com

Credentialing updates should be sent to:

2300 Clayton Road, Suite 1000

Concord, CA 94520

Participating providers are expected to validate and attest to demographic information available to Healthplex members every 90 days. Demographic information can be attested to through the Provider Self Service function of the provider portal at UHCdental.com.

If you have any questions, contact Provider Services at the telephone number listed in Section 2.1 for guidance.

Panel Closures

General dentists may request that Healthplex close their panel to new members.

Provider Relations must be notified in writing and be given at least 30 days advance notice of the requested closure date.

Provider/Member Communication

Appropriate Treatment: A determination by Healthplex that a particular course of treatment is not a covered service does not relieve the Provider from providing or recommending such care to Members as he/she deems to be appropriate, and that determination may not be considered to be a medical determination made by Healthplex.

Healthplex expects participating practitioners to communicate with each of their health plan members in the same manner and to the same extent that they would with any patient, consistent with ethical principles and good patient care.

Participating practitioners are free to advise their health plan patients of any particular decisions affecting their treatment in any way, and of any treatment recommendation or coverage decisions made by Healthplex. Practitioners may fully disclose their recommendations regarding a course of treatment or alternative courses of treatment regardless of whether such treatment may or may not be provided by the patient's health benefit program. In the event the recommended course of treatment is not covered by the patient's benefit plan, Healthplex expects participating practitioners to advise their patients accordingly.

This affirms Healthplex's understanding of participating practitioners right to full and open disclosure to their patients of any information determined by them to be necessary and/or appropriate for the diagnosis and care of that patient.

Groups or Additional Offices

The following outlines the requirements for groups or additional offices:

IF...	THEN...
The dentists are practicing in a group setting	The minimum office hours apply to the group and not to the individual dentists.
The practitioner has more than one approved office	The number of hours from each approved location may be combined to meet the standard.

10.3 FRAUD, WASTE, ABUSE

Fraud and Abuse

Every Network Provider and third party contractor of Healthplex is responsible for conducting business in an honest and eithical 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 practitioner. The emphasis is heavily weighted toward education

and corrective action. In some instances, correction action ranging from reimbursement of over payment to additional consideration by Healthplex's Peer Review Committee - or further action, including potential termination - may be pursued.

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

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN4649244

Healthplex Billing Verification

Healthplex has a billing verification process in place for prevention of possible fraud, waste, and abuse. This program evaluates submission patterns and/or billing practices for appropriateness and compliance with expectations. Your office may receive a phone call or letter requesting information necessary for validation of a billing practice or claim amendment according to the below grid:

Change Requested	Verification Letter	No Verification Letter*	Notes
Provider submits request for payment – when should have been prior- authorization	✓		
Services submitted in error	✓		
Date or Code Change	✓		Affects benefit payout (eligibility, time limitation, maximum allowable, etc.)
Prosthetics	✓		Provider should bill upon date of completion (insertion) as based on plan guidelines.
Palliative Treatment on same date as other services	✓		Based on plan guidelines.
Unbundled Services	✓		Based on Healthplex/Provider agreement; for tracking purposes only.
Consultations to Comprehensive Oral Evaluations	✓		Based on plan guidelines.
Periodontal Scaling 4 Quads Performed on Same Date and/or changed to separate dates to allow for payment, or Prophy changed to Perio Scaling or Full Mouth Debridement	✓		Based on plan guidelines.
Incidental Date or Code change		✓	Does not affect benefit payout

Change Requested	Verification Letter	No Verification Letter*	Notes
Tooth # Changed		✓	
Dentist Refunds Money		✓	Cases not involving formal complaint investigations only. For tracking purposes only.

*Tracking – Verification Letter, Site Visit and/or Chart Audit only if pattern detected.

Orthodontic Treatment — Orthodontists are allowed to submit claims for contracted amount regardless of actual dates of service. *Should a member file a complaint, they will be advised that offices are allowed to charge for the contracted amount not the specific dates of service. Once the office is paid for the 24 months of treatment, the office is responsible to complete the treatment.

Please respond to all verification requests expeditiously in order to minimize delays in claims processing and/or payment.

10.4 MEMBER RIGHTS & RESPONSIBILITIES

Member Rights

- All members have the right to receive pertinent written and up-to-date information about Healthplex, the managed care services Healthplex provides, the participating dentists and dental offices, as well as member rights and responsibilities.
- All members have the right to privacy under federal law that protects health information and to be treated with dignity when receiving dental care, which is a private and personal service. Personal information is to be used as part of its regular business, such as payment for services.
- Members cannot be treated differently because of their race, color, national origin, age, religion, disability sex or sexual orientation.
- All members have the right to have decisions pertaining to their treatment based solely upon the appropriateness of care, service and existence of coverage.
- All members have the right to fully participate with caregivers in the decision making process surrounding their health care and to learn all the treatment choices in a clear language they understand.
- All members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
- All members have the right to voice a complaint against Healthplex, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the member's expectations.
- All members have the right to appeal any decisions related to patient care and treatment.
- All members have the right to get health care services in a language they can understand in a culturally sensitive way.
- All members have the right to receive emergency care when and where it is needed.

Member Responsibilities

- All members have the responsibility to provide, to the best of their abilities, accurate information that Healthplex and its participating dentists need in order to provide the highest quality of health care services.

- All members have the responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.

10.5 HIPAA & PRIVACY REGULATIONS

HIPAA & Privacy Regulations

Healthplex providers must comply with all requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information, and agree to cooperate with Healthplex in its efforts to ensure compliance with the privacy regulations put forth under HIPAA and other related privacy laws.

HIPAA and related privacy laws require that providers safeguard member Protected Health Information (PHI) in such administrative activities as claim submission, record keeping, and sharing of member information. Providers must take care to share member information only with entities who have the authority to receive such information, and only with those individuals who need access to such information in order to conduct processes such as treatment, payment, and health care operations.

Please refer to your Healthplex Provider Agreement for detailed HIPAA and privacy information and related requirements.

10.6 APPOINTMENT AVAILABILITY

Standards

Patient Situation	Examples	Timeframe for Appointment
Urgent/Emergency Care	Pain, swelling, bleeding	Within 24 hours of request
Routine	Routine exam, cleaning	Within 28 calendar days

Survey Procedure

Healthplex Provider Servicing staff calls provider offices as if they are members making an appointment.

If the appointment given meets the above standards, the provider office has passed the survey.

If the appointment given is outside the above standards, the provider office has failed the survey.

Survey Failures

Educational outreach regarding the failure will occur with the provider office with remediation that may result in the following actions:

- An office may be closed to new patients until the office is able to accommodate new patients in the timeframe established;
- The office could be terminated from participation with Plan(s).

Appointment Availability Requirements for Connecticut

All PPO Providers in Connecticut are required to follow the required appointment availability standards:

- Urgent appointment wait times within 48 hours.
- Non-urgent appointments for primary care (general dentist) within 10 business days.
- Non-urgent appointments for specialist care within 15 business days.

In addition, the state regulator requires Connecticut dental providers to employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care. As part of the regulation, Healthplex is required to conduct random survey to ensure the after-hours standards are being met.

Appointment Availability Requirements for Maryland

All PPO Providers in Maryland are required to follow the required appointment availability standards:

- Urgent appointment wait times within 3 calendar days.
- Non-urgent appointments for primary care (general dentist) within 45 calendar days.
- Non-urgent appointments for specialist care within 60 calendar days.

In addition, the state regulator requires Maryland dental providers to employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care. As part of the regulation, Healthplex is required to conduct random survey to ensure the after-hours standards are being met.

10.7 AFTER HOURS SURVEY & PLAN PARTICIPATION CALLS

After Hours Survey

Survey calls are made after normal business hours to verify that providers are either available to take patient calls or have a mechanism in place to direct patients appropriately on how to obtain emergency care 24 hours a day, 7 days a week.

Acceptable mechanisms include an answering machine with an outgoing message giving a telephone number and/or directions on how to reach the provider, or an answering service that will contact the provider in an emergency.

After Hours Survey Failures

Educational outreach regarding the failure will occur with the provider office with remediation that may result in the following actions:

- An office may be closed to new patients until the office is able to have acceptable mechanisms in place;
- The office could be terminated from participation with Plan(s).

Plan Participation Calls

Calls are made to ascertain whether the provider office staff answering the phone recognize the Plan(s) with which they participate.

Education on Plan participation and follow up information is provided when necessary. Provider education calls or site visit orientations may be scheduled on a periodic basis to further promote an understanding of the Plans.

10.8 CREDENTIALING

To become a participating provider in Healthplex's network, applicants must complete the full credentialing process and receive approval from our Credentialing Committee. To maintain participation, all practitioners are required to undergo recredentialing - typically every three (3) years, unless otherwise mandated by state regulations.

Initial Credentialing

Before acceptance into the network, a dentist's credentials are thoroughly evaluated. Healthplex partners with SKYGEN Dental Hub to collect the necessary data for both credentialing and recredentialing. Timely responses to inquiries from SKYGEN or Healthplex are essential to ensure the process is complete efficiently.

Credentialing includes a review of state license status, sanctions or disciplinary actions, malpractice insurance coverage, and other relevant professional credentials. If any adverse findings are identified, we will request a written explanation, including details of the incident, its resolution, and a corrective action plan to prevent recurrence.

For certain plans or markets, initial facility site visits may be required based on state-specific regulations. Each location must pass the facility review before activation. Your Professional Networks Representative will inform you if a site visit is necessary during the recruitment process.

The Credentialing Committee evaluates all submitted information against established criteria, which are reviewed and approved with input from practicing network providers to ensure alignment with accepted industry standards. If discrepancies are found in submitted forms, Healthplex will request clarification or correction. Providers have the right to:

- Review and correct erroneous information
- Be informed of their application status

Recredentialing

Recredentialing is required to maintain participation and is a condition of your provider agreement. Failure to comply with the recredentialing process may result in termination for cause.

Recredentialing requests are sent months prior to the recredentialing due date. In the request, you will be directed to the SKYGEN Dental Hub to start the process. If SKYGEN is unsuccessful in obtaining a complete recredentialing packet, Healthplex will make additional outreach attempts. If there is no response, a termination letter will be issued to the provider.

In addition to the items verified in the initial credentialing process, Healthplex may also 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

For more details on credentialing, refer to the Credentialing Guidelines available at UHCdental.com.

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

10.9 TERMINATION FROM PLAN PARTICIPATION

Panel Participation Terminations

Participation terminations initiated by Healthplex conform to the applicable contracts and state insurance laws.

Types of Terminations

Automatic terminations include, but are not limited to:

- Loss of license
- Final disciplinary action by a governmental agency or licensing board that impairs the practitioner's ability to practice
- Conviction of fraud
- Insolvency or Dissolution
- Practitioner's death
- Determination of imminent harm to patient

No hearings are required to be offered for automatic terminations.

Terminations for cause include, but are not limited to:

- Failure to comply with Healthplex Quality Assurance Program
- Failure to comply with credentialing criteria
- Unsatisfactory site visit
- Consistent below-average utilization reporting
- Failure to comply with Healthplex and/or State access and availability requirements

Hearings are offered for terminations for cause.

Non-renewal of Practitioner Agreement:

- The Agreement is automatically extended for successive one-year periods unless either party notifies the other that it elects not to renew upon 60 days' written notice prior to the renewal date.

No hearings are required to be offered for non-renewals.

Transition Period

Transition care is used to assist members and to provide continuity of care for patients who are currently undergoing treatment. Practitioners are advised in the termination notice that they must complete any dental work in progress before the termination date. Any exceptions must be approved, in advanced, by Healthplex.

10.10 PROVIDER COMPLAINTS AND GRIEVANCES

Providers can file complaints and grievances in writing to the claim disputes or appeals address listed in Section 2.1 Healthplex Client Reference Guide.

Please include all pertinent information and supporting documentation. Missing information will extend the time period in which complaints and grievances can be resolved.

Provider complaints and grievances will be acknowledged within 15 calendar days.

Determination letters will be sent within 45 calendar days from date of receipt of complaint or grievance, or from date of receipt of all pertinent information and supporting documentation.

Providers are not penalized for filing complaints and grievances.

Provider Information Demographic Change Submission Form

United Healthcare | Dental Benefit Providers

Description of when to use form: To be used by provider if the provider has made changes to ANY of their demographic information (name change, address change, TIN change, etc.). *Form must be signed at bottom to be processed. Please list all providers associated with this change.* ***Failure to sign, list all associated providers requesting the update or attach required documentation will delay your request.***

Providers: To ensure your claims are processed correctly and on a timely basis, if you have had any changes to your demographic information, please ensure you submit your demographic changes **PRIOR** to submitting your claim(s) and within 30 days of the change taking place. For real-time updates and to reduce turn around times by 3-5 days, please visit the Self Service section after registration and log-in on **uhcdental.com**

Please check **ALL** the demographic items that **need** to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right on this box:

Mailing Address: Dental Benefit Providers, Inc. (DBP-CA Inc)
ATTN: Dental Provider Services
PO Box 30567, Salt Lake City UT 84130
Fax: 248-733-6372
Email: dbpprvfx@uhc.com

☐ Please check box if making a TIN (Tax ID Number) change. (***Copy of updated W-9 form is required)*** ***May be subject to new contracting.***

Current Tax ID:	**New Tax ID:**	**Effective date of change :**	**Reprocess Claims? :** ☐ ***Yes***

☐ Please check box if making a dentist name change. (***Copy of updated dental license is required***)

Current Name: (Last) (First)

New Name: (Last) (First)

☐ Please check box if changing specialty. (***Copy of specialty certification is required)*** ☐ Please check box if board certified.

Effective date of the following information change: ☐ Please check if office is handicap accessible.

PRACTICE LOCATION:

(Only complete applicable fields)

☐ Please check box if ***updating practice name or address***

Previous Practice Name:	**New Practice Name:**
Previous Physical Address: (Suite #)	**New Physical Address:** (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)

REMITTANCE ADDRESS:

(Only complete applicable fields)

☐ Please check box if ***updating mailing address*** ☐ Please check box if ***remit is same as office location***

Previous Remit Address: (Suite #)	**New Remit Address** (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)

ADDITIONAL DEMOGRAPHIC INFORMATION

(Only complete applicable fields)

Languages Spoken Other Than English:	**Directory Office website:**	**Directory Email Address:**
Phone Number:	**Fax Number:**	**Internal Email Address:**

New Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun

☐ ***Please check box if Associate Provider(s) need to be termed.*** **Term Reason:** ☐ **Provider Left Practice** ☐ **Other**

Provider(s) associated with the requested change:

Notice*** ***Effective Date*** *may be different than the date of signature on this form. Please be sure your effective date reflects the actual date the change took place.*

AUTHORIZED SIGNATURE: **DATE:**

WPN: Prov W9 Rev Oct 2024

Note: This form should accompany your prior authorization request. It should be attached to the prior authorization through the web portal. Please be sure that the personal health information (PHI) contained on this form pertains to our member and our member's information is not shared with another party or insurance carrier.

Justification of Need for Replacement Prosthesis Form

NEW YORK STATE DEPARTMENT OF HEALTH - Bureau of Dental Review

Provider Name:_____ NPI:_____

Member Name:_____CIN:_____ Age:_____

ADDRESS BOTH ARCHES - COMPLETE EACH APPROPRIATE SECTION

---

1. Reason for replacement of existing maxillary appliance: ___worn/broken teeth ___loose __broken base/framework, __extraction of additional teeth ___lost ___stolen __other

2. Reason for replacement of existing mandibular appliance: ___worn/broken teeth __loose__broken base/framework, __extraction of additional teeth ___lost ___stolen __other

_____

3. If lost, provide explanation of circumstances:

_____.

4. If stolen, provide copy of police report (if available) or a statement containing a detailed explanation of circumstances of the theft. Please indicate which document you are submitting with this form below:

_____ Police Report

_____Statement of circumstances

5. Required field for Partial Dentures:

Maxillary Arch: teeth being replaced:_____, teeth being clasped:_____.

Mandibular Arch: teeth being replaced:_____, teeth being clasped:_____.

6. Has the member requested replacement dentures previously? ___Yes ___No

6a. If yes, is this request being made within eight (8) years of the member's prior request for replacement dentures? __ Yes ___No

6b. If yes, provide an explanation of the preventative measures instituted by the member/caretaker to alleviate this member's need for further replacements:

_____

_____

7. Additional comments pertaining to treatment plan:_____

_____

Provider signature:_____ Date:_____

Note: This form should accompany your prior authorization request. It should be attached to the prior authorization through the web portal. Please be sure that the personal health information (PHI) contained on this form pertains to our member and our member's information is not shared with another party or insurance carrier.

Evaluation of the Dental Implant Patient Form

NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Dental review

Dentist Name:_____ NPI:_____

Member Name:_____ CIN:_____ Age:_____

Medical History:_____

_____

_____.

Current Medications:_____

_____

_____.

Allergies to Medications:_____.

List any significant medical conditions that the member is currently being treated for: _____

_____.

Identify the physician(s) currently treating the member for any of the above-listed medical condition(s):

_____.

Detail the member's medical necessity for dental implants: _____

_____.

Detail why other covered functional alternatives for prosthetic replacement will not correct the member's dental condition:

_____

_____.

The above patient is an acceptable candidate for dental implant surgery: _____Yes _____No

_____

Dentist signature:_____**Date:**_____


healthplex